

PSYCHOSOCIAL ASSESSMENT

IN MENTAL HEALTH

EDITED BY

STEVE TRENOWETH

AND NICOLA MOONE



PSYCHOSOCIAL ASSESSMENT



IN MENTAL HEALTH

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ABOUT THE EDITORS AND CONTRIBUTORS

About the editors

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Nicki Moone is an experienced mental health nurse who works as a lecturer practitioner in Berkshire Healthcare NHS Foundation Trust and the University of West London. As a mental health practitioner Nicki has been involved in developing and delivering services to families and carers for many years. She established a Family Intervention service in Berkshire in 2002, before moving to a lecturer practitioner post in 2009. She is a senior lecturer and the course leader for the BSc, Pg Cert, Pg Dip and MSc in Psychosocial Interventions for Psychosis-Thorn accredited course. Her broad experience as a mental health nurse has led to her specialising in community based mental health care and the use of evidence-based practice. Nicki is currently undertaking a professional doctorate looking at ways to maintain well-being at work amongst mental health practitioners.

About the contributors

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uses methods such as action learning sets and quality improvement methodology. Caroline has a passion for working with carers and facilitates family work in her own Trust. She is involved in several research projects from using sports with people who have severe and enduring mental health problems to CBT and sleep in inpatient mental health wards, and her expertise in service development has been utilised successfully in various areas on inpatient mental health wards.

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John Butler is an experienced mental health nurse, former consultant nurse (Acute Mental Health & Psychosocial Intervention) and Head of Practice Development for a large NHS Trust, and former honorary chairperson of the Luton-based charity, Caraline. John joined University of Central Lancashire as a senior lecturer in mental health in January 2013. He is currently the Course & Mental Health Field Lead for the MSc Pre-Registration Nursing, and Course Lead for the Grad Cert Psychosocial Mental Health Care. Having undertaken specialist training in cognitive behavioural, behavioural family and mental health medication management interventions, which formed the focus of his clinical practice, John has been involved in facilitating educational workshops, short courses and university programmes for mental health

practitioners and student mental health nurses since 1997. John has contributed a number of publications and conference presentations on a range of topics, which have included: the assessment and management of risk in mental health practice; the interface between primary care and specialist mental health teams; understanding generalised anxiety disorder and the anxiety disorders; collaborative approaches to managing depression; service improvement initiatives (including the Productive Mental Health Ward programme, caseload management, and protected therapeutic and engagement time); and the implementation of psychosocial intervention.

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Mark Gillespie is a programme leader and nurse lecturer at the University of the West of Scotland. He has been involved in mental health care for over 30 years, working across a variety of clinical specialisms in both inpatient and community settings. Currently a doctoral student, his thesis investigates the role of assistant grade staff on the clinical development of student mental health nurses and previous research has investigated other aspects of student nurse learning. His current role includes coordinating a masters level programme in mental health care, with pathways available for the development of therapeutic skills, leadership or educational abilities. He has authored several journal articles and is keen to promote publication of the impressive materials generated by students. He has an interest in the Spanish Civil War and has authored a short book on the subject.

Jackie Glenister has been a mental health nurse for several years in a range of posts. She has a particular commitment to working with people using evidence-based approaches and developing these skills within the workforce. She has worked in most mental health services in her career and her special areas of interest are working in community settings and developing services within the community as an alternative to hospital admission. She is a joint service manager for a large urban community mental health team with particular interest in developing the skill mix

of the team with a focus on; encouraging practitioners to undertake psychosocial interventions that will enhance service user experiences of mental health services. She strongly believes that mental health practitioners in a clinical setting are in a position to make a genuine difference to their clients in the journey towards recovery by using a considered and systematic approach to care delivery. Her current focus is to support practitioners to understand the importance of a systematic approach when drawing together assessment information to help the client make sense of their experiences.

Tracey Kearns is a lecturer in the School of Nursing working in the mental health division at The University of Central Lancashire. She is involved in teaching on a number of modules for the Pre-Registration Degree and Masters in Nursing. She also provides teaching on the BSc (Hons) & Grad Cert Psychosocial Mental Health Care. Tracey has provided clinical supervision to students in the clinical setting studying the BSc (Hons) Psychosocial Mental Health Care. She also gained experience in lecturing working as a lecturer-practitioner for 12 months on a part-time secondment at University of Central Lancashire before commencing her current full time position. An experienced mental health nurse and former Specialist Practitioner for Psychosis for a large NHS Trust, Tracey worked with individuals and their families with severe and enduring mental health illnesses and completed additional training to deliver specific family intervention. Tracey has completed additional continuing professional development studies including Brief Solution Focused Therapy and Mentorship and is currently working towards her Post Graduate Certificate in Education. Tracey's main areas of professional interest are: schizophrenia and psychosis, psychosocial intervention, recovery and family interventions.

Fiona Martin is a lecturer in the School of Nursing and Midwifery, Queen's University Belfast and has been active in developing the mental health profile within the School since the early 2000s. Co-production has been an important aspect of her teaching, which she finds brings an authenticity to the learning environment. More recently Fiona was awarded a Florence Nightingale Foundation travel scholarship to explore 'Open Dialogue', a mental health systems approach originating in Finland.

Vicky Naidoo is an occupational therapist who graduated from the University of Southampton in 2007. She is currently working as a clinical lead within the Slough Community Mental Health Team (CMHT) Recovery Team. Vicky is extremely passionate about the recovery approach within mental health services and promotes recovery in all that she does both clinically and academically. She has most recently been responsible for developing a recovery college within her CMHT and the first year of its launch has been very successful. She has worked in mental health services for the duration of her career and completed a PG Dip and then later an MSc in Psychosocial Interventions for Psychosis this year, which focused on carers support groups in particular. Vicky found that specialising within this particular area of mental health was very important in developing her knowledge of the most up-to-date evidence-based practices to support people with severe and enduring mental health conditions. Vicky is currently in the process of publishing her MSc dissertation and hopes that this will be completed early next year.

Mary O'Toole is qualified in both adult and mental health fields of nursing. She has worked in a variety of mental health and general health settings, and has a particular interest in psychosis, medicines management, drug and alcohol addiction and self-management of long-term mental health conditions. She has published a number of articles and book chapters. Mary is a lecturer in mental health nursing at Plymouth University, teaching on both undergraduate and post graduate nursing programmes.

Reuben Pearce is a senior lecturer in mental health nursing at the University of West London leading and teaching on a wide range of courses including BSc/PG Dip pre-registration nursing programmes, independent and supplementary nurse prescribing, crisis intervention and suicide prevention. He has a broad experience working as a mental health nurse with a career spanning over 20 years. He continues to maintain a strong presence in practice through involvement in various initiatives with NHS Trust partners, in particular, skills development in areas of communication skills underpinning systematic assessment, risk assessment and suicide prevention. Reuben is currently undertaking a doctorate exploring educational techniques that improve communication skills in mental health nurses.

Alicia Powell is a senior nurse practitioner. She began her nursing career at West London Mental Health Trust in 2003 after emigrating from Australia. Prior to this she graduated with a Bachelor of Behavioural Science in Psychology from Griffith University, Brisbane in 2000. In the UK, Alicia began as a health care assistant working in secure forensic units at St Bernard's Hospital, Ealing. This was followed by a 3 year secondment to undertake student nurse training at Thames Valley University where she graduated in 2008 with first-class honours. As a registered mental health nurse she initially worked as a staff nurse in an acute ward before moving into community-based mental health services. She has extensive community experience including working within integrated community teams as well as within a dedicated assessment service. In 2016 Alicia helped in the development and delivery of a new Single Point of Access service providing a streamlined entry point into mental health services and 24 hour access to crisis support for service users and their family and friends. Alicia has particular interests in recovery and social inclusion, health promotion, student development and education.

Brian Thomson comes from a background as a community psychiatric nurse and cognitive behavioural therapist, and moved into academia in 1999 to teach CBT and mental health nursing, eventually becoming Course Director for the Masters programme in CBT at the University of Hertfordshire. In 2013 he moved to Paisley where he has developed the Post Graduate Programme in CBT at the University of the West of Scotland. Brian developed the “nine box model” for Formulation as part of his PHD studies and has demonstrated its use both in class and at conferences over the past two years.

Francis Thompson registered as a mental health nurse in 2003, graduating from Southampton University. Francis has worked in a variety of clinical areas across inpatient and community services including older adults services, the National

Psychosis Unit and addictions services. Francis has also spent time as a charge nurse, a community dual diagnosis specialist, a practice development nurse and in education as a lecturer in mental health at King's College London. He has also worked in a number of senior management roles: as the lead for nursing development at Oxleas NHS Foundation Trust and the head of nursing education and standards at West London Mental Health Trust. He joined Plymouth University in August 2014 as an associate professor where he currently leads the mental health nursing team.

Alison Toner has been in nursing for 30 years working in both adult and mental health fields with experience in urology, learning disabilities, older adult, addictions, acute mental health care and education. She is a lecturer in mental health nursing at the University of the West of Scotland and currently the programme leader for the BSc Mental Health Nursing course covering 4 campus sites within the largest school of health, nursing & midwifery in Scotland. Before joining the higher education sector she was the charge nurse of an inpatient dual diagnosis unit. She has 14 years of experience working with pre-registration and post registration nurses both in designing and delivery of programmes. Her main areas of interest are ePortfolio, skills development for mental health student nurses, comorbidity and physical health care of people experiencing mental health issues. Current research interests as part of her Professional Doctorate study relate to resilience in student nurses and student teachers. She is registered with the NMC and is a Fellow of the Higher Education Academy.

FOREWORD

STEPHEN TEE

Mental health care in the UK, and in some other parts of the world, has been through radical transformation over recent decades. There has been a growing awareness of the potential for recovery and new systems of service delivery and coordination that emphasise achievement of a fulfilling life, with those who use services having a greater role in self-determination.

Transformation of this scale will only be sustained by a workforce who understand and embrace the value-set of hope and recovery that enables people to achieve positive life choices. It is therefore perfect timing for a book such as this that focuses on a collaborative and emancipatory approach to psychosocial assessment, the cornerstone to effective mental health practice.

This book is a highly informative and welcome addition to the mental health practitioner toolkit and a ‘must have’ text for anyone working in modern mental health practice. It is not, however, just a ‘how to?’ book of useful techniques, although these are there in abundance, but something much deeper than that, for it explores the contemporary mental health discourse enabling readers to situate their practice within a sound philosophical framework, developing a positive professional identity, which is enlightened, purposeful and transformative.

The move to a socially inclusive, recovery-oriented philosophy is a long way from the overly paternalistic and oppressive approaches of a bygone era, but unless practitioners appreciate the significance of the journey travelled, practice can easily regress. This book not only embraces an overtly psychosocial philosophy but enhances our understanding by relating complex concepts such as normalisation, resilience and psychosocial stress to a practical context so that readers can see the application to real life scenarios. This is further enhanced through helpful exercises and reflective points to deepen understanding.

I would strongly argue that where this book’s key strengths lie is in its engaging and accessible prose rooted in the extensive expertise of the multidisciplinary group of highly experienced health professionals and academics. The depth and scope of clinical knowledge of each of the authors speaks to both existing practitioners and those who are developing their skills and knowledge in preparatory nursing, occupational therapy and other mental health programmes. It is also interspersed with service user quotes that emphasise salient points and make explicit the focus on doing ‘with’ rather than doing ‘to’.

As someone who has worked extensively in mental health care and education I am acutely aware that what practitioners often want is clarity about their role identity and the tools and techniques to engage with service users, and work purposefully toward some shared meaningful goals. This three-part book has been structured in

a considered way that directly addresses these needs. For instance an important element of professional identity is to understand the policy and psychosocial context of practice that guides our stance as practitioners. The first few chapters of Part 1 helpfully spell out UK policy development tracing its origins from the recovery narrative of the 1980's and the need for collaborative and jointly negotiated understanding of needs, wants and wishes, as well as strengths and abilities.

Achieving this is often easier said than done and so in Part 1 the reader is taken on a journey that examines the dimensions and holistic nature of psychosocial assessment. The aim ultimately is to develop a sophisticated case conceptualisation, which is examined in much more detail in Part 3. The authors admit that this can be a complex process but never shy away from their goal to provide clarity and help the reader navigate the challenges they are likely to encounter along the way.

Importantly there is consistency throughout all chapters on emancipatory and empowering approaches and the skills and values that facilitate assessments in partnership with service users. In practice there has been a tendency to resort to the use of rating scales to measure change without fully understanding their use and value. Whilst extremely useful, it is recognised that training in their use is required and so the authors provide helpful tips for achieving competence.

Part Two of the book looks more deeply into the process of psychosocial assessment and on understanding the person's history, their social and interpersonal world as well as their performance and confidence within it. There are always risks that any 'process' can become mechanistic and dehumanised and I found in reading this book there is consistency in the emphasis on the end goal, namely an accurate case conceptualisation. I particularly like the suggestion that the different elements of a full psychosocial assessment can, in themselves, be used as a therapeutic tool for building engagement, developing understanding and fostering hope. In other words, practitioners should never underestimate the opportunity that psychosocial assessment can bring.

A key tenet of the recovery approach is the emphasis on hope and I found this tone reflected throughout the book. One particular example was the examination of satisfaction and happiness and those techniques that can enable individuals to flourish and achieve meaning and purpose. Perhaps one of the most challenging aspects is effective risk assessment and resultant safety planning, in the areas of suicide and self-harm, self-neglect and violence. This is comprehensively addressed examining factors that reduce longer-term risks. Such risks are often exacerbated in the presence of alcohol and drugs and the chapter on substance misuse provides further useful guidance.

It was particularly pleasing to see an oft-neglected area being addressed, namely physical health. Those working in mental health have been criticised in the past for not attending to the physical health needs of people that use mental health services and there is welcome emphasis on health promotion factors that may undermine physical health, such as a lack of exercise, poor diet and smoking.

The need for positive and purposeful engagement is captured in Part 3 which reflects the culmination of the whole process, namely to identify goal statements that are personalised and meaningful and monitored and reviewed within a collaborative and creative relationship. The authors help the reader navigate the process of analysis and integration, case formulation, strengths and needs statements and goals that ultimately seek to make sense of the service user's experiences.

Whenever I am seeking a new text to recommend to my students, I have three basic requirements: is it written by experts who understand contemporary mental health care? Is it underpinned by evidence from research? Is it strongly rooted in recovery-oriented philosophy that reflects modern mental health care?

In this book the editors Steve Trenoweth and Nicki Moone have created a resource that easily meet all these requirements and captures the essence of effective psycho-social assessment. This text will assist mental health practitioners everywhere, to work alongside people with mental health problems in more deliberate, informed and purposeful ways.

PREFACE

As mental health practitioners we are charged with supporting people on their journey towards recovery. Regardless of our area of practice, we are committed to ensuring that service users are empowered to achieve optimal wellbeing and that services offer timely and effective care. As mental health practitioners by nature, we strive to ensure a person-centred approach that reflects a belief in the uniqueness of every person that we work with.

It has long been expected that we offer evidence-based practice to our service users and their families. The combination of clinical skill and best evidence available ensure that we are able to guarantee that service users are offered services to meet with expectation. Comprehensive assessment facilitates good-quality mental health care. Recent developments in mental health care advocate genuine collaboration with service users and their families with an emphasis on hope and optimism. Within the reality of the ever changing mental health care arena, comprehensive assessment is surely the building block upon which all care should be delivered.

In writing this book, we aim to illustrate how the principles, knowledge and techniques of psychosocial assessment in mental health care can complement the specialist skills and knowledge of mental health practitioners to deliver the best possible care.

Scope of this book

This book is intended to introduce psychosocial assessment in mental health. There are many books available on the use of psychosocial interventions in mental health but none that focus specifically on the process of assessments that will inform evidence-based interventions. As mental health practitioners we decided to explore this area in more detail to highlight the necessity of a robust assessment process to underpin and inform decision-making about how best to proceed. We have decided to focus on the service user journey from contact with services through to goal setting to guide the reader through a systematic approach to the assessment process. Although mental health practitioners are well rehearsed in the skill of broad mental health assessment, a challenge faced by many is developing an assessment process that makes best use of the evidence and uses a range of approaches to identify service user strengths and needs. Therefore, as the book progresses it will explore the assessment process from broad mental health assessment through to clarifying assessment strategies to provide the most accurate reflection of the service user's experience. The final chapters of the book will discuss how the information gathered during the assessment process can be drawn together to develop a case conceptualisation. The case conceptualisation helps develop a working hypothesis of the service user's experience, strengths and needs and is used to inform the plan of evidence based interventions.

To set the context of the book, the initial chapters provide an overview of assessment in mental health care and explore the approaches and methods that can be used to develop a robust assessment process. This section also includes the principles that underpin the selection of rating scales and assessment tools to ensure best use of the evidence available and to encourage critical understanding of the processes that underpin clinical decision making. Throughout the book we have tried to ensure that the text is clear and concise and we hope this will ensure that practitioners are more easily able to translate content into the real world of practice. To facilitate this further, we have included opportunities at the end of each chapter to explore and reflect on practice. We hope that by completing exercises at the end of each chapter, this will provoke exploration and adoption of different ways to undertake each phase of the assessment process.

The main body of the book focuses on psychosocial assessment in mental health care. The aim here is to build on the reader's existing understanding of the key concepts that underpin assessment. Simply put – to guide a path from presenting problem towards a comprehensive assessment that reflects collaboration with service users to facilitate their recovery journey. This section is drawn together by exploring mental well-being and strengths and is in line with the philosophical underpinning of the book; the value that is placed on the uniqueness of the individual and an intention to promote optimal well-being.

The final section of the book explores methods to facilitate the process of analysing and integrating the information gleaned during the assessment process. These chapters use a case scenario to help guide the reader through the process of making sense of the wealth of information gathered and explores how to make best use of this to inform evidence-based interventions in line with service user priorities. It is hoped that the final chapters will help assimilate the knowledge garnered throughout previous chapters to develop a clear understanding of how and why a systematic approach to assessment can inform optimal treatment and intervention plans.

Foremost this book has been developed to be a practical guide for practitioners to add to their existing knowledge and skills in conducting mental health assessments. Our intention is to encourage critical appraisal of existing methods of mental health assessment and promote commitment to develop a systematic evidence-based approach to the assessment process. Throughout, the focus is on working in collaboration with a service user using a range of clinical skills and methods. Throughout the book attention has been given to language used to ensure that it reflects the real world of practice. Time and attention has likewise been given to ensure the accessibility of the book, no matter the clinical area of the mental health practitioner. In principle this book is a straightforward text which provides a practical guide to psychosocial assessment in mental health care.

Who is this book for?

This book is intended to be a core textbook for mental health practitioners who are both pre and post registration. Mental health care is delivered in a range of settings and our intention is that the book will meet with expectation of mental health practitioners in all settings and act as a guide to best practice. Each chapter provides an opportunity to explore the content within the reader's area of practice and it is hoped this will promote both reflection and transfer of new skills and knowledge to practice.

The material in the book is most relevant to mental health practitioners but may also act as a resource for allied health professionals working with service users who have mental health issues to provide an overview of areas that may need consideration.

This book provides an overview of the central concepts and techniques of psychosocial assessment in mental health care as relates specifically to use in practice. Its applied approach is designed to ensure that both pre and post registration mental health practitioners will be able to use the content to enhance and develop their practice.

How to use this book

This book outlines how to develop a systematic approach to psychosocial assessment in mental health care. The principles and methods that underpin practice are explored and opportunities are afforded in each chapter to explore the content within the context of practice. Each chapter builds on the last in order to provide you with a full understanding of the assessment process. However, if you have a particular interest in a chapter topic, that chapter may be read independently as you will be directed to related content in others which will enhance your understanding.

Each chapter uses a similar approach to helping you make sense of the content and has been written to ensure that application to practice lies at the core. The learning activities at the end of each chapter have been written specifically to encourage you to think more critically about your practice and to assimilate what you have learnt. Each chapter starts with a set of learning objectives detailing the knowledge you will gain from reading it. Chapters end with a simple summary of the main points for revision and a reflection activity to help you to apply your new knowledge to your practice.

The final section of the book uses a case scenario to highlight how to make best use of the assessment process. The case scenario illustrates the development of a case formulation and subsequent formulation of goals and treatment plans. You are also encouraged to consider how you can make best use of the information gathered during assessment in your own area of practice.

Technical words are highlighted in the text in **bold**, the definitions of which can be found in the glossary at the end of the book.

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PART 1

THEORY AND PRACTICE OF

PSYCHOSOCIAL

ASSESSMENT IN MENTAL

HEALTH CARE



1

OVERVIEW OF ASSESSMENT IN MENTAL HEALTH CARE

STEVE TRENOWETH AND NICKI MOONE



CHAPTER OVERVIEW

This chapter:

- Gives a contextual overview of psychosocial assessments in mental health care.
 - Explores how psychosocial assessments can contribute to quality mental health care.
 - Identifies the central features of, and professional skills needed for, a comprehensive assessment approach.
 - Highlights how the **recovery approach** should underpin assessments by working in partnership and collaborating with service users and clients, an important aspect of contemporary mental health practice.
-

Introduction

Comprehensive assessment facilitates good-quality mental health care. Without knowing what a person's strengths and needs are, or at least might be, one is not in a position to offer appropriate help and support. In recent years, our ideas about

how mental health care and support should be offered have been seen within the context of the recovery approach (National Institute for Mental Health in England, NIMHE, 2005). It is no longer acceptable to do *to* – we must now do *with*. This has considerable implications for any assessment process in terms of not only *what* is assessed but also actually *how* any assessment is conducted. The recovery approach emphasises the importance of a hopeful, optimistic positive approach to mental health care and treatment and of supporting people to live a life of personal value and worth. It also stresses the necessity for active involvement, collaboration and partnership working with mental health service users throughout all care processes, including assessment, in the context of a supportive and **empathic** professional relationship. It values negotiation and shared decision-making between service users and health care professionals, with the aim of supporting self-determination, self-advocacy and self-management by the development of resilience, self-esteem, optimism, a sense of mastery and control of one's life. In the context of psychosocial assessment, the recovery approach stresses a holistic view of the person and focuses on user-defined perceptions of their own strengths, needs and **goals**, recognising that individuals have personal strengths and abilities as well as needs (Department of Health, 2001; Future Vision Coalition, 2008; Jenkins et al., 2008).

EXPERT VOICE

The challenge for the mental health practitioner is trying to meet the competing demands of the service with the expectations of service users and their families. In practice, we develop strategies that help us to manage large amounts of information and very quickly make decisions on how best to proceed. It is this ability that often comes at the cost of developing a systematic approach to assessment. In reality, we often complete a brief assessment based on minimal information and then move swiftly to intervention. Therefore, there is not enough detail to develop a shared understanding of what strengths, needs and priorities are. Without understanding these challenges, the mental health practitioner is likely to develop their own plans of care on behalf of an individual in line with what they believe should be the priority.

The origins of the recovery approach can be found in the early writings of Patricia Deegan (1988) and the social recovery model described by Warner (1985). More recently, the work of the Centre for Mental Health (see, for example, the excellent *Making Recovery a Reality* by Shepherd et al., 2008) and the mental health service user movement in general have also been influential in the development of the approach.

There have also been a number of strategic policy initiatives that have endorsed the principles of the recovery approach, such as the now defunct NIMHE *Guiding Statement on Recovery* (2005), which have set the context for contemporary mental health care in England.

In 1999, the New Labour government set out its policy in the Department of Health's (1999) document, the *National Service Framework for Mental Health* (NSFMH), which sought to identify national service standards for mental health as part of an overall modernisation agenda, including: mental health promotion; access

to primary care; delivering of effective services for people with severe mental illness; caring about carers; and preceding suicide (*ibid.*). Effective assessment and screening was seen as vital in ensuring that people were referred to appropriate services for advice, treatment and care and that the national standards were met. The strategy outlined the criteria that should be used in an effective, holistic assessment:

Assessment should cover psychiatric, psychological and social functioning, risk to the individual and others, including previous violence and criminal record, any needs arising from co-morbidity, and personal circumstances including family or other carers, housing, financial and occupational status [and] physical health needs. (*Ibid.*: 43)

The NSFMH also recognised that mental health and social care services should be culturally competent and that assessments are enhanced in a multi-professional context and where a partnership exists between health and social care staff. The need for prompt assessments and subsequent treatment with vulnerable groups (such as prisoners and young people with the first signs of a psychotic illness) was also recognised (DH, 1999).

The replacement for the NSFMH proposed by the New Labour government, prior to the election of the Coalition government in 2010, was *New Horizons: Towards a Shared Vision for Mental Health* (DH, 2009). These proposals sought: to emphasise the need for preventing mental ill health, building individual and community resilience and promoting mental health; to integrate physical health and mental well-being; early intervention; to tackle stigma and promote social inclusion; and the delivery of personalised care with a focus on recovery and ensuring that care is based on an individual's wishes and needs (*ibid.*).

In 2011, the Coalition government built on the proposals outlined in *New Horizons* in their mental health strategy for England, *No Health without Mental Health* (DH, 2011). The strategy takes a **life-course approach**:

recognising that the foundations for lifelong wellbeing are already being laid down before birth, and that there is much we can do to protect and promote wellbeing and resilience through our early years, into adulthood and then on into a healthy old age. (*Ibid.*: 2)

The strategy also seeks to empower mental health service users – ‘no decision about me without me’ (*ibid.*: 3) – to have more of a say about their care and treatment, including choice of provider. Emphasis is also placed on measurable quality outcomes (rather than process targets) and on the freedom for mental health services to innovate and improve the quality of services.

The role of the National Institute for Health and Care Excellence (NICE) is strengthened in the 2011 strategy, as, too, are the quality standards developed by NICE to support the delivery of care, inform commissioning decisions and underpin service inspection (DH, 2010, 2011). For example, the recent NICE Clinical Guideline (CG136) *Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services* (NICE, 2011) outlines a number of quality statements as listed in Table 1.1. Emphasis in

these standards is placed on collaborative working with service users, and on shared decision-making. During the assessment phase, this collaboration should reveal a joint and negotiated understanding of the service user's perceived needs, wants and wishes, and also details of their strengths and abilities.

Table 1.1 Quality standards developed by NICE, 2011

Quality Statements	
1	People using mental health services, and their families or carers, feel optimistic that care will be effective.
2	People using mental health services, and their families or carers, feel they are treated with empathy, dignity and respect.
3	People using mental health services are actively involved in shared decision-making and supported in self-management.
4	People using community mental health services are normally supported by staff from a single, multidisciplinary community team, familiar to them and with whom they have a continuous relationship.
5	People using mental health services feel confident that the views of service users are used to monitor and improve the performance of services.
6	People can access mental health services when they need them.
7	People using mental health services understand the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues.
8	People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.
9	People using mental health services who may be at risk of crisis are offered a crisis plan.
10	People accessing crisis support have a comprehensive assessment, undertaken by a professional competent in crisis working.
11	People in hospital for mental health care, including service users formally detained under the Mental Health Act, are routinely involved in shared decision-making.
12	People in hospital for mental health care have daily one-to-one contact with mental health care professionals known to the service user and regularly see other members of the multidisciplinary mental health care team.
13	People in hospital for mental health care can access meaningful and culturally appropriate activities 7 days a week, not restricted to 9 a.m. to 5 p.m.
14	People in hospital for mental health care are confident that control and restraint, and compulsory treatment including rapid tranquillisation, will be used competently, safely and only as a last resort with minimum force.
15	People using mental health services feel less stigmatised in the community and NHS, including within mental health services.

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Acknowledgement: National Institute for Health and Care Excellence, *Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services*. Manchester: NICE, 2011. Available at: <https://www.nice.org.uk/guidance/qs14>

What is a Psychosocial Assessment for?

A psychosocial assessment in mental health care seeks to illuminate and clarify the strengths and needs of an individual as a prelude to setting personally meaningful goals. This will, in turn, support the negotiation of individualised care plans, bespoke intervention and treatment options and of measuring the success of such interventions in meeting an individual's **personal recovery outcomes** (see, for example, Ion et al., 2013).

As we have seen from the discussion above, an assessment is an activity that must be done *with* an individual – that is, in keeping with the recovery approach, it must be a person-centred and collaborative process. To this end, the NICE Clinical Guideline 136 (2011; and Table 1.1) highlights another important feature of modern mental health care, that of self-management. By this, we mean the process by which individuals are empowered and supported to take charge of their own care and to recognise when care and treatment may be needed. This is a central feature of crisis management – people recognising an impending emergency and then taking steps to mitigate its impact. In order to facilitate this, mental health assessments should be clear, transparent and instructive. This will help individuals to learn from their experience and recognise both their needs and also their strengths (and how to identify them) in overcoming issues and capitalising on their abilities.

SERVICE USER VOICE

An assessment should be a shared understanding of what is happening for the service user and should be between them, the practitioner, family and anyone else who is involved with the service user. It is crucial that the service user is helped to build on their strengths and that the practitioner understands the different ways that this can be done and in light of the service user's own learning styles. Assessment is not a solitary piece of work, completed and never seen again. Assessment can be used repeatedly to reiterate and determine areas of need and strengths and skills. It is part of a process and not an activity. My understanding is that assessment is often the first step that should help develop meaningful plans; you cannot decide what is the most important thing to concentrate on if you have not looked at everything that affects you. Finally, recovery means different things to us all: perhaps thinking about recovery as a way of acknowledging difficulties and being able to live your life and fulfil your dreams is what we all strive for.

The recovery approach is also about moving beyond the medical/biological dimension of the person, important though this is, to an understanding of the *whole* person. As a consequence, in contemporary mental health care, assessments should be *holistic* and *comprehensive*, encompassing all dimensions of the *self* – from the physical, to the psychological and emotional, to the social and spiritual. This is, indeed, a complex process, as there will also need to be a consideration of the interplay between each of these dimensions.

There are, of course, important elements of shared expertise in this assessment approach (DH, 2001). While service users, their families and carers will have considerable expertise in the experience of the individual, mental health professionals will need to use their clinical expertise and must also be equipped with the latest evidence base. This is an important resource to be drawn upon when negotiating understandings about an individual's current problems, and when collaborating with other members of the multi-professional team on decisions about the way forward in helping the person improve the quality of their lives.

The Assessment Process

While a holistic and comprehensive assessment is likely to be complex, the process itself should be systematic. That is, the assessment process should start off by exploring the current issues that a person is facing (see Chapter 4), before moving on to develop a deeper, shared understanding of the problem(s). This deeper understanding will encompass a number of key areas (see Figure 1.1 and Chapters 5 through to 11 for further information) and there is no particular order in which they should be conducted:

- *Presenting Problem:* the presenting problem will include an initial understanding or conceptualisation of the person's current issues (stressors that may have triggered the problem, factors which have aggravated and maintained the problem, along with factors which help to alleviate the problem) and a review of current treatments. It is vital that the assessment captures the service user's understanding of their current troubles.
- *Social and Environmental Context:* Including the person's family life, current relationships, working relationships, and overall social and vocational functioning. This also includes consideration of the environmental and community context of the individual.
- *Physical Health:* Co-morbid physical health problems should be considered, along with the impact of the mental health need on the individual's current functioning.
- *History:* The person's history may have increased their vulnerability to mental distress and needs to be understood by the assessor, as this may contribute to the ongoing difficulties the service user might be experiencing. Central to this theme is the consideration of factors which may also have previously assisted and supported the client which can be used in the present to support their individual journey to their recovery.
- *Mental State Examination:* A mental state examination will be needed and this will include an individual's appearance and behaviour; speech and language; emotional and mood state; thought and thinking processes; cognition; and the individual's ability to organise and regulate information, along with their insight, problem-solving, decision-making, judgement and planning.
- *Risk Assessment:* Safety is a vital part of assessments in mental health care. A risk assessment for adults must cover, as a minimum, the most common types of risk in mental health care, namely violence, suicide, self-harm and self-neglect.

- *Substance Use:* The possibility of a co-morbid and concurrent substance misuse issue must also be considered in any assessment. An assessment must catalogue the individual's pattern, and extent, of their usage (if any), and possible links to risks must be considered.
- *Strengths and Abilities:* Psychosocial assessments must consider not only the difficulties that a person may be facing in their lives, but also the skills, talents, abilities and assets that help them to cope and manage their current troubles. Assessments must consider the individual's mental well-being and overall satisfaction with life.

It is likely that a variety of different assessment approaches, techniques and methods will be used in the assessment process (including interview, direct observation, questionnaires, **psychometric tools** and rating scales, **self-report** measures, clinical screening and physiological assessments and so on (see Chapters 2 and 3 for more details) in order to explore and gain a deeper and triangulated understanding of the need. However, it is unlikely that all the information required for a comprehensive assessment will be obtained in one session.

There is an associated challenge for mental health professionals here – that is, how to render meaningful the large quantity of assessment data which is likely to be accumulated in this process. The process of analysing assessment information is complex. This includes how to organise and make judgements about assessment data, and



Figure 1.1 An overview of psychosocial assessment in mental health

identifying themes and conceptualising needs in order to build a coherent story of the service user's current experiences. People may present with multiple and complex needs, which may be interrelated, and one of the most important challenges here is to be able to understand and clarify not only the needs but also their strengths and abilities. This process is known as a **case conceptualisation**, where mental health professionals offer structured feedback in order to facilitate a shared understanding and develop a working hypothesis of the need (see Chapter 12 for further information). A case conceptualisation summarises assessment information with an aim of developing a clearer understanding of the issue(s) in order to identify and prioritise needs. This is especially helpful where there are many multiple and complex issues. Crucially, this process helps to collate, organise and summarise information in a way that facilitates communication with service users and other members of the multi-professional team.

A **needs statement** is formulated to clearly illuminate an aspect of the service user's current troubles but it is also important to identify strengths, talents and abilities, which protects the person from harm and which the person can draw on to support their recovery (see Chapters 11 and 13 for further information). This facilitates discussion and affords agreement and shared understandings with the service user. Once a need has been clearly identified, then action can be taken to identify ways to address issues.

These actions are summarised in a **goal statement** (see Chapter 14 for further information). Goal statements are those that clearly identify, prioritise and define personal goals and how any potential obstacles may be identified and overcome. In supporting the achievement of a goal, mental health and non-mental health resources (such as friends, contacts and organisations) may be identified that are supportive of, and relevant to, the achievement of an individual's goals.

The process is summarised in Figure 1.2.

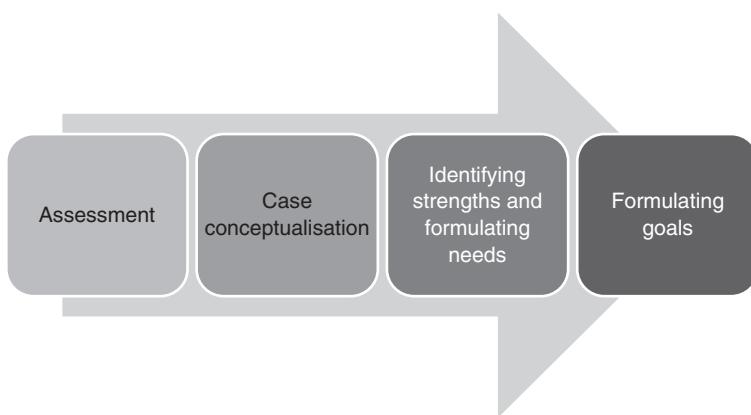


Figure 1.2 The assessment process

Supporting the Assessment Process

The assessment process is complex and there needs to be support for the assessor at both the individual and organisational level. Assessors should have access to clinical

supervision, where they can discuss assessments they have undertaken, so as to check for accuracy and to discuss complex cases and resolve therapeutic stalls in the process. There will also need to be organisational and management support for the sort of assessment discussed above, through the use of policies and ring-fenced time and space. Comprehensive and holistic assessments, grounded in a recovery approach, are likely to be more involved and time-consuming than a medical, symptom-based assessment. However, such assessments are also likely to be more revealing and more helpful in identifying an individual's needs and wishes, and thus more supportive of their personal journey to recovery.

SERVICE USER VOICE

Mental health care is changing all the time: the idea of recovery has replaced the older approaches of just looking at symptoms and not thinking about living life. The recovery approach is based on giving the service user a sense of hope and supporting someone to have a quality of life which is meaningful to them and their family. Recovery is the service user's journey, in which the aim is to reach their full potential and be able to live, cope with and manage their illness and mental health conditions. Recovery will have a different meaning to each individual. For some, recovery will be being completely symptom free, where for others, recovery may be being able to get out of bed in the morning or being able to return to work.

Mental health practitioners need to understand what the service user thinks their recovery is and also share how they, as the practitioner, will help and support this. There is a lot of focus on recovery at the moment and this needs to be more about words: some practitioners still seem to not really understand the recovery philosophy.

Chapter Summary

In this chapter, we have given a contextual overview of comprehensive and holistic assessment in mental health care. Psychosocial assessments in mental health care should be collaborative, recovery-focused and person-centred. Personal and professional skills of rapport-building and engagement facilitate the assessment process. Assessments must be comprehensive, holistic and systematic, and are likely to take into consideration a number of factors, including: the presenting problem; social and environmental factors; physical health; history; mental state examination; risk assessment; substance use; and strengths. This facilitates the shared understanding of development of a case conceptualisation, bringing clarity to the person's need(s) and strengths statements, and the setting of goals.

Assessments must contribute to quality care and we have identified the central features of, and professional skills needed for, a comprehensive and collaborative assessment approach. The recovery approach should underpin psychosocial assessments by working in partnership and collaborating with service users and clients, an important aspect of contemporary mental health practice.

EXERCISE



1. Using the references at the end of this chapter, explore how mental health policy has influenced care delivery. Read *No Health without Mental Health* (DH, 2011; available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf) and then consider the impact that this strategy may have on how contemporary mental health assessments should be undertaken.

CONSIDERATIONS FOR PRACTICE

1. How should the recovery approach influence the assessment process?
2. What preparation does the assessor need to undertake prior to beginning the assessment process?
3. How might the assessor engage with an individual who appears reluctant to collaborate on an assessment?

Further Reading

Barker, P. (2004) *Assessment in Psychiatric and Mental Health Nursing: In Search of the Whole Person*. Cheltenham: Nelson Thornes.

A comprehensive book that clearly makes the case for holism. Barker reminds us that, while technical knowledge and skills in mental health care are important, it is the interpersonal nature of professional caring relationships that facilitates the assessment process.

Nelson-Jones, R. (2014) *Practical Counselling and Helping Skills*, 6th edn. London: Sage.

An excellent and comprehensive guide to counselling and helping skills. Nelson-Jones reminds us of the core skills which are needed to relate to and understand an individual during the assessment process, and as a prelude to offering interventions and support.

Rogers, C. (1951) *Client-Centered Therapy*. London: Constable.

An important and still relevant book that establishes the humanistic nature of the professional helping relationship in mental health care. Rogers reminds us that the goal of helping is not the data that we accumulate through the assessment process, but that this is a means to support the personal road to their recovery, and it is the support of the individual which is the ultimate aim of mental health care.

Shepherd, S., Boardman, J. and Slade, M. (2008) *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health.

An excellent and key resource that outlines, clearly and concisely, the principles and practice of the recovery approach. This work also identified the barriers and resistance to the implementation of this approach and how they may be overcome.

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2

ASSESSMENT APPROACHES AND METHODS

STEVE TRENOWETH, REUBEN PEARCE
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CHAPTER OVERVIEW

This chapter:

- Gives an overview of the different approaches to comprehensive and holistic assessment in mental health care.
 - Explores how assessments can contribute to quality care.
 - Identifies the central features of, and professional skills needed for, a comprehensive assessment approach.
 - Shows how the recovery approach should underpin assessments by working in partnership and collaborating with service users, an important aspect of contemporary mental health practice.
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Introduction

The purpose of any assessment approach is to help the individual convey and narrate their current experiences. There are, of course, many challenges with this and however

we may try, psychosocial assessments in mental health care are not neutral or objective. They reflect the experiences, understanding, motivations and biases of the mental health service user and, in turn, the experiences, understanding, motivations and biases of the assessor. And we can never really fully or completely appreciate another's experience as if we were that person – the best that we can hope for is an understanding that is a close approximation of their experience. Assessments, then, must be approached with a degree of humility and an understanding that such assessments can never be considered definitive. They must be revisited and revised over time, particularly when new information or insights into a person's experience come to light.

Skills and Values Needed for Assessment

Assessment is a skilled process, requiring considerable technical knowledge and skill that aims to support a person to convey a meaningful narration of their experience. There are therapeutic skills that are needed to ensure a person-centred approach, and to promote engagement and develop rapport, and to facilitate and guide discussions. These encompass core skills of agenda setting, communication, **active listening**, using reflective statements, questioning, boundary setting, affirmation and summarising (see below). The assessor will also need attention to detail, and be able to analyse and synthesise complex information. Skills of negotiation and collaboration with service users and the multi-professional team will also be needed.

SERVICE USER VOICE

In order to ensure that the service user is able to feel that they are an essential part of the process of assessment they will need support in managing their current difficulties and in living a fulfilling life. It is my experience that not all practitioners have the same skills or interest in the assessment process and the information that can be derived. Sometimes practitioners' priorities can come into play, ranging from pressure from the organisation, their feelings towards the service user, through to their own stress and difficulties. Practitioners need to understand the issues that affect their judgement and be honest about this. By doing this, the focus can remain on what should be focused on and a genuine commitment to collaborative work with the service user can be had. Service users should also be self-aware and if this is not possible, the practitioner should gently help facilitate this.

There are also personal skills and qualities that the mental health professional needs to demonstrate as part of the assessment process. The assessor will need to have warmth, patience and perseverance and demonstrate a willingness to hear the person's story. They should convey a hopeful and optimistic attitude and be both personally reflective and **reflexive**. Rogers (1951) identified a person-centred approach to counselling, and the qualities needed to facilitate this process. In particular, he identified three central features:

- **Empathy** –Developing an understanding of the service user’s point of view.
- **Congruence** – Being a genuine person.
- **Unconditional positive regard** – Acceptance and being non-judgemental.

EXPERT VOICE

To be a mental health practitioner in health care services today requires a range of values, skills and attributes which enable a person to be able to provide the highest standard of care. Traditional nursing values, including being caring, compassionate and empathetic, are the core qualities that a mental health practitioner should possess. To be able to care for people with mental health issues should be seen as a privilege, and those in this role should embody values such as respect and inclusion of all people, irrespective of their religious, cultural and ethnic group, gender and age. In an ever-changing health care service, those in mental health settings should also be able to serve as a visionary for the future, to improve practice and service provisions, to be part of innovations in order to help change services for the better and to be able to provide a high standard of care.

There are also professional values that are needed to underpin any helping relationship in modern mental health care, and these are guided by ethical codes and guidelines issued by relevant professional bodies. Such values will include empathy and compassion, ethical values and moral principles and the requirement to treat people with dignity and respect. Crucially, the assessor must: approach an assessment with an open mind; possess a desire to reflect on their own practice; have a degree of self-awareness, and a willingness to recognise how their own biases and misunderstandings may lead to subjectivity in the assessment process.

Essential Communication Skills for Assessment

Undertaking an assessment in mental health care requires an ability to communicate effectively. Without effective communication, it is unlikely that any collaborative discourse will occur. Poor communication can hinder the formation of a therapeutic alliance, of which assessment is a crucial part. In fact, poor communication alongside a lack of self-awareness can even lead to a misinterpretation of someone’s experiences. So, the skills needed in order to be an effective assessor are: excellent facilitative communication skills; a desire and an ability to develop positive relationships with service users and their families and friends; and a degree of self-awareness through reflective and reflexive practice.

A practitioner who is demonstrating high-quality active listening skills can sometimes begin to help someone who is distressed to feel better based on the use of those skills alone (Kagan and Evans, 1995). Active listening demonstrates to the person that you can appreciate what their difficulties mean to them as an individual. Active listening is more than just demonstrating patience and hearing. It involves a range of skills that can be developed by the practitioner’s toolkit for communicating and

relating. Appropriate use of body language, minimal verbal interaction and the art of using the power of silence where appropriate are key components to active listening.

There are three essential active listening skills:

- Appropriate use of silence.
- Minimal verbal interruption.
- Demonstrating active listening through body language.

Such skills, effectively demonstrated, can provide the person with a safe emotional space to think and talk (McCabe and Timmins, 2013). As Rollnick et al. argue: 'A few words carefully chosen, delivered slowly and respectfully, are worth more than many mouthfuls of busy talk' (1999: 33). That is, there is a value to choosing words carefully and in a considered way that facilitates, rather than hinders, the person's narration of their experience. It also provides the practitioner time to reflect and consider their verbal interaction so that it is appropriate, constructive and person-centred. Silence can make the practitioner uncomfortable and feel the need to fill the silence with words which can often be unnecessary and be more about the uncomfortable feeling with the silence, rather than what the person experiencing distress is feeling (Stein-Parbury, 2005).

Types of Assessments

Often, when we are meeting someone for the first time, or when we do not have a clear understanding of the person, we will need to undertake a broad and holistic scoping of the person's current experience. This is the start of what is frequently referred to as a **funnelling approach**, where one starts with initial, broad, opening questions before moving on to probe a specific issue in more depth through detailed questioning. It is vital that, at first, a complete, wide-ranging and holistic assessment is undertaken to enable a full understanding of each individual. If we focus too early on the specific areas, the individual's experience may become 'fractured' and the global picture is lost. As such, other areas that may impact on, or be related to, the perceived primary need may be unknown, ignored or go unmet.

Global Assessments

Global assessments provide an initial framework for a broad understanding of the person's current experiences and encompass all aspects of the biological, social, psychological and even spiritual self. Any health care problem, whether this is primarily psychological or physical in nature, can impact on our holistic health and functioning. Global assessments must reveal the person's subjective understanding of their current difficulties and how this interconnects with, and subsequently affects, the totality of their lives.

For example, a problem we are facing can impact on our personal and interpersonal world and our experiences within it, from our social life (such as our

personal and intimate relationships, finances, work, leisure and so on) to our psychological health (such as our perceptions of our self-efficacy and confidence, and beliefs about our selves and others, including our self-esteem). This can impact our emotional well-being as the person may experience fear, stress, distress and uncertainty about the course that their disorder may take (Sin and Trenoweth, 2010). That is, it is important to understand the individual's perception of their own health, particularly that which is ongoing, long term or resistant to treatment.

There are many examples of such global assessments – one is undertaken by asking a simple question: 'How are you?' or 'How are you feeling today?' Other examples of more structured assessments of health and social care needs use rating scales (such as the Camberwell Assessment of Need; see Phelan et al., 1995) or global assessments of symptomatology – such as the **Brief Psychiatric Rating Scale (BPRS)** (Overall and Gorham, 1988; also see Chapter 3).

Clarifying Assessments

Once an issue or area of need has been identified from the global assessment, this can be clarified and explored more fully by careful and elaborative questioning so as to pursue the topic or line of thinking in more detail. This is known as a **clarifying assessment**. This also reinforces the issue and encourages contemplation.

There are many questioning techniques that can be used to encourage elaboration and to clarify the person's current needs. For instance:

- Asking for a specific example (e.g. 'for example', 'such as ...').
- Asking for clarification (e.g. 'how much', 'when', 'in what way?').
- Use verbal and non-verbal prompts (e.g. 'anything else?', 'what else?', 'can you tell me more about that?').

Specific rating scales can also be used to clarify a person's meaning and to explore their experiences in greater depth (see Chapter 3). For example:

- Beck Depression Inventory (BDI-II) (Beck et al., 1996)
- Beck Anxiety Inventory (BAI) (Beck et al., 1993)
- Beliefs About Voices Questionnaire (BAVQ) (Chadwick et al., 2000)
- Positive and Negative Symptom Scale (PANSS) (Kay et al., 1987)
- Social Functioning Scale (SFS) (Birchwood et al., 1990)

The Assessment Interview

Whatever approach is taken, all assessments need to be facilitated within the context of an interview. Interviewing is a complex and highly skilled task that is designed to help the person to share their experiences verbally. In structuring an assessment interview, a number of key issues need to be considered (see Figure 2.1).



Figure 2.1 The psychosocial assessment

Venue

Before any assessment, consideration needs to be given to the arena within which it will take place, that is, the venue. The venue should be a comfortable and welcoming environment, private and quiet, free from distractions, as this is conducive to developing a collaborative therapeutic alliance. Consideration must be given to the safety of both the service user and assessor, in line with service policies and practice.

Engagement Skills

The best interviews are conversational in style, and seek to put the person at ease. The interviewer should be supportive and reassuring, adopting a quiet, curious tone to encourage talk. Time must be taken to establish a psychologically safe environment within which the person is open and willing to share their experiences without fear. It is important to consider how one's dress, grooming and appearance impact on engagement.

Nelson-Jones (2003) suggests the following to demonstrate to others that you are ready and willing to engage with them in a helping relationship:

- Adopt a relaxed and open body posture.
- Lean slightly forward.
- Use appropriate gaze and eye contact.
- Convey appropriate facial expressions.
- Use 'good' gestures.
- Use touch sparingly.
- Be sensitive to personal space.

Opening Skills and Agenda Setting

Introductions should not be forgotten, along with clarification as to how the person wishes to be addressed. The purpose of the assessment should be clearly explained to the individual. Be honest about the agenda. Explain what the assessment is and how it will be administered. Highlight what you hope to understand and how it will help health care staff to understand the person's experience.

It is important to stress that this is a collaborative activity and the person must feel fully involved in the process. While you, as the assessor, will have your agenda, the service user may have their own, equally important, agenda and you must establish if there is anything that the individual wishes to discuss first. Questions or concerns about the assessment should be answered clearly and directly. Permission to talk and to undertake the assessment should be sought, along with reassurances that the person can bring the interview to a close whenever they wish. A time limit for the assessment should be clearly established and strictly adhered to.

For example:

- 'Hello, my name is Simon. Is it OK if I chat to you? ...'
- 'I have something I would appreciate the chance of talking to you about. It would take about 20 minutes. Would that be OK?' ...'
- '... is there anything you feel we should talk about first? ...'
- '... I would appreciate the opportunity of discussing with you what you feel your current needs are. I have an assessment tool which will help us. I wonder if we could talk about this?'
- 'If it's not convenient to talk to you now, could I have a chat with you later?'

Questioning

Questioning is another key skill that you must develop in order to facilitate successful assessments. Questioning is the main way of getting the information we need. It is important to strike a balance between asking enough questions so that the service user is feeling listened to, but not so many that an intervention begins to feel like an interrogation.

Interviews vary in terms of the amount of structure. Commonly, semi-structured questioning is used to structure an assessment interview. Thought should be given to the phrasing and sequencing of the question, and the interviewer needs to be attuned to the emotional impact of the questions on the individual and the degree to which the questioning makes the person feel comfortable. Checking for understanding and clarifications should be sought on both sides in order to minimise the possibility of misunderstandings.

Throughout an assessment interview, appropriate communication skills should be used to encourage the individual to ‘tell their personal story’. While it is likely that specific questioning will form an integral part of any interview, it is also vital to ensure that people are able to present their problems as stories and that this has led to a ‘narrative-based approach’, which helps the person to describe (and the interviewer to understand) their experiences (Launer, 2002). One such useful approach, used in **motivational interviewing** (Miller and Rollnick, 2012), facilitates and structures the individual’s sharing of their frame of reference and is that of the ‘typical day’ strategy. Here, the service user is asked to conversationally describe a usual or common day in their life, and to annotate how their health status, problem/need or condition impacts on this (Rollnick et al., 1999).

Typically, questions used in interviews are *open* or *closed*.

Open Questions

Open questions are very important, particularly in the initial stages of an interaction. An example of a good open question to begin an interaction could be (after initial introductions): ‘Can you tell me what has brought you here today?’ An open question will very often start with a ‘Can you tell me about’ or ‘How’, ‘What’, ‘Where’, ‘When’, ‘In what way.’ These questions are not at all specific, giving the service user the opportunity to respond in a variety of different ways. Open questions give the service user the opportunity to tell their story and can provide a lot of information that can easily be missed if closed ‘yes’ or ‘no’ questions are used straightaway (Dickson and Hargie, 2006). An open question provides the service user with the opportunity to talk about their own individual experience of the issue, rather than it becoming about the practitioner making their own subjective interpretation. This can reduce the practitioner’s influence on the direction of the service user’s response and can also demonstrate that they have time to listen, which can help in building rapport.

Open questions can provide broad information around the information required. The practitioner can then clarify points and elicit some specific information based on some of the content in the broad response from the service user. The practitioner can then move on to using slightly more focused open-ended questions. An example of this might be that a service user, when responding to the practitioner’s open questions, mentions that they have had a lot of difficulty with relationships. The practitioner might ask a focused question such as: ‘You mentioned that you are having some difficulty with relationships, can you tell me a bit more about this?’

Closed Questions

Closed questions are used to get a very specific response. This might be to gain a crucial piece of information once a service user has talked openly. For example, in trying to understand a person’s feelings prior to a recent suicide attempt, the practitioner

might ask them whether they intended to end their own life or not. Another example might be in the case of the service user who is depressed, malnourished and has said that they are lacking appetite, the practitioner might then ask: 'When did you last eat?', 'Did you manage to finish your meal?' or 'Have you ever felt like this before?'

Closed questioning can be extremely useful in interactions when the person is unable to engage for any length of time due to their current mental state. Service users who are struggling to process their thoughts may find it easier to respond to simple 'yes' or 'no' questions. At the other extreme, closed questioning may be helpful with someone who is excitable and over-stimulated and who may find it difficult to concentrate on, or respond to, open questions because their thoughts are racing.

EXPERT VOICE

If you reflect on many of your own interactions, you can probably assume that you make a lot of decisions over whether you like someone or not very quickly, often within seconds or minutes of meeting them. This demonstrates how much first impressions count and it is therefore important that you work hard on those initial rapport-building stages of your interactions with people who are emotionally distressed. When a person is mentally distressed, some basic communication skills that people value when they meet people for the first time can be lost – such as a warm smile and non-verbal acknowledgement. This may be due to personal anxiety about how to manage the situation. Setting the scene for an interaction is crucial when working with mental distress. Remembering to introduce yourself, your role, why you are there, offering a warm smile, offering eye contact and giving careful consideration to your opening statement can really make the difference to the success of the intervention. Remember to be reading for verbal/non-verbal communication cues as you enter into the room to greet the person. 'How are you today?' with a big smile may not always be an appropriate greeting for somebody who is extremely depressed, agitated or angry! In this case, it may be more appropriate to start the consultation with an empathic statement such as: 'I can see that you are very distressed, thanks for taking the time to see me.' You can also introduce yourself and verbalise your observation by saying: 'I can see that you are very upset. I am here to see if there is something I can do to help you.'

Reflective Statements

Simple reflective statements can be very powerful in encouraging and supporting talk. It also encourages the person to consider and pursue a particular line of thinking when sharing their experiences. There are three core types of reflective statements: repeating, rephrasing and paraphrasing.

Repeating

That is, simply repeating what the service user has said. For example:

Service User: 'I'm so angry at being in this state. Nobody ever listens to me ...'
Interviewer: 'You are angry that nobody ever listens to you ...'

Rephrasing

Expressing the remark in a slightly different way using synonyms. For example:

Service User: 'I'm so angry at being in this state. Nobody ever listens to me ...'

Interviewer: 'It seems to you that no one hears what you are saying ...'

Paraphrasing

The meaning of the service user's remark is inferred and reflected back. A good paraphrase can provide reflections, and underlying meanings/emotions, that are clearer and more succinct than the original statements (Nelson-Jones, 2003). However, a paraphrase should not be a guess, but a statement based on a deep understanding of the person's current position. It should be expressed tentatively, and the service user should be given the opportunity to confirm or deny the paraphrase. For example:

Service User: 'I'm so angry at being in this state. Nobody ever listens to me ...'

Interviewer: 'You feel that you would like to be able to make more decisions about your life ...'

It is also possible to use reflective statements *selectively*. This technique involves focusing on a significant aspect of the person's behaviour and reflecting this back, using selective repeating, rephrasing or paraphrasing. This encourages the pursuit and clarification of a particular line of thinking. For example:

Service User: 'I worry that I drink too much. It helps me cope with my pain.'

Interviewer: 'Your drinking worries you'.

Service User: 'Yes, it does worry me. It's probably time I stopped. I'm still in pain, anyway.'

Interviewer: 'You feel alcohol is not controlling your pain. This worries you and you feel that it's time that you gave up drinking.'

Rating Scales and Assessment Tools

Rating Scales and assessment tools are another way of assessing an individual's experience (see Chapter 3). Typically, they are questionnaires or inventories (or psychometric tests) and are often used to quantify a person's experience. They ask a series of questions, usually in survey form, about a general or particular experience, and ask the rater(s) to assign a value to it. In this way, rating scales are structured ways of asking people to give specific responses to predetermined questions. Examples include symptom-focused rating scales of mental state as mentioned above, such as Beck Depression Inventory (Beck et al., 1996); assessments of physical health, such as pain inventories (e.g. Cleeland, 2009); and personality assessments (e.g. Minnesota Multiphasic Personality Inventory (MMPI); see Hathaway and McKinley, 1940).

Data gathered from such numerical rating scales or tests can be **ordinal** (which refers to the rank ordering of data, such as establishing preferences amongst a choice of options); **nominal** (a fixed number of categories or possibilities, such as 'yes' or 'no', gender, ethnicity, blood type); **ratio** (where each unit of a scale is equivalent

but where there is not a meaningful zero point, such as a Likert rating scales, which allows people to express how much they agree or disagree with a particular statement); or interval (as with interval data but with a zero point, such as height).

Affirming

Affirming statements are a way of demonstrating an empathic understanding, recognition and acknowledgement of the difficulties the person is experiencing or has experienced. Such statements are a means of providing direct, genuine support and encouragement but they can sound insincere or even patronising if you are not being genuine. This is a core element of a **normalising rationale** (see Chapter 4). Examples of affirming statements include:

- ‘That must have been very difficult for you ...’
- ‘I think if I were in your position, I would also find that very difficult.’
- ‘You certainly have had a lot to cope with – more than most people, perhaps’.

Summarising

Summarising is repeating what someone else has said in your own words. In order to do this, a practitioner will need to have been listening carefully. Summarising demonstrates to the service user that they have been listened to and the practitioner is interested in what they are saying. It is also a useful way of drawing a conversation to a close.

Summarising prevents misunderstandings and misinterpretation of information (Moss, 2008) and is an open and non-judgemental technique (Rogers, 1959). The practitioner can view this as an opportunity to share their thoughts about what they have been told and to clarify their own understanding of the service user’s experience – a way of checking with the service user that they have correctly understood.

For example:

‘I’d like to pull together some of the things that you have said so far. Let me know if I have misinterpreted something or if I have missed something out. So, you feel that ...’

‘... is that a fair summary? Have I left anything out?’

Assessment Issues

Remote Assessment

In recent years, there has been an increase in the use of *telemedicine*, that is, *digital* and *remote technologies* (such as telephonically, videotelephony and

teleconferencing, email and mobile technologies via tablets and smartphones) to assess, diagnose, monitor symptoms and treat a range of illnesses and health care problems. For example, **telephone triage** can be used to offer health care advice and guidance, whilst **remote patient monitoring (RPM)** can raise the alarm if a vulnerable person has a fall at home, whilst specialised equipment can monitor a range of vital signs, including weight and blood glucose, at home sending data directly to health care practitioners. This is convenient, and has increased access and availability of general and specialist health care advice, support and treatment, whilst reducing travelling time and costs. However, telemedicine has added a level of complexity for the assessor and awareness of factors that may impact on the **reliability** and **validity** of remote assessments is vital for any assessor. This seems particularly true for **telemental health (TMH)**. Luxton et al. (2014), for example, highlighted the following challenges for remote assessments:

- The lack of an in-person physical presence may mean that the establishment of rapport is compromised or that subtle non-verbal cues (such as body posture, facial expressions, body language and so on) may be missed, along with more overt clinical observations, such as hygiene, self-neglect and use of alcohol.
- Technological issues, such as the quality of connections, bandwidth and equipment, which may mean that remote images are of poor quality, subject to picture break-up or to time delays.
- Service user acceptance of, satisfaction with, and comfort with technology.
- Procedural and ethical issues, such as confidentiality and the possibility that remote assessments may be overheard, or if the person becomes distressed or there are concerns about safety.

In 2012, the Mental Health Foundation (MHF) set up an inquiry to consider the nature of mental health care in the UK in the next 20 to 30 years (MHF, 2013). The outcome recognised that new technology may bring improvements in the delivery of mental health care, but they were cautious, adding:

One-to-one human contact, a smile and kind words have a timeless benefit to people with mental health problems ... Many people will continue to need active support to gain equal benefit from new technology, and this support must be available from within the future mental health workforce. (*Ibid.: 5*)

Recovery-Focused Assessments

In order for an assessment to be a collaborative exercise, it can be very useful for the service user to be involved in collecting information about themselves. Some rating scales and tests are by nature self-report, but there are many other ways in which the service user can be an active participant in the process, and these include keeping journals and diaries about their thoughts, feelings and experiences.

There are also a number of recovery-focused assessments that can be used to help the person consider their current needs and the progress they are making towards their goals and improving their quality of life. For example, personal **timelines** are ways of helping the person to chronologically capture, narrate and review significant events, both positive and negative, successes and failures that have occurred over their life. This can be visual, such as via a river of life (see: www.kstoolkit.org/River+of+Life), which uses the representation of a river as the course of a person's life experiences.

Other recovery-focused assessments include the **Mental Health Recovery Star™** (see www.outcomesstar.org.uk/mental-health/ for further information). This is a tool for supporting and measuring change when working with adults of working age who are accessing mental health support services. It is designed to support individuals in understanding where they are in terms of recovery and the progress they are making. It identifies and measures 10 core areas of life:

- Managing mental health
- Self-care
- Living skills
- Social networks
- Work
- Relationships
- Addictive behaviour
- Responsibilities
- Identity and self-esteem
- Trust and hope

The star also helps to identify any difficulties that people using services are experiencing in each of these areas and how far they are towards addressing them and moving on (in terms of whether the person is currently 'stuck'; or whether they are accepting help; or is believing that their life could be better; or whether the person is learning about themselves and working towards their goals; or whether they are, ultimately, self-reliant and taking control of their lives). In this way, it provides both the service user and the health-care worker a shared language for discussion of mental health and well-being.

Chapter Summary

In this chapter, we have considered the various approaches that may be used in undertaking comprehensive and holistic assessments in mental health care. We have also explored the skills and values that are needed by mental health practitioners to facilitate assessments and have shown how the recovery approach should underpin assessments by working in partnership and collaborating with service users.

EXERCISE



1. Take a close look at the **Mental Health Recovery Star™** (available at: www.outcomesstar.org.uk/mental-health/) and consider how you might use this to structure a recovery-focused conversation to help identify the person's goals, needs and strengths.

CONSIDERATIONS FOR PRACTICE

1. What skills and values do you bring as a practitioner to the assessment process?
2. What assessment approaches might you use with people who are difficult to engage with?
3. Imagine that you are going to assess a person for the first time. How will you plan the initial assessment process?

Further Reading

Nelson-Jones, R. (2016) *Basic Counselling Skills*, 4th edn. London: Sage.

A clearly written book that outlines core therapeutic engagement and communication skills to underpin the therapeutic process. Nelson-Jones is an excellent communicator and his book is highly recommended.

Phelan, M., Slade, M., Thornicroft, G., Dunn, G., Holloway, F., Wykes, T., Strathdee, G., Loftus, L.P., McCrone, P. and Hayward, P. (1995) 'The Camberwell Assessment of Need: the validity and reliability of an instrument to assess the needs of people with severe mental illness', *British Journal of Psychiatry*, 167 (5): 589–95, and doi 10.1192/bjp.167.5.589.

The Camberwell Assessment of Need is used throughout the world as a way of structuring conversations about a person's global health and social care needs. This article shows that the tool is a valid and reliable assessment instrument. It has the benefit that it can be learnt easily and quickly by practitioners from a range of professional backgrounds.

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3

PRINCIPLES OF SELECTING RATING SCALES AND ASSESSMENT TOOLS

MARK GILLESPIE, ALISON TONER
AND MICK FLEMING



CHAPTER OVERVIEW

This chapter:

- Gives a contextual overview of the principles of selecting psychosocial and mental health assessments.
 - Identifies and explains psychometric considerations, including concepts such as validity and reliability.
 - Reviews the practical factors that need to be addressed when selecting a method and process of assessment.
-

Introduction

As assessment is considered the bedrock that supports subsequent treatment choice (Coombs et al., 2013), it is important to understand the options available and the scope of deliberation needed in order to inform a safe, effective and appropriate choice of how best to complete a mental health assessment.

The use of psychosocial and mental health assessments are indicated within several clinical treatment guidelines, adding weight to the efficacy of the use of such assessments in order to ensure that the best treatment is offered to the person. The National Institute for Health and Care Excellence (NICE, 2013) highlight that the aim of psychosocial assessments are to identify personal factors which may explain issues such as self-harm, and can also be an effective way to begin the therapeutic relationship and the journey to recovery for the service user. In addition to inclusion within several of the NICE guidelines (e.g. NICE, 2014), psychosocial assessment is also indicated in many of the guidelines published by the Scottish equivalent of NICE – the Scottish Intercollegiate Guidelines Network (SIGN) (e.g. NHS Quality Improvement Scotland, 2007, 2008; Health Improvement Scotland, 2013) – thus supporting the idea that a robust assessment is a requirement for the treatment that is subsequently delivered.

Psychosocial assessments in mental health care often involve the use of rating scales and assessment tools. Practitioners must select the best scales, meaning those that are: well designed and constructed; the most relevant and effective for the information that needs to be gathered; and the most helpful to the individual to share their experiences. Subsequent information which we gather from people must ultimately be of value to them, and to us. However, unless we are careful, this can become more of a tick-box exercise so that we can evidence that the person has been thoroughly ‘assessed’. Moreover, the importance of selecting the ‘right’ assessment must be of benefit to the person whilst helping to gain sufficient information to support discussions of the best treatment plan.

So, what then is the purpose of undertaking any assessment? It is an information-gathering and structuring exercise so that, as practitioners, we can use our skills and knowledge to help people share and narrate their experiences with the aim of supporting them to move towards recovery. As we saw in Chapter 2, by using interpersonal skills, we begin therapeutic engagement to empower and enable the person to work towards recovery once both parties have a clear idea of the issues to be addressed and the support and abilities that the person has available to them.

What are Rating Scales?

Rating scales can capture people’s experiences of both physical and mental health conditions, ranging from depression, brain injury, cancers, cardiovascular disease and chronic long-term conditions, and allows structured investigations of issues such as severity of symptoms, social function, beliefs and experiences. Rating scales are tools that can be used to obtain a clearer idea about the person’s condition, current problems or needs, or an aspect of those problems or needs. They provide structure to an assessment. They may ask people for their agreement with particular statements or ‘items’ or ask people if they have particular experiences (often by ticking a box marked either ‘yes’ or ‘no’), and, if so, to then rate the extent of such experiences (often by using an ordinal scale). For example, the Satisfaction with Life Scale (SWLS; Diener et al., 1985; also see Chapter 11 and Table 11.3) is a 5-item self-report scale, which respondents rate on a 7-point ordinal scale their agreement with particular statements, where:

- 1 = Strongly Disagree
- 2 = Disagree
- 3 = Slightly Disagree
- 4 = Neither Agree nor Disagree
- 5 = Slightly Agree
- 6 = Agree
- 7 = Strongly Agree

Having a numerical score can be useful to compare an individual with a population mean (to see how far a person's experiences might deviate from the average or general population), and also to compare an individual's score over time – to see if there has been an improvement or deterioration in an aspect of their experience.

Rating scales can be self-report (which are completed by the service user) or clinician-administered, where the practitioner asks a series of questions and completes the appropriate form or interview schedule. This, in effect, becomes a way of structuring an interview.

Later on in this chapter, we will discuss specific issues about how the scales are constructed – suffice it to say that before they are published, a number of techniques are used by the authors to ensure that they are fit for use. For example, if a rating scale was used to try to establish the extent of a person's low mood, then the tool must be able to measure that (known as 'validity'). It should also measure this aspect of a person's experience consistently (known as 'reliability'). After publication, it is not uncommon to see other researchers subsequently testing the claims made by the original authors to see if they can also demonstrate the validity and reliability of the tool, or to make suggestions or modifications to the tool so as to ensure that it continues to be appropriate to use.

Choosing a Rating Scale or Assessment Tool

There are many issues to consider when choosing the appropriate rating scale or tool to use in an assessment. In order for a scale or tool to be effective, there must be a cohesive link between a variety of factors. As outlined in Figure 3.1, the choice of assessment is influenced by: the purpose of the service within which the interaction takes place; the purpose of the assessment in relation to the processes within that service; the documentation used by, and available to that service; the theoretical influences guiding the assessment; the expertise of the practitioner; and by service user need, preferences and capabilities.

In short, for an assessment to be effective, consideration must be given to its *appropriateness, availability* and *usability*. The details of these requirements are explored below in order to identify the key considerations required around the factual and practical influences on the assessment process.

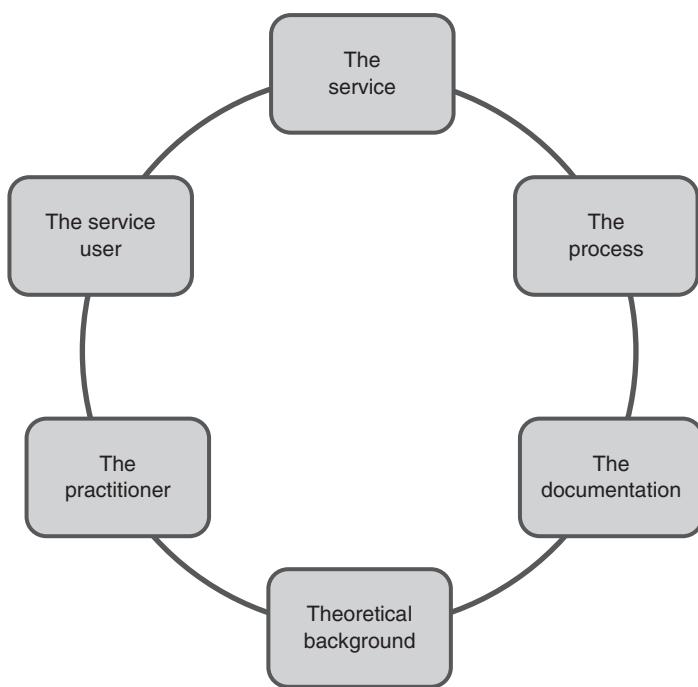


Figure 3.1 Influences on the selection of an assessment format

Appropriateness

A tool can be considered appropriate if it allows us to discriminate between those that have a particular health condition and those that do not have the health condition, or to evaluate and assess the effectiveness of treatment programmes or to predict changes in health conditions (Portney and Watkins, 2009). Practitioners draw inferences from the data collected and will often base clinical decisions on their interpretation of this data. Rating scales or tools are designed to provide structure, consistency and meaning to the process of measurement within clinical practice.

An important aspect of selecting the appropriate assessment tool is to have some indication at the outset of what the psychosocial and mental health difficulties broadly are, and this is often achieved by completing a global assessment (see Chapter 2). This enables the assessor to select the most relevant tool that will ensure that the information-gathering process is a succinct one because, when the assessment is being carried out, the person may be cognitively impaired or in some distress. In a study by Bradford and Rickwood (2012), the authors suggested that most people aged 12 – 25 years preferred pen-and-paper format or verbal disclosure, whereas younger people found self-administered assessments more acceptable. This possibly indicates a generational shift in the understanding of who is responsible for the individual's health. Such individual factors must be taken into account to maximise the accuracy of the assessment. If we use a format that the individual is not familiar with, then will the results of the assessment be a true reflection of the individual's

psychosocial functioning? A further study by Bradford and Rickwood (2014) outlined how, by engaging with relevant stakeholders at the conceptualising stage of development of psychosocial assessment, this ensured person-centred design and a self-reporting tool that was acceptable to users. Selection may also be influenced by a number of factors that do not include which tool is the most relevant. Other considerations include: cost, availability, service preference and skills and qualifications of the practitioners to undertake the assessment because many tools involve pre-administration training (see below and Chapter 2).

Mental health practitioners collect assessment information over time (longitudinally) in order to investigate changes in measured variables such as symptoms, functioning and quality of life, and evaluate the meaning of these changes for treatment. At the same time, the reality of team-working also means that more than one practitioner may undertake and interpret the assessment of the same service user.

Factors Affecting Consistency

A further significant problem with any rating scale or test is that the outcome can be exaggerated or minimised by the rater. This means that the results can be influenced by an individual's personal motivations and goals – a person is free to 'fake good' or 'fake bad'. The way in which the test is administered can also have an impact. For example, if a person is watched when completing the test, then the results are likely to be different than if completing it in private. That is, social expectations are likely to influence a person's responses.

These issues can significantly affect the accuracy of the assessment process as there needs to be consistency in the way in which service users are assessed each separate time, and there needs to be consistency in the way in which each separate practitioner assesses the same service user over time. Meaningful comparisons of measures taken over time require stability in the findings, which relies on the consistency of the assessment (Portney and Watkins, 2009). For rating scales and tools to be consistent, they must demonstrate that they can produce the same values for the same service user each time they are used for assessment purposes. This should be the case, even when the assessment instrument is used by different practitioners (Coolican, 2009). Without this consistency, comparisons are meaningless and any changes found may occur as a consequence of the lack of consistency, rather than real changes in the measured variable caused by treatment interventions.

Design of the Rating Scale

The wording of the questions used in assessment instruments, the structure and the scoring system can mediate the accuracy and credibility of those instruments. If the wording of questions does not comprehensively capture the meaning and true definition of the construct being measured, then the assessment instrument will not measure the actual construct and the assessment findings become invalid. The meaning of words can be misunderstood, or a variety of meanings can be applied by different

groups of people from different countries, continents and cultures. The consequence of this is that assessment instruments can produce different assessment findings in different groups of people. Again, this may influence the accuracy of the assessment and clinical decision-making based on the evidence from the assessment instrument.

Properties of the Rating Scale

Practitioners need to be aware of the potential for inaccurate assessment when selecting assessment instruments for use in their clinical work. In order to ensure that the findings that accrue from an assessment instrument are meaningful, consistent, accurate and trustworthy, instruments are evaluated against a scientific criterion. This criterion is made up of a series of rules and conventions based on statistical techniques, and the term that is applied to this scientific method is known as ‘psychometrics’. Psychometric validation is the process by which these rules and conventions are applied to assessment instruments to check their robustness and to test their accuracy (Bowling, 2004). It is important for practitioners to be confident in the quality and accuracy of the evidence that they have collected from assessment instruments as this forms the basis for clinical decisions, case conceptualisation and treatment planning.

Practitioners reviewing the psychometric properties of rating scales or tools with a view to selecting an appropriate instrument for use should consider simple contextual factors. The design of measurement instruments is based on a theoretical model of a construct (Portney and Watkins, 2009). For example, the Positive and Negative Syndrome Scale (PANSS; see Kay et al., 1989) is based on a dichotomous model of two distinct sub-types of **schizophrenia** (positive and negative symptoms). This model is reflected in the structure of the PANSS, which has a positive symptoms domain made up of seven items (delusions, conceptual disorganisation, hallucinatory behaviour, excitement, grandiosity, suspiciousness/persecution and hostility) and a negative symptoms domain made up of seven items (blunted affect, emotional withdrawal, poor rapport, passive/ apathetic social withdrawal, difficulty in abstract thinking, lack of spontaneity and flow of conversation and stereotyped thinking). Each measurement instrument should reflect the theoretical underlining of the construct that it alleges to measure.

Psychometric properties of rating scales and tools such as reliability and validity are related to the population and context in which they are used (Portney and Watkins, 2009). That is, rating scales and tools can perform differently in different groups or populations, and practitioners need to consider this when reviewing the suitability of an instrument for clinical use. Consulting the literature reporting testing of rating scales in specific groups is a prerequisite for all practitioners selecting a suitable measurement instrument. The discussion on cultural and age-related considerations elsewhere in this chapter indicates how these factors can influence the application of assessments.

Reliability

Another issue when considering the appropriateness of a tool is ‘reliability’. Simply put, reliability refers to the consistency with which a scale reveals its results. Coolican (2009) makes a distinction between two types of reliability: **internal** and **external reliability**.

'Internal reliability' is the consistency within the measurement instrument itself. As with all psychometric principles, internal consistency is a single continuum with low internal consistency at one end, which indicates that service users have answered the questions that relate to each other in an inconsistent manner. At the other end of the continuum, there is high internal consistency, which would indicate that service users have answered the questions that relate to each other in a consistent manner. There are a number of factors that can influence the consistency with which service users answer questions on an assessment instrument. One of those factors may be the wording and understanding of the questions being asked. It is important that practitioners are aware of how consistent the service user answers have been when the assessment instrument has been used. Many psychometric studies that have tested the internal consistency of assessment instruments studies report a statistic that provides a numerical value relating to the internal consistency of the instrument. This numerical value allows practitioners to make an informed decision about whether an instrument has sufficiently high internal consistency to use in clinical practice.

The most commonly cited value is the Cronbach's alpha, which provides a value of 0.0–1.0. Values closer to 0.0 indicate low internal consistency, whilst values closer to 1.0 indicate high internal consistency (Brace et al., 2009). An alpha value of 0.7 or above is considered to be good enough for use in clinical practice (*ibid.*). Another statistical test for internal reliability is the split-half method – whilst the test uses a different method for calculation, the values provided (0.0–1.0) and a value of 0.7 indicating acceptability for clinical use are the same as those for the Cronbach's alpha (Brace et al., 2009).

'External reliability' relates to consistency over time and between different raters using the same instrument. Within clinical practice, measurement instruments are used several times over a period of time, particularly over the period of treatment. In situations where the aim is to evaluate the efficacy and effectiveness of treatments, practitioners will be required to measure pre- (baseline) and post-treatment and then compare the findings from the two measures to see the extent of differences between the two measures. The length of time between pre- and post-measures depends on the type of treatment being evaluated, for example if it is the effects of anti-depressant medication, the time between measures may be weeks. However, if the treatment is family intervention with a family, where there is a member with a diagnosis of schizophrenia, the time between measures may be 6–9 months. At other times, practitioners may monitor trends and changes in functioning, mood, symptoms and quality of life to evaluate longer-term outcomes of psychosocial treatments.

In both of these cases, the measurement instrument needs to provide consistent and stable results over a specified period so that any comparison is meaningful. If there is any inconsistency over time, then the comparison will be meaningless and any clinical decision based on this comparison will also be meaningless. Psychometric testing of measurement instruments often takes account of test-retest reliability, especially where instruments are likely to be used longitudinally or to take measurements across time. Researchers will report test-retest figures after taking at least two measurements from the same sample in the form of correlations. Kappa figures between the values of 0 and 1 are used when the data in the measurement is ordinal level and Pearson's correlation coefficient where the data in the

measurement is interval level (Bowling, 2004). Values closer to 1 indicate a larger magnitude of consistency between the two measurements; conversely, values closer to 0 indicate weaker strength of consistency between the two measurements. Values of 0.75–0.8 or above would indicate a good enough level of consistency for the measurement instrument to be used in clinical practice (Coolican, 2009).

There may be an issue in cases where measurements of the same service user with the same instrument is made by different practitioners. Although measurement instruments are made up of standardised questions and response options, others rely on observation and interpretation of responses to standardised questions. Where there is interpretation required as part of the assessment/measurement, there is an increased risk for variations and inconsistency between the ratings of practitioners. ‘Inter-rater reliability’ is the term used to describe consistency between different raters. Psychometric studies will often report the findings in relation to inter-rater reliability or the level of agreement between raters in terms of correlations, which indicate the strength of agreement or association between the raters. Where ordinal data is collected, Kappa figures are used to indicate poor (<0.59), fair (0.60–0.74), good (>0.80) levels of agreement. Where the instrument collects interval data, Pearson correlation coefficient is used to indicate the level of agreement, with values of >0.70–0.80 indicating a good level of consistency in agreement for the measurement to be used in clinical practice (Bowling, 2004; Clark-Carter, 2010).

Validity

When applied to measurement instruments, validity refers to whether a rating scale or test measures what it is supposed to measure. Bowling (2004) notes that instruments have to be exposed to repeated rigorous and satisfactory testing before validity can be claimed. It is the responsibility of practitioners to consult the reports of these validation studies and consider the findings as part of the selection process. There are four types of validity that practitioners need to consider:

- **Face validity:** Is a basic form of validity and is an intuitive and subjective evaluation of the acceptability, relevance, suitability and appropriateness of the appearance, structure of the measurement instrument and the questions and rating criteria. Face validity needs to be established for both the practitioners – to ensure that the findings are accurate and meaningful – and for those being assessed because an instrument needs to be acceptable and understandable.
- **Content validity:** Is more rigorous than face validity and relates to the extent and breadth to which the content of a measurement instrument measures the aspects of the construct it alleges to measure. Content validity can refer to an instrument’s inadequacy in covering sufficient aspects of the construct, the rigour and weighting with which the construct and its domains are covered by the instrument and/or the inclusion of irrelevant items that do not relate to the construct.
- **Construct validity:** Relates to the ability of the measurement instrument to measure the theoretical underpinning constructs from which the instrument was designed. Using the example of the PANSS, construct validity would be a

measure of the ability of the PANSS to measure the positive and negative symptoms of schizophrenia. The process of testing construct validity involves comparison with related and relevant measures. This allows researchers to evaluate the level of association between items representing the theoretical construct on the measurement instrument and related items that represent the theoretical construct on other measures or instruments.

- **Criterion validity:** Is commonly reported in psychometric studies and relates to the extent to which a measurement instrument produces the same findings as an established and already validated instrument, usually a ‘gold standard’. If, through comparison with an established and already validated instrument, another measurement instrument is found to produce the same findings, then this measurement instrument fulfils the requirement of criterion validity. The process involves identifying the magnitude of association (correlation) between participant responses to items on the measurement instrument and participant responses to items on the ‘gold standard’. The use of statistical values provides a useful method for comparison of the performance of the two instruments. One of the assumptions underlying this comparative process is that the ‘gold standard’ instrument should be relevant to both the phenomena being measured and to the measurement instrument being tested (Portney and Watkins, 2009). There are two forms of criterion against which measurement instruments are tested/compared: where a measurement instrument produces the same findings as the ‘gold standard’ instrument then the measurement instrument is said to have **concurrent validity**; where the measurement instrument accurately predicts an event or phenomena such as changes in, e.g., psychotic symptoms, relapse, recovery, self-harm or the development of a specific condition, then the instrument fulfils the criterion for **predictive validity** (Clark-Carter, 2010).

A thorough exploration of reliability and validity of psychological tests is outside the scope of this book (for a comprehensive overview see, for example, Fernandez-Ballesteros, 2003).

Sensitivity and Specificity

Within clinical practice, practitioners need a measurement instrument to be sensitive – that is, the instrument is capable of accurately identifying people with a condition, particularly any new cases. **Sensitivity** is the ‘true positive rate’ – that is, it is a measure of how many people the rating scale or test have accurately identified as experiencing the phenomena of interest (the percentage of people who are correctly identified as being depressed or anxious and so on). Similarly, instruments should be capable of accurately discriminating those that do *not* have a specific condition. Measurement instruments that are capable of accurately discriminating are said to have **specificity**. This is the ‘true negative rate’ and is a measure of people who are correctly identified as *not* experiencing the phenomena of interest (that is, the percentage of people who are correctly identified as not being depressed or anxious and so on).

Cultural Diversity

The interviewer needs to take into consideration any issues of diversity which may impact on the assessment. These include issues relating to race, culture, religion, gender, disability, sensory impairments, age, sexuality and so on. A considerable level of sensitivity and understanding of the diverse nature of individuals within society is needed in the assessment process, which requires us to be aware of our own beliefs and attitudes and how this may colour our perceptions.

Understanding the service user's individual and cultural background is key in gauging the appropriateness of an assessment format, and in determining the need for adaptation of that format to suit. Consider the impact, then, of asking how many friends a socially isolated adolescent has, or when the last time a devout Muslim woman went nightclubs. Bernstein et al. (2014) identify barriers to Korean Americans accessing mental health services in the USA which include a culturally held understanding of mental distress based around energy flows, and mental distress being perceived as a sign of weakness and/or emotional strain. As these beliefs can strongly conflict with the illness-based perceptions that underpin much of Western mental health care, so we can understand why some groups avoid accessing mental health services, why some commonly used assessment formats may not be particularly productive across all of today's multicultural society, and why choice and flexibility are important in selecting and applying an appropriate assessment.

Availability

Copyright and Fees

Some rating scales or tests are copyrighted and this means that you cannot use them without the express permission of the copyright holder. The production of an effective assessment tool is a lengthy and complicated process that requires significant effort on the part of the developers. Recognition for their efforts is often presented in the copyrighting of the approach and the subsequent control over access and possible financial reward that this facilitates. To use such a tool, therefore, frequently requires both payment and involvement within a training or preparation programme which ensures a fidelity to the developer's original model. Breach of copyright is serious and leaves the miscreant open to public and private prosecution and it is, therefore, imperative that the copyright status of any assessments are confirmed prior to use. Assessment tools will often display standard information around copyright, showing statements such as: 'All rights reserved,' 'Permission granted to be used for educational and personal use only' or even the simple © symbol (see the Copyright Licensing Agency, n.d., for more information on what each of these statements actually means). If you are unsure about the copyright status of the tool and no information is available, you should consider contacting the original authors for clarification.

You should also be aware that a fee is sometimes charged for the use of a test, and occasionally you may be required to pay for the forms. The record forms

for the BDI-II, for example, are currently charged at £54.50 for 25 forms (see: [www.pearsonclinical.co.uk/Psychology/AdultMentalHealth/AdultMentalHealth/BeckDepressionInventory-II\(BDI-II\)/BeckDepressionInventory-II\(BDI-II\).aspx](http://www.pearsonclinical.co.uk/Psychology/AdultMentalHealth/AdultMentalHealth/BeckDepressionInventory-II(BDI-II)/BeckDepressionInventory-II(BDI-II).aspx)).

You should always assume that a test is copyrighted, unless the authors have clearly stated that it is in the public domain. If you are in doubt, you should always seek permission from the authors, who may wish to monitor the usage of their scale.

Usability

Training

It is vital that you have sufficient training and experience to use a rating scale or test. That is, you should always ensure that you are capable to safely apply any rating scale or tool within a specific practice setting before using them with a service user/family. This preparation could involve observation of a more experienced practitioner, role rehearsal to try the approach in a practise scenario, receiving feedback from others on your performance and reflecting on how best to use the approach. You should never read an assessment tool as you apply it for the first time.

For example, the American Psychological Association (APA) identifies a three-tiered system based on levels of qualification that are required in order to use particular tests (the BDI-II, for example, requires at least Qualification Level B, as described below).

Qualification Level A

There are no special qualifications required.

Qualification Level B

Tests may be used by individuals with one of the following:

- A Master's degree in psychology, education, occupational therapy, social work, or in a field closely related to the intended use of the assessment, and formal training in the ethical administration, scoring and interpretation of clinical assessments.
- Certification by, or full active membership in, a professional organisation that requires training and experience in the relevant area of assessment.
- A degree or license to practice in the health care or allied health care field.
- Formal, supervised mental health, speech/language and/or educational training specific to assessing children, or in infant and child development, and formal training in the ethical administration, scoring and interpretation of clinical assessments.

Qualification Level C

Tests with a C qualification require a high level of expertise in test interpretation, and can be purchased by individuals with one of the following:

- A doctorate degree in psychology, education or closely related field with formal training in the ethical administration, scoring, and interpretation of clinical assessments related to the intended use of the assessment.
- Licensure or certification to practice in a field related to the test.
- Certification by, or full active membership in, a professional organisation that requires training and experience in the relevant area of assessment.

However, you must always be guided by the legal and ethical codes of your own profession, and you must not use any scale or test without prior thought and/or preparation and training.

Intended Use

Rating scales and tools will always clearly state its intended use. If, for example, a tool is designed to be used with an adult population (aged 18–65), then it is not suitable for use with children. This can give misleading results that can affect the quality and accuracy of an assessment. Also, you should not modify any scale or tests without the express permission of the authors.

Accessibility

It is important to determine the accessibility of any assessment format before use. With a large-scale UK government study recently suggesting that 17 per cent of the population of England had what they termed low proficiency in literacy, and that 18 per cent had similar difficulties with problem-solving (Department for Business Innovation and Skills, 2013), it is imperative that we consider the cognitive and reading abilities of those being assessed when selecting an appropriate assessment format. With many mental health conditions causing or contributing to cognitive impairment and the average reading ability in the UK being compared with that of a nine-year-old (See a Voice, 2010), thought and effort needs to guide the selection and adaptation of assessments, and some of the more commonly used word-processing programmes have inbuilt facilities that will grade the readability of documentation.

Linguistic complexity is not the only factor influencing comprehension, though. Within the UK, there are currently somewhere between 200 and 300 languages spoken, with the most common of these originating from places as diverse as Africa, Europe and the Indian Subcontinent (British Council, 2013). We should never assume, therefore, that the service user's grasp of English will accommodate comprehension of documentation, which is often densely packed

with obscure phrases that originate from a specialist medical, psychological or research setting. Even for those for whom English is understandable, there are cultural and generational nuances influencing interpretation, both in the assessor and in those being assessed. It is suggested that higher levels of cultural dialect use equate with lower levels of understanding of mainstream language (Edwards et al., 2014), further emphasising the need for deliberation around the service user's abilities and, indeed, the abilities of the assessment to meet those needs.

Overload

The chance of getting the perfect-fit assessment poses some challenges, given the wide choice of formats available. It is essential that we consider the *assessee*, who must feel as though they spend a considerable amount of time in the midst of a crisis, with a variety of health professionals who appear to ask exactly the same questions, over and over. If we consider a person who is experiencing such a crisis involving their mental health: they are often initially seen by their GP, who refers them to hospital, where they are assessed by a junior doctor and then a nurse, social worker, occupational therapist, dietician and so on. As most of these professionals will be asking the same questions, to get to know the person and their story, and to develop information for their records, this means that the assessment process is driven by the needs of the health professionals, rather than being efficiently tailored to suit the person's needs. Conversely, as health professionals, we are duty-bound to manage issues such as risk – issues that are most effectively managed when we have as much information as possible. There is a balance, therefore, between accessing relevant and current information and potentially harassing the person. As assessment relies on the person responding truthfully on how they are feeling or thinking or around what has happened to them, so must we endeavour to develop the collaborative working relationship that will facilitate this sharing of information. This will be best accommodated through tailoring the assessment process to suit the individual.

The practitioner is responsible for providing a clear explanation of the assessment and its purpose, and for identifying a strong rationale for the use of such an approach. This is not always the experience for service users, though: in a study by Hunter et al. (2013), some participants indicated that they thought that psychosocial assessment was an exercise to protect staff. Therefore, it is essential that the person is at the heart of the assessment and not merely a participant of a tick-box exercise that has limited benefit to them.

Format

As improvements in technology advance, assessments that may in the past have been undertaken in a traditional pen-and-paper format may now be delivered electronically, however what practitioners need to consider around this is that this

format appears more relevant to younger people, who are generally more computer literate. We need to remember, then, that the format of the psychosocial assessment used may be driven more by availability and custom, rather than by need of the person.

A study by Gies et al. (2014) discusses assessing the needs of caregivers who have a relative with Alzheimer's disease, using a web-based psychosocial assessment, which is less time intensive and may fit around the caring responsibilities of the carer. However, for it to be effective, it is necessary that the practitioner is proficient with the technology being used, and can also develop a rapport with the carer, in circumstances where face-to-face interaction may not take place. Accessibility will dictate whether an electronic assessment will be used, rather than a paper format. One factor that we must take into account where multi-formats are available is the impact on engagement. It is important to remember that, whilst as practitioners we have a purpose to ensure that a thorough assessment is carried out for the person, this may be a limited opportunity for engagement with someone. Thus, we have two people with differing agendas, hoping for the right outcome.

Self-Report or Clinician-Administered

It is vital to consider how the originators of a rating scale intended it to be used. Sometimes, this can be given to the service user for their completion, either within an interview or at a later date. Sometimes, the rating scale or test is clinician-rated. As such, the tests act as a prompt or guide to a clinical conversation. In order to build and maintain trust, thought must be given to how this is administered and explained to the service user and how the results of the test may subsequently be shared with them.

Chapter Summary

The selection of an appropriate and effective assessment process or tool is key to the development and maintenance of a positive therapeutic relationship, and provides a vehicle through which a detailed and comprehensive understanding can emerge of a service user and of the factors that influence their health and well-being. As the information arising from the assessment provides the foundation for all subsequent interactions with that service user and their family, it is imperative that the assessment process is well planned and includes consideration of the individuality of the service user, and balances this with the requirements and capabilities of the assessment format. A well-chosen and well-delivered assessment will underpin a collaborative approach to care delivery and will in itself provide therapeutic benefits.

Practitioners working within settings where mental ill health influences service user outcome should familiarise themselves with the scope of assessment formats suitable for their service user group and plan, apply and refine their ability to incorporate such assessments successfully within their routine practice.

EXERCISE



1. Choose a rating scale that you would like to explore in more depth. Using search terms relevant to the measurement instrument you want investigate (e.g. Positive and Negative Syndrome Scale) and other related words (e.g. psychometric, reliability, validation), access relevant academic databases (e.g. PubMed, MEDLINE, CINAHL and PsycINFO) to search for research papers relating to your chosen instrument. Consider how this tool has been/could be used in your clinical practice.
2. How reliable is your chosen rating scale?
3. What steps have been taken to demonstrate the validity of your chosen rating scale?

CONSIDERATIONS FOR PRACTICE

1. Outline the stages that you would follow when selecting a rating scale.
2. Reflect on a time when you have been undertaking assessments in practice:
 - a) Did you use an assessment tool?
 - b) If so, to what extent did the person have a choice in the selection of the assessment tool?
 - c) In future practice, how can you maximise the opportunity for the person to have a choice in the assessment tool and the format used?
3. What factors do you take into account when considering the format of an assessment?

Further Reading

Simmons, J. and Griffiths, R. (2014) *CBT for Beginners*, 2nd edn. London: Sage.

This book provides the underpinning theory that guides much of our current assessment practice and explains the factors influencing choice within specific assessment processes.

Smith, G. (2012) *Psychological Interventions in Mental Health Nursing*. Maidenhead: Open University Press.

This book connects the assessment process with available interventions across a range of common mental health conditions.

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PART 2

PSYCHOSOCIAL ASSESSMENTS



4

THE PRESENTING PROBLEM

SUSAN BOWMAN AND FIONA MARTIN



CHAPTER OVERVIEW

This chapter:

- Identifies the core components of a presenting problem.
 - Discusses how to structure and undertake an initial meeting.
 - Guides the reader through a framework in order to understand the person's presenting problem.
 - Discusses how to develop an **initial conceptualisation** so as to make sense of the service user's presenting problem, based on a shared understanding of the individual's presenting strengths and needs.
-

Introduction

The concept of the 'presenting problem' is often not clearly defined in the health care literature. However, Owen et al. (2014) suggest a definition of the presenting problem as essentially getting the answer to the question: 'Why has this person

presented in this way at this point in time?’ Sadock et al. (2014) and Morrison (2014) use the term ‘chief complaint’ in place of ‘presenting problem’, describing it as why the person has come or been brought for help. Hamkins (2014), a supporter of narrative inquiry, describes the presenting problem as the initial reason for which a person seeks help, as well as their efforts and successes in overcoming it. Seikkula and Arnkil (2006) use more ordinary language to describe what we understand as the presenting problem, and suggest that it is finding out: ‘What has happened?’ or ‘What has changed?’

Whichever way it is defined, any psychosocial assessment must begin with a broad, general understanding or sketch of the person’s presenting problem, leading to a preliminary initial conceptualisation, which, in turn, becomes the foundation for the later, more detailed, assessment.

The Initial Meeting

At the initial meeting, it is impossible to know how long the person will need to talk about what is worrying them. That is because the person does not always know what exactly is wrong, and may describe what is troubling them as unpleasant physical experiences, emotions or frightening thoughts. What is known is that one of the significant ways through which individuals make sense of, and give meaning to, their experiences is to organise them in a narrative form (Mishler, 1986).

It takes courage to confide in others, but it is done in the hope of a compassionate response. Meeting with service users in a way that is unconditional and respectful will facilitate the start of the service user’s narrative about their source of distress/presenting. For this to happen, it is essential that the practitioner communicates very quickly to the individual, and that they remember that taking time to listen and to develop a shared understanding are the most important objectives of the first meeting. A situation where a professional is in a hurry is more likely to produce a rapid solution that is not in the best interest of the person in distress or their immediate support network (Seikkula and Arnkil, 2006). The initial goal for practitioners is to psychologically engage with the service user, while holding an attitude of acceptance, empathy and authentic collaboration (Rogers, 1980). These fundamental values have been echoed by the Francis Public Inquiry, which urges that ‘Patients/clients must be the first priority by ensuring that, they receive effective care from caring, compassionate and committed staff’ (The Mid Staffordshire NHS Foundation Trust Public Enquiry, 2013: 3).

Using a Normalising Rationale

A ‘normalising rationale’ is a way of validating an individual’s experience(s). It aims to reduce distress by enabling the individual to make sense of their present experiences and by conveying an understanding that their response is understandable. Kingdon and Turkington (1991) first introduced the use of a normalising rationale to help reduce the distress caused by auditory hallucinations. For example, while hallucinations are typically associated with psychosis/schizophrenia, they can also

occur in the realm of everyone's experiences such as when we have a very high temperature (pyrexia); sometimes when an excessive amount of alcohol is taken, or when psychotropic drugs are used. Hallucinations are also not uncommon as an aura before a seizure; following a head injury; when we are deprived of sleep/stimulation; or after bereavement. A normalising rationale describes how a person's experience is very reasonable and very understandable, considering recent events/experiences; and also that their response to the distress may be very reasonable. A normalising rationale aims to reassure people that they are not alone in their distress. While normalising the distress might not significantly change the reality of the situation that is causing the distress, it can be an effective way of decatastrophising the experience and of providing hope for the future. It can focus on any experience, not solely hallucinations, and provides a useful reflection and reminder for the service user that they are not alone in their distress and difficulty.

Practitioners have different competencies in using this particular skill. The potential to deepen understanding and demonstrate empathy is significant and this is why a normalising rationale is a very useful and effective skill. However, there is always the potential to be seen to minimise or discount a person's experience or distress using a normalising rationale and practitioners need to be sensitive to the service user's reaction and not assume that everyone will find it useful.

The Presenting Problem Interview

At your first meeting with a service user, you will need to help the person set the scene by cataloguing what has gone wrong in the person's life and also what has gone well. This will involve developing a shared understanding of the person's strengths as well as needs. A collaborative, inquiring style of opening question should be adopted. This allows the person freedom to talk about what is important to them. It also helps to build rapport and promote a relaxed style early in the interview, which can enhance the quality of information gathered. Open questioning is the best way to develop an initial, broad and general understanding of the person's situation, by asking such questions as:

- I understand you have been to see your GP recently. Can you tell me about that?
- I know it might be difficult for you to talk about why things might have been distressing for you recently, but it would be an idea for us to talk about this so we can both make a bit more sense of what is happening recently.
- What has changed in your life?
- Please tell me, in your own words, what you see as the problem?
- What do you feel have been some of the good things that have happened to you recently?
- What do you think your family/friends think about your current situation?

These initial opening questions have qualities that will affect the information you will receive. It is worth taking time to help the person consider these issues as it helps to let the person know that you want to help them. It also provides the practitioner with an opportunity to gain a shared understanding of the

meaning the person gives to their experiences. When gathering information about the presenting problem, the service user is the most important source of that information: *there is no room for guesswork, jumping to conclusions or making assumptions.*

The focus and interaction is person-centred, working collaboratively with the individual, but remember that the person's family/personal network will have invaluable knowledge to share in this process. The majority of people presenting in distress are living with their family, or have close contact with them, and they can often assist in developing a knowledge base of the individual's strengths and attributes as a person. For this reason, the family/personal network is always relevant. Families know the individual and how they were before illness. They can remember details, help with timelines and can often help with identifying anything that may have increased the individual's vulnerability to illness. The presenting problem is also a time to mobilise supportive resources for the service user and the family.

The mental health professional should be able to engage with families/personal network in ways that are meaningful to them and the service user. Authentic engagement with families/personal networks require that you:

- Have a genuine desire to want to listen and understand.
- Work through a spirit of negotiation and collaboration.
- Validate concerns, take their concerns seriously.
- See the family/personal network as experts in their experiences.
- Resist the urge to jump to conclusions based on your beliefs.
- Understand that the majority of families are doing, or trying to do, their best.
- Understand the impact of illness on the family's life/routine/plans/aspirations.

Often, there can be more than one presenting problem, therefore it is essential that you:

- Identify all problems by encouraging the service user to talk freely about their understanding of why they are there.
- Ask the service user if they have other concerns.
- All problems should be individually listed, collaboratively with the individual and their family/support network.
- Problems should be listed in order of severity – starting with the most distressing. (Aquilina and Warner, 2004; Kinsella and Kinsella, 2015)

After setting the scene, it is important to develop a more focused understanding of the current presenting problem (which will help develop your initial conceptualisation). A structured approach makes best use of the service user's and family's time with you. It can prevent the service user/family feeling overwhelmed; help maintain focus on what is important; enhances feelings of certainty; and ensures that everyone is involved.

In developing your initial conceptualisation, it would be useful to structure the conversation by considering a number of factors (see Figure 4.1).

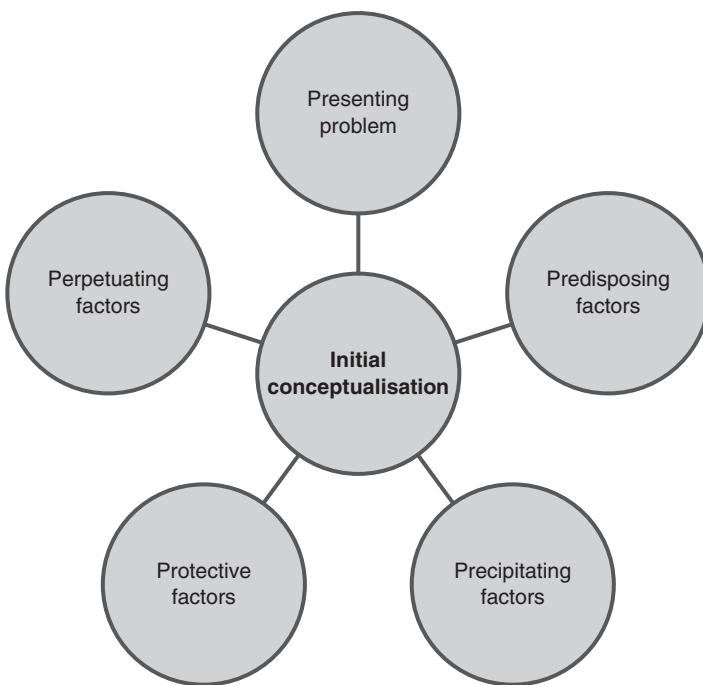


Figure 4.1 The initial conceptualisation

Presenting Problems

These are factors that impact on the person's difficulties, and their current health and functioning. They include psychiatric symptoms, emotions, bodily sensations, problem behaviours. Changes in somatic functioning such as sleep pattern, appetite, cognitive ability, sexual functioning should also be noted. Here, in exploring the presenting problem, current risk factors also need to be considered.

People are usually referred to specialist mental health services from primary care (such as GPs) and there will usually be accompanying referral information, which will contain important details about the person's current presenting problems. It can help provide some context for the current problem. Likewise, the family/personal network may also provide background detail to the person's present problem. However, it is crucial to capture the service user's own idea about what might be happening for them (in their own words) – this will provide a valuable insight into the perspective of the service user (Carlat, 2004). Because of the nature of mental and emotional distress, the service user's statement may differ greatly from the family, carer or referrer's assessment of the situation and may be at odds. This does not mean that the service user's perspective should be discounted, but it is important to note that there are different perspectives and interpretations of the person's current presenting problems. It can sometimes be useful to offer the concerns raised by a family member, carer or referrer (such as the GP) and allow the service user to comment on other people's perspective of their current concerns.

The current presenting problem, and the history of the presenting problem, may be difficult to separate, especially in more complicated cases. However, what is important is that you get a good account of what is troubling the service user and thoroughly investigate any associated symptoms (Buckley et al., 2005). In some cases, for example, someone may not feel that there is a problem, or may feel that the problem is caused by other people and is beyond their control to resolve. It is still important to explore any issues and record the information from their perspective. It is also an initial opportunity to observe the individual's actions, body language and speech.

Questions here may include:

- Could you tell me a little about how you have been feeling recently?
 - What has your mood been like?
 - Have you been feeling unusually sad? Or happy?
 - Have you had any strange experiences?
 - Have things not seemed real to you at times?
 - Have you been doing anything that you feel is unusual for you?
 - Have you been doing anything that has been out of character?
 - Have you had any strange ideas that have been worrying or even frightening?
 - Have you had any problems with your thoughts?
- Have you been having difficulties with your family, friends or work colleagues or other people? In what ways?
- What impact has this had on your daily life and everyday functioning?
 - Have you been unable to do anything that you could usually do?
 - Has this impacted on your social life?
 - Has this affected your work?
 - Has the problem changed the way in which you care for yourself? Are you able to keep yourself clean?
 - Have there been changes to your eating habits?
- Have you been having any physical health problems? Do you think they might be connected to how you feel at the moment?
- Do you think it is likely that you might harm other people or yourself? Do you worry that you might harm other people or yourself?

If a problem or issue has been identified, it is useful to consider with the person how much of a problem it is for them. Here, you may wish to clarify this initial problem a bit more by asking:

- How often do you experience this? How many times a day, for example?
- When you do experience it? How intense/bad does it seem to you?
- When you do experience it? For how long does it last each time?
- Is the problem/symptom there all the time? Does it come and go?
- Does it seem to be improving or getting worse?

Predisposing Factors

Issues which may have led the person to be more vulnerable to developing mental health problems are **predisposing factors**, e.g. attachment history, early upbringing, their core beliefs and underlying assumptions about themselves, the world and their future. A defining condition of being human is our urgent need to understand and order the meaning of our experiences, and to integrate this with what we know. Frequently, things appear to happen as a bolt out of the blue, but quite often the person in the midst of the distress cannot see the connections to their previous experiences or events.

Concepts of vulnerability to illness can be traced back to when psychiatry began to evolve into a scientific discipline. For example, in 1977, Zubin and Spring argued for a ‘new view of schizophrenia’ that sought to explore how stressors could lead to a breakdown of coping in people vulnerable to schizophrenia. They argued that we all have a degree of vulnerability which can be *inborn* (for example, due to a person’s genetic profile) and/or *acquired* (for example, the influence of disadvantageous early life experiences, traumas, perinatal complications and formative life events), which due to the interaction and presence of challenging circumstances (or **exogenous stressors**) may provoke a crisis for a person’s mental health. Zubin and Spring (*ibid.*) argue that such stressors include background, ambient day-to-day stresses and crises brought about by significant life events (such as bereavements, marriage, divorce) that require a degree of coping and readjustment in the person’s life. Vulnerability, therefore, may be seen as an inability to cope and adapt to stresses that may place their mental health under strain and increase the likelihood of mental ill health or relapse.

Questions, which may help to understand a person’s vulnerability, include:

- Could you tell me a little about your background?
- How long have you felt/been feeling like this?
- When was the first time you noticed this?
- When you think back, is there anything you think might have contributed to how things are for you now?

Precipitating Factors

There are recent events that might have contributed to the onset of the person’s current difficulties, such as recent life events and stressors. It is difficult to be precise about the exact time frame for considering those factors that may have precipitated the current situation as this is likely to be different for each person. We suggest that a time frame of the previous eight weeks should be considered.

In identifying **precipitating factors**, you are, in effect, taking a recent history of presenting problem as a chronologic account of the events leading up to the

current contact with the mental health professional. It includes a description of the evolution of the service user's symptoms that covers onset, duration and changing of symptoms over time. Exacerbating factors of the current distress should be explored, and the practitioner should precisely describe factors that may have precipitated the current distress (Aquilina and Warner, 2004). Stress can arise from events which may be seen as both negative (for example, bereavement, divorce, job loss) and positive (such as getting married, job promotion).

Zubin and Spring (1977) defined vulnerability as an individual's threshold for tolerating stress, where stress was defined as either ambient/everyday stress or life-event stress. It is now almost universally accepted that the stress, which will cause major illness in one individual, will cause barely a ripple in another. Put another way, this means that a crisis will either be contained homeostatically or lead to an episode of illness/ill-health, depending on the individual's resilience/**protective factors** and vulnerability.

The basis of the Stress Vulnerability hypothesis is that everyone varies in their capacity to remain well in the face of personal and environmental stressors (*ibid.*). People who are predisposed to have a low threshold for tolerating stress are more vulnerable to the effect of ambient and life-event stress. What might be perceived as slight changes in a person's life may be sufficient to increase their vulnerability to becoming unwell or to experiencing a relapse. Thus, whilst getting a clear picture of the presenting problem, the practitioner needs to accurately identify, if possible, all of the changes that have occurred in the service user's life circumstances.

Questions that may be helpful in understanding precipitating factors include:

- What do you make of how things have been going for you recently?
- How would you describe your life over the recent number of weeks?
- Have you experienced any stress recently? Have there been any crises?
- Any problems with your family or social circles? How is work?
- What has led up to your current difficulties?
- Would you say that your problems have been continuous or intermittent over this time?
- When was the last time you felt well?
- How did the condition develop? Is this a long-standing problem? Or has it developed suddenly, gradually, over a period of time?
- How have you been coping? What have you been doing to help you cope?

A timeline is another way of helping the person share recent previous experiences that may impact on the presenting problem. A timeline can be a textual narrative and/or graphical depiction of key events and responses in a person's life ordered chronologically (Kirk, 1994). It can help the person see how a series of apparently unconnected events are, more often than not, connected. It can organise confusing experiences; help the person recognise their strengths and vulnerabilities; and identify recurrent themes and patterns. Some people find written accounts, diagrams or charts easier to follow (e.g. Table 4.1) than listening to verbal explanations.

Table 4.1 Example of a timeline

Event	Time	Response
Announcement of redundancies at work	30 May 2016	This was such a shock. I was frightened that I was going to lose my job and income. I thought they were trying to get rid of me.
Asked to speak to my manager about my fears of losing my job. Manager refused to talk to me about this.	1 June 2016	I felt that I was already being targeted. Anxious that I would lose my job. How will I pay the mortgage? Felt that I have not been performing well and that's why they wanted to get rid of me.
Received a letter telling me I was 'at risk' of losing my job. Needed to attend a redundancy interview for my job on 4 July 2016.	2 June 2016	Increasingly anxious. Losing sleep. Couldn't eat. Felt sick. Didn't want to talk to anyone. Kept myself to myself. Having arguments with family. Feeling angry with everyone.
Sick leave	25–30 June 2016	Couldn't go to work. Too tired. Exhausted and feeling the world is against me. Drinking too much alcohol.
Day of the redundancy interview	4 July 2016	Phoned in sick and cancelled the interview. Had not slept well for days. Lost weight. Couldn't stop thinking about the interview and losing my job. Felt that I was worthless.
Attended GP appointment	5 July 2016	GP feels I might be depressed. Wants me to be seen by a mental health professional. Worried that if work find out, they will make me redundant.

EXPERT VOICE

The way I complete a timeline is to literally draw a straight line across one or two large pieces of paper and, through a collaborative process between the practitioner, service user and family member(s), as appropriate, encourage them to think back and tell you their life story to date. Be aware that this may be a very painful process for some people due to the fact that, most commonly, people who have a psychotic illness will have experienced trauma or abuse in their past, which you are encouraging them to talk about. Ensure that this session is not rushed and that you have allowed enough time to complete it with them. For example, that you don't have back-to-back service users booked in on that day. This exercise may also take more than one session but, generally, the most useful and accurate timelines work best when not rushed.

Protective Factors

Protective factors include personal strengths and coping abilities, resilience, helpful beliefs, positive relationships, situations where the person feels better, skills, functional coping skills and so on.

As mentioned above, a timeline, and discussions about precipitating factors, can help to identify significant factors in a person's life that underpin the current problem. This can also be helpful in establishing the person's resources and ability to cope. *Helpful coping strategies* – such as talking things through with a confidant, doing something pleasurable, having a laugh, getting out and about – are often protective to the person's psychological health. Affirmative feedback (see Chapter 2) should be offered when a person has devised elaborate, novel, sophisticated or ingenious ways of coping with the distress caused by their problems.

Questions include:

- How have you coped?
- Has anything helped you to cope over this time?
- Who has been helpful? In what ways?
- What are some of the good things in your life?

Perpetuating Factors

Factors that maintain the person's problem, such as unhelpful or dysfunctional coping skills, negative automatic thoughts and so on are **perpetuating factors**. Coping strategies, of course, can be both helpful and unhelpful. While *helpful coping strategies* may be seen as protective (see above), *unhelpful coping strategies* may perpetuate a current problem or prevent a resolution to ongoing difficulties. Such strategies include apathy, avoidance, denial, anxiety, fear, bursts of anger, and the misuse of alcohol and drugs. There is an opportunity here to acknowledge that such coping strategies are not likely to be very helpful in the long term and may ultimately cause additional stress and difficulties for the person.

Questions include:

- Has anything made the situation worse for you over this time?
- What has not been helpful?
- Is there any reason that you have not sought help up until now?
- Has anything happened to prevent the situation from improving?
- Have you done anything, such as using alcohol, to cope with or avoid the situation?

Initial Conceptualisation

An 'initial conceptualisation' uses a normalising rationale (Kingdon and Turkington, 1991) and factors discussed above (see Figure 4.1) to help the individual make sense of what has been happening. The practitioner's aim is to help translate the service user's narrative into an authentic shared understanding/conceptualisation (Persons, 2012). This helps the service user and practitioner to better understand what is often seen as a diverse set of unrelated problems and sources of distress (*ibid.*). The initial conceptualisation of the presenting problem also facilitates an understanding of the possible origin(s) of the difficulties against the backdrop of the service user's strengths/resilience and vulnerabilities/needs and enables the development to the next stage in the care planning process.

Sharing Your Initial Conceptualisation

Below is an example of how you might share an initial conceptualisation using the example of the timeline described in Table 4.1, but remember that this will be an initial sketch and further assessment discussion may reveal a deeper understanding of the problem(s) or issue(s):

- *Normalising rationale:* Coping with the threat of redundancy has been very difficult for you. It is not surprising that you have experienced problems with losing your appetite and not going to work. It is understandable that you have been worrying about losing your job – this is a concern that most people would also have.
- *Presenting problem:* You are losing weight and you feel very tired at the moment. You feel you can't concentrate on anything and you are quick to anger. You feel low in mood and have not been eating or sleeping well. You have been isolating yourself and having arguments with your family.
- *Predisposing factors:* You have told me that your situation reminds you of your father losing his job when you were at school and you feel that it led to his premature death. You are still angry as you feel that his employers took him away from you.
- *Precipitating factors:* You have described a number of current stresses for you. You are worried that you will be unable to provide for your family if you lose your job. You have money worries. Your mortgage is very high and you worry that you are not able to keep up payments, and you have no idea how you would cope if you lose your job. You have been worried that you are not performing as well in your job as some newer members of staff and that your manager wants to get rid of you.
- *Perpetuating factors:* You say you have been drinking heavily recently, and it is understandable that you have done this to help you cope, but this is likely to prove unhelpful if you were to continue in that way. It may lead to addiction and cause additional stresses for you and may prevent you from working on a resolution to the current situation. You feel distant from your wife and not able to talk to her about the situation and your fears. You feel she will blame you.
- *Protective factors:* You love your family and they are supportive of you and each other. You enjoy your job and you feel you have good working relationships with your colleagues. You are usually determined to succeed. You have kept on top of your work and usually know to seek out help when things are getting on top of you. You are keen to be proactive and want to look at ways of managing these stresses more effectively.

In sharing your initial conceptualisation, you should acknowledge the person's feelings, remaining empathic and hopeful. Be flexible: if the person does not agree with you, then provide them with the opportunity to discuss.

Above is an example of how you might share your initial conceptualisation conversationally. However, it would also be a good idea to provide this in written form so that it can be revisited and reviewed later.

Seeking Feedback

It is very important that you check that the person can validate this initial conceptualisation and that you obtain feedback from the service user. This helps to ensure your shared understandings and that any inaccuracies or misunderstandings can be corrected. Helpful questions here might include:

- How do you feel about what I have said?
- Do you think what I have said accurately captures the situation for you?
- Is there anything I have left out or misunderstood?
- Is there anything else you would like to add?
- Do you have any questions?

Hypothetical Questions

In developing a shared understanding of the initial conceptualisation, the use of **hypothetical questions** allows you to gauge how the person might act or what they think about a possible situation moving forward. They are effective in getting a person to think about and discuss new ideas or approaches to a problem from a different perspective. Hypothetical questions can usually be perceived as less challenging than open questions. It is important to emphasise that, in this situation, we are not suggesting that hypothetical questions are used to assess judgement and reasoning, or to evaluate the person's response, but purely as an alternative to gaining an understanding of the presenting problem in a manner that may be less stressful for the individual. For example:

- Tell me how things would be if everything was OK.
- How would things be different if you didn't have these concerns?
- If this continued, what do you think would happen?
- If you didn't manage to resolve this current difficulty, what do you think would happen?
- If these feelings/experiences didn't stop, what is the worst thing that might happen?

Difficulties with Understanding the Person's Presenting Problem

Sometimes, of course, there is considerable difficulty in understanding the person's presenting problem. This may be due to the fact that the service user is too distressed or unwell to discuss the issues with you – or they might find it difficult to talk about

painful issues. You might also encounter difficulties in trying to make sense of the person's problem or in finding the words to accurately capture the complexity of the person's situation. This can be very frustrating but it is not uncommon. The skills and techniques we have described in this chapter require practice and you should always ensure that you have access to an experienced colleague with whom you can discuss your initial conceptualisation and who can help you to consider issues for your personal and professional development when using psychosocial techniques.

Chapter Summary

The presenting problem is just the beginning of appreciating what is causing the person distress. More detailed information needs to be gathered through a comprehensive assessment to develop a shared understanding of strengths and needs and to collaboratively develop an effective treatment plan. Throughout, the practitioner needs to be able to maintain a style that fosters collaboration and, in order to achieve this, they must have, or develop, the ability to engage the service user and family/personal network, expressing empathy and showing compassion.

A meeting between a service user and professional is a direct intervention in their lives, and a minimum requirement for such an encounter is that they leave this first meeting feeling more empowered and knowing that something can be done to lessen their distress (Seikkula and Arnkil, 2006).

EXERCISE



When new styles of therapeutic conversation are being entered into, it can take a considerable amount of time to become familiar with them and to become proficient in the skills. You may first want to test out your skills of questioning with a colleague to build your confidence:

1. Use the above framework to structure an initial presenting problem interview. It can be helpful to test out questions in a safe environment, so that you can stumble, reflect and repeat, as it is not unusual to find new ways awkward, unnatural or uns spontaneous to use.

CONSIDERATIONS FOR PRACTICE

1. Asking helpful questions requires the practitioner to have current knowledge of mental health and mental ill health. How would you rate your knowledge and understanding of the impact of illness? How might you develop your subject knowledge?

(Continued)

(Continued)

2. How might you deal with the following challenges in interviewing:
 - a) The person has difficulty organising his/her thoughts.
 - b) They find open-ended questions too difficult to answer.
 - c) They are struggling with voices, intrusive thoughts, overwhelming emotions.
 - d) They seem fearful and unable to trust others.
 - e) They are frightened and concerned of the consequences of sharing information.
 - f) They are overwhelmed by negative past experiences.

Further Reading

Cooper, P. (ed.) (2012) *The Complete Overcoming Series*. London: Constable and Robinson.

This is a compilation of everything in the Overcoming Series, which uses a cognitive behavioural approach to understanding and treating very common causes of mental distress. The books successfully combine a person-centred and methodical approach to gaining a shared understanding of the individual's distress from presenting problem to successful outcome.

Filer, N. (2014) *The Shock of the Fall*. London: Borough Press.

This fictional novel could be used very easily as a parallel text to a psychiatry text. Each stage of the protagonist's (Matt Homes) journey from early resilience, to the emergence of psychosis is expertly ascribed to paper. In this book, Matt Homes narrates his experiences of mental illness. Filer deftly captures the authentic meaning of narrative.

Gawande, A. (2011) *The Checklist Manifesto: How to Get Things Right*. Croydon: Profile Books.

There seems to be no profession where a checklist might not help, health care included. There are good and bad checklists: the good checklists are precise, efficient, to the point and easy to use, and they provide reminders of the most critical and important steps. This is not to suggest that therapeutic conversations become formulaic or manual driven. We all refer to guiding ideas of some sort in the development of therapeutic conversations, but frequently they are invisible and unavailable to critical reflection. Gawande is very convincing in his argument that checklists work to guard against complacency in practice.

White, M. (2011) *Narrative Practice: Continuing the Conversation*. New York: W.W. Norton.

Michael White is one of the pioneers of narrative therapy. White's approach creates space for therapeutic dialogue that clears the way for narratives of hope, possibility and change. Via real therapeutic conversations with service users, he captures each of the five main areas of narrative practice and provides readers with an explanation of the practical implications of these conversations.

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5

SOCIAL AND ENVIRONMENTAL CONTEXT

STEVE TRENOWETH



CHAPTER OVERVIEW

This chapter:

- Considers the quality of an individual's social life.
 - Discusses factors relating to an individual's social and environmental context and those that impact on the social health and well-being of the individual.
 - Highlights those factors that facilitate and support, or impede and undermine, the individual in their social and interpersonal functioning.
-

Introduction

In this chapter, we consider the issues that potentially affect how the individual is grounded within their community, society and wider environmental context. We will also consider issues relating to an individual's *social performance* or *competency*. This will inevitably consider issues such as the impact of social inclusion/exclusion, social and interpersonal stressors, stigma and stereotyping, community integration

and social functioning but we will also consider the impact of the built and natural environment on the individual's well-being. Specifically, we will consider the individual's interpersonal and intimate relationships, family and work, but also activities which forge social and community engagement (**prosocial activities**), including the culture, language and identity, and the positive role that organised religion, social clubs and groups can play. A number of assessment approaches and rating scales are described to illustrate how we can help the person to share their social and interpersonal experience.

Psychosocial Stress

An individual's social context (their social circumstances and the environment in which they live) can have a profound impact on their mental health and well-being. The Stress Vulnerability model (Zubin and Spring, 1977; also see Chapters 4 and 11) reminds us of the factors which impact on our ability to cope with challenging circumstances in our lives. While the model originally considered an alternative view of the development of schizophrenia, it has, over time, been seen as a useful theoretical approach to explain the possible influences and interplay of social and environmental contexts on our biological mechanisms (Goh and Agius, 2010).

The model suggests that it is the exogenous stressors (such as bereavements, divorce, marriage, childbirth and so on) that may precipitate a crisis, and may pose challenges for an individual's ability to cope and adapt to such stresses and subsequently readjust their lives. One of the most widely cited scales used to capture the impact of such stressors on your social and interpersonal lives in research is the Social Readjustment Rating Scale (SRRS) (Holmes and Rahe, 1967), which seeks to capture the impact of life events on our health. The SRRS seeks to catalogue the impact that 43 stressors have on health and our chances of becoming ill as a consequence, such as: bereavements; changes in our social circumstances (such as moving house, having a child, divorce), work-related difficulties; and problems with family relationships. Interestingly, the scale highlights the psychosocial stress we experience from what we might consider positive experiences (such as an outstanding personal achievement, holidays and Christmas!). Each factor is weighted in terms of its psychological impact and stressors are considered to compound one another to which numerical values are assigned. For example, if a person experiences the death of a spouse (which on the SRRS is given a value of 100), with a concomitant major change in financial state (which scores 38), and a subsequent revision of their personal habits (which scores 24), then this person's overall score is 162 – which suggests a 50 per cent risk of developing a stress-related health problem over the next two years.

However, there have been criticisms of the major life-events approach, in that it does not consider the individual impact of each life-event stressor on our daily lives or factors that may mediate and protect us from psychological harm in the face of such events. It should also be remembered that not all events carry equal weight to individuals in terms of their psychological impact – that is, not everyone will necessarily experience a bereavement in the same psychological manner (Office

for National Statistics, ONS, 2002). Kanner et al. (1981) suggest an approach that considers the psychological impact of daily 'hassles' (i.e. irritating, frustrating, distressing demands or practical difficulties) for the individual in their transaction with their environment. Such daily hassles can involve:

- Social (e.g. crowding, queuing, being ignored or talked over).
- Interpersonal (e.g. family problems, work-related conflict, arguments).
- Situational (e.g. traffic jams).
- Practical (e.g. accommodation problems, financial difficulties, debt).
- Environmental (e.g. noise, pollution).
- Any of the above in combination.

Kanner et al. (1981) further argue that everyone can expect to experience a number of hassles in their lives, but any impact of such stressors on an individual's physical and mental health will depend on, for example:

- The number of hassles.
- The repetition and frequency of hassles, particularly if the person remains in the same context (e.g. due to their routines, lifestyle choices and habits, work or marriage).
- The compounding effect of daily hassles during a rare occurrence, life event or a crisis, such as a serious injury, bereavement or the birth of a baby.
- Hassles that have particular psychological importance for the individual, such as receiving an unexpected bill when the person is already experiencing financial problems.
- The ability of the person to cope and manage hassles.

There are also a number of issues which may be very detrimental to a person's psychological well-being but which may not be accounted for within a life-stress inventory and/or may be given sufficient weighting. People who experience mental health problems, particularly psychosis, are disproportionately far more likely to suffer victimisation than the general population (ONS, 2002). The ONS survey of 2002 found that, amongst people diagnosed with a psychotic disorder: 47 per cent said that they had been bullied; 37 per cent had been subject to violence in the home; 34 per cent had run away from home; 31 per cent cited sexual abuse; 28 per cent had been homeless; and 11 per cent had experienced violence at work.

'Uplifts', on the other hand, involve positive experiences and help mitigate daily hassles, such as having a good night's sleep; engaging with nature; solving and overcoming challenges; shopping; getting good news and so on. Kanner et al. (1981) suggest that assessing the balance of hassles and uplifts may be a better approach to understanding the person's experience of, and ability to cope and adapt to, life stress. That is, in assessing the quantity and quality of an individual's daily hassles, an assessment would also be needed of what might be considered mitigating factors – namely, daily uplifts, that is, positive experiences such as relief at receiving good news, support from friends and colleagues and so on. (See Kanner et al., 1981, for further details of the 'Hassles' and 'Uplifts' Scale.)

Social Inclusion/Exclusion

Social exclusion is defined as: 'the phenomenon where particular people have no recognition by, or voice or stake in, the society in which they live' (Charity Commission, 2001: 2). For Maslow (1943), social inclusion, in the form of belongingness and love, were essential motivational needs. This included friendship, romance and intimacy, affection and love and from relationships from work colleagues, family and friends.

A sense of belonging, access to social networks and an affiliation to a community can bring significant psychological and practical benefits to individual citizens. While it is arguable that everyone is motivated in the same way to fulfil such social needs, social exclusion from a community (or communities) can drastically reduce access to services, facilities and amenities and their life chances (such as career prospects) and from participating fully in wider society. It can also, of course, significantly impact on their mental health and well-being.

Community affiliation occurs when an individual becomes attached to a group who share similar aims and ideals, and helps to create a feeling of belonging and group identification. This can take many forms, including membership of, for example:

- Organised religions: While for some people their religion is an important part of their spiritual lives, organised religion represents a set of shared beliefs and values between people that can also offer community support.
- Cultural and ethnic groups: Expressed through language, beliefs, national, ethnic and personal identities.
- Political organisations.
- Occupational groups.
- Associations and social clubs.

Such affiliations provide opportunities for engagement in social and recreational activities and prosocial behaviour (Birchwood et al., 1990).

There are many possible reasons why a person, group or community may be socially excluded (including self-exclusion, where people may remove themselves; see Charity Commission, 2001), such as:

- Unemployment.
- Financial hardship.
- Youth or old age.
- Ill health (physical or mental).
- Substance abuse or dependency, including alcohol and drugs.
- Discrimination on the grounds of sex, race, ethnic origin, religion, creed or sexuality.
- Poor educational or skills attainment.
- Relationship and family breakdown.
- Poor housing (i.e. housing that does not meet basic habitable standards).
- Crime (either as a victim of crime or as an offender rehabilitating into society).

Mental ill health may be just one factor for social exclusion, compounded by others, facing an individual, which further undermines their social inclusion.

Social exclusion often occurs following the stigmatisation of a person or group and people with mental health problems can be amongst the most excluded in society (ONS, 2002). Similarly, the fear of being stigmatised may lead to a reluctance to seek help and support, which may have an effect on the recovery rates (Norman and Malla, 2001). Stigma originally referred to a distinguishing mark that was burned or cut into human flesh (Goffman, 1963) to identify slaves or criminals so that others would know their status in society. The term today reflects societal attitudes towards people who are deemed by a group to be less valued or who are to be excluded in some way (Link and Phelan, 2001; Porter, 2004).

Stigma can result in marginalisation from society, oppression, distress, poorer prospects of training for employment and associated socioeconomic restrictions, loneliness, loss of self-worth and feelings of hopelessness, or in extreme cases deliberate self-harm or even suicide (Bracken and Thomas, 2005). There is evidence, too, which suggests that stigma may have a negative impact, not only on the onset of a person's mental health problems, but also on the trajectory and course of the condition (Penn and Wykes, 2003). Families and friends can also feel stigmatised by association, which can, in turn, negatively impact on family dynamics and relationships (Link et al., 2001).

It is important to help the person share their social and community experiences by asking questions such as:

- Do you feel a part of your local community? Tell me about this.
- Are you an active member of an organised religion? Do you feel a part of this community?
- What groups, clubs or societies do you belong to?
- What hobbies/social/sport/recreational activities do you enjoy? Do these involve other people? In what ways?
- Tell me about your culture. Do you feel a part of your community?
- How often do you visit (or are visited by) family and friends?

Work

Work potentially bestows a sense of personal development, growth and achievement along with financial independence, but in social terms it can offer a sense of team spirit and collegiate camaraderie that is both personally and interpersonally rewarding. However, it has long been recognised that people with mental health problems consistently find obtaining meaningful work challenging. The *Social and Economic Circumstances of Adults with Mental Disorders* survey (ONS, 2002), for example, found that about a third of respondents in the sample group (no disorder, alcohol dependency, dependency, neurosis or psychosis) were unemployed or economically inactive, but amongst those diagnosed with a psychosis this rate was more than double at 72 per cent. People with a diagnosed disorder were represented more in the manual social classes: 39 per cent in the no disorder group contrasted to 44 per cent of those with a diagnosed neurotic disorder, 52 per cent and 54 per cent of those with alcohol and drug dependence and 61 per cent of those with a psychotic disorder (*ibid.* p.x). However, people diagnosed with an alcohol or drug-related problem were more likely than others in the sample to work in skilled manual occupations (such as craft, metal-working, textile, vehicle maintenance and so on).

Any psychosocial assessment, then, needs to explore not only the person's occupational history (see Chapter 7), but also their training, talents, abilities, skills, opportunities and motivations to obtain current meaningful employment, for example:

- What is your current job?
- What skills, abilities and knowledge do you have that may be valuable in the workplace?
- Have you any occupational training?
- What job would you like to do? What are your ambitions?

Social Support and Relationships

An important part of any social assessment (see Figure 5.1) is that of capturing an individual's social support because there is evidence that people with mental health problems have a poorer social network than the general population (ONS, 2002). Likewise, there is much evidence that adults with a primary support group

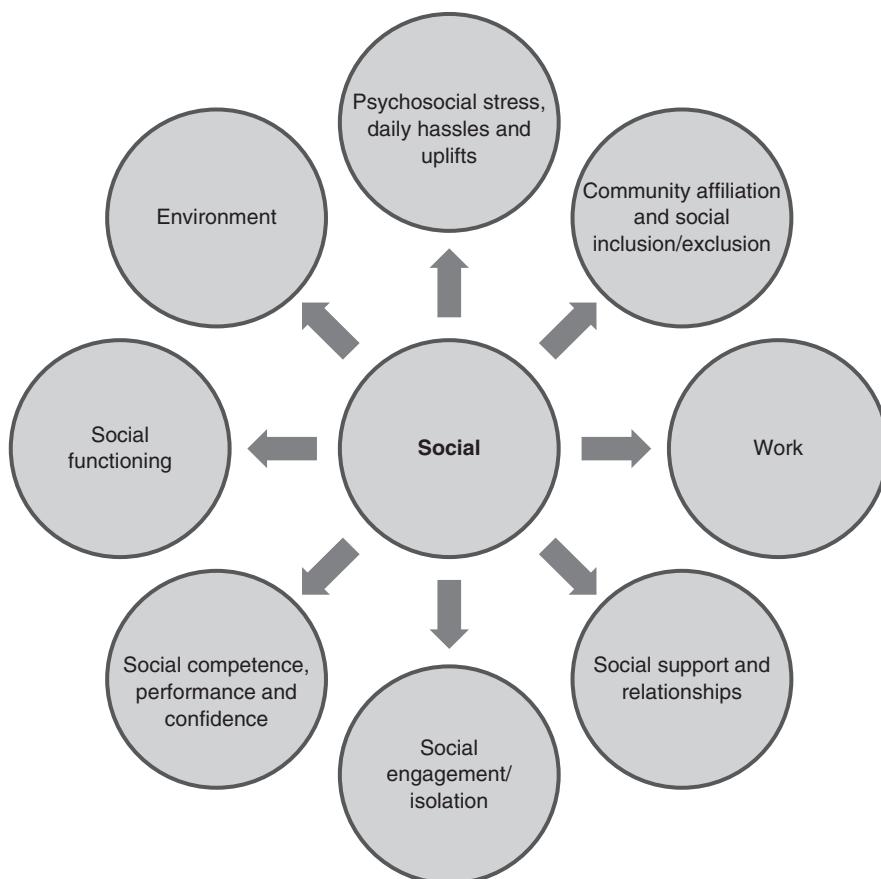


Figure 5.1 An overview of social assessments

(comprising close friends and relatives) of three people or fewer are at greatest risk of developing mental health problems (Brugha et al., 1993).

The ONS survey (2002) found that those with a diagnosed mental health problem are more than twice as likely to have a small primary support group of less than four people (9 per cent), compared to those with no mental health problem (4 per cent). The survey also found that 32 per cent of those people with a diagnosed psychotic disorder had a primary support group of three or fewer people.

There are a number of ways of capturing an individual's family and social networks. A **sociogram**, for example, is a graphical representation of a person's social networks, as illustrated in Figure 5.2 (we will be introduced to Emily in a later chapter).

There are a number of online tools for drawing, some free and some requiring a fee, (e.g. www.text2mindmap.com). A sociogram can be a powerful visual tool for helping the person to identify the quantity and quality of their social and interpersonal networks.

Likewise, a family tree is a visual representation of a person's ancestry and genealogical descent, and can be a helpful way of exploring the relationship(s) of all members of their family. This can be done very simply with a pen and paper but there are also some online tools that could be used (these, however, tend to be ancestry sites for which a charge is usually required).

There may also be a number of questions that you want to ask here to fully understand the person's social support network, for example:

- Do you feel you have a good social network?
- Tell me about your friends.
- Do you have a partner/children? How is that for you?
- Tell me about your parents. Do you have any brothers and sisters? Do they have families? Are you close?
- Do you feel able to talk freely to your friends and family about problems or issues you may have?

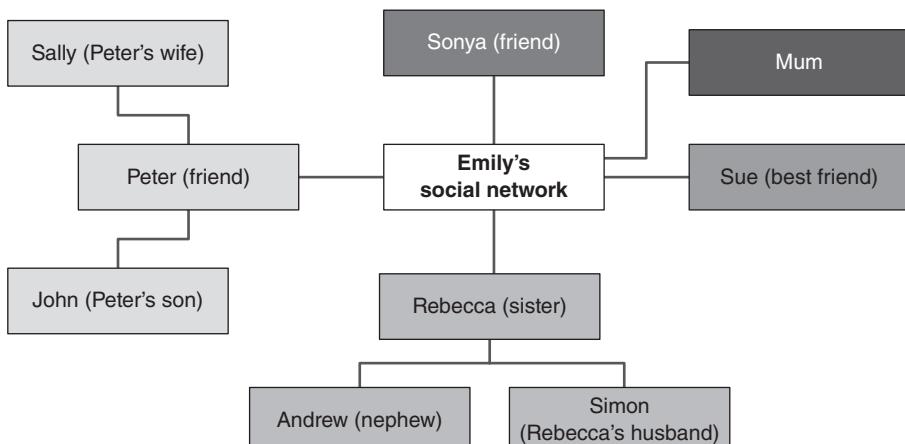


Figure 5.2 A sociogram of Emily's social network

Social Engagement/Isolation

People with mental health problems are more likely to experience social isolation, particularly people diagnosed with a psychotic disorder. The ONS survey (2002) found that amongst people with a psychosis, 10 per cent had seen no friends in the past week, compared to a rate of 4 per cent across the entire sample group (no disorder, alcohol dependency, dependency, neurosis or psychosis), and 45 per cent had only seen one or two friends, compared to an overall rate of 18 per cent.

Here, it is important to capture details about the person's level of social engagement or withdrawal. A number of questions might be helpful, such as:

- Tell me about how you structure your day? How much time do you spend by yourself?
- Do you feel socially isolated?
- Do you ever feel that you would like to avoid people or social situations?
- Do you enjoy occasions when you are alone?

Social Performance, Competence and Confidence

Birchwood et al. (1990) make an important distinction between a person's *competence* in social functioning (which refers to skills that have been lost or are absent) and the *performance* (which they see as the disuse or non-use of a skill). We may add that a person's social performance and competence is also a feature of how much *confidence* we have in ourselves. This may, in turn, be influenced by *internal factors* (such as our mood, fears, expectations, motivations and so on) and *external factors* (which may be situation-specific, such as the presence of people whom the individual finds intimidating, the number of people and other audience factors which may facilitate or inhibit social interactions, e.g. level of support or hostility).

In attempting to understand a person's interpersonal social performance and competence, it is likely that the practitioner will use their observation skills in assessing the quality of an individual's social skills. For example:

- Is the person able to establish eye contact?
- Do they initiate and/or sustain conversations?
- What is the quality of their communication?
- Are they monosyllabic or are they able to sustain a conversation?
- Is their communication clear and understandable?
- How is their body language?
- Do they use active listening?
- Do they follow social conventions, for example by saying 'hello' and 'goodbye'?

It is also important to ascertain the person's perception of their social performance, competence and confidence. Here, a number of general questions may be helpful to structure such a conversation, for example:

- Do you feel awkward in social situations?
- Do you find it easy to make conversation?

- In the past, did you used to find it easier to have conversations with people than you do now?
- How comfortable do you feel around people you don't know very well?
- Do you find yourself being annoyed or having arguments with other people?

Social Functioning

Social functioning can be broadly described as the ability to gain and maintain employment and interpersonal relationships, and generally to look after oneself (Erol et al., 2009). As such, our social functioning is an essential part of our ability to live, adapt to, and operate within, our social and interpersonal world. This is, of course, affected by our current mental state and other factors, such as our level of education, employment and financial status, and the amount of social support available to us (McDonald and Badger, 2002). Psychological factors also affect our social functioning such as memory, concentration, judgement, attention and executive and neurocognitive functioning, which are outside the scope of this book (see, for example, Erol et al., 2009). Here, we are concerned with those self-care, domestic and social skills necessary for community living and functioning.

There are a number of rating scales that can be used – such as Birchwood et al.'s (1990) Social Functioning Scale (SFS), as well as the Global Assessment of Functioning (GAF) scale and the Social and Occupational Functioning Assessment Scale (SOFAS) – to help structure conversations around social functioning. General areas for consideration when assessing social functioning are listed in Table 5.1.

Table 5.1 Areas for assessment of social functioning

Community living	Use of public transport, shopping, community orientation, knowledge and use of public amenities and council offices
Dealing with paperwork	Writing letters, sending cards or filling in forms
Financial	Budgeting, paying bills
Communication	Use of telephone, Internet
Vocational	Looking for a job, occupational skills and behaviour such as attendance, punctuality
Functional mobility	The ability to get around in the community independently; the physical ability to go shopping or visit local amenities

Environment

The environment in which we find ourselves can affect our physical and mental health (Evans, 2003). The built urban environment, for example, can have direct and indirect effects on our mental well-being. Some authors would go even further and argue that our mental well-being is affected by the apparent disconnection between ourselves and the natural world (Buzzell and Chalquist, 2009). It is further argued that we, as human beings, are part of a complex ecosystem. For example, in his Gaia hypothesis,

Lovelock (1979) suggests that the earth could be viewed as a self-regulating entity with interdependent component parts, including humanity. While this hypothesis has advocates and opponents (and further discussion is outside the scope of this book), it does draw our attention to the idea that we, as human beings, cannot be isolated from our environment (Sackett, 2010). The positive health effects of contact with the natural environment are becoming increasingly well recognised (Barton et al., 2012; Annerstedt and Wahrborg, 2011). Hartig et al. (2003), for example, found that spending time in a natural setting reduced blood pressure, stress levels and feelings of anger when compared with an urban setting, and Mitchell and Popham (2008) found that mortality rates were lowest in areas with the greatest exposure to green space.

The quality of our accommodation also has a significant bearing on our mental well-being. For example, cramped, high-rise housing and poor-quality housing appears to increase psychological distress (Evans, 2003). The *Social and Economic Circumstances of Adults with Mental Disorders* (ONS, 2002) survey found that those with a mental disorder were much more likely to be living in rented accommodation than those with no disorder (38 per cent compared to 24 per cent). Approximately 50 per cent of people with a diagnosed psychotic disorder were living in accommodation rented from a housing association or local authority. People with mental health problems are also more likely to live in accommodation that is in a poor state of repair and with a lack of space (*ibid.*). Other accommodation concerns are security and safety; financial problems in meeting rent; the lease or contract running out; domestic problems; and problems with the landlord or agent (*ibid.*). These are often conditions that are imposed on people and there may be little subsequent chance of home ownership. There is also a strong link between homelessness and poor mental health, with consistently reported high rates of people with mental health conditions and substance misuse among the homeless population (NHS Confederation, 2012).

Here, it is helpful to understand the person's perception of their environment by asking such questions as:

- Where do you currently live?
- Are you happy with the general environment where you live?
- Do you have any concerns about your living arrangements and accommodation?
- Are there any problems with the quality of your accommodation?

Chapter Summary

Our social and interpersonal environment is complex and can affect our mental health and well-being. Psychosocial stress arises not only from any number of life events but also from daily hassles, which may be mitigated by positive social experiences, social support and uplifts. Social inclusion, and a sense of belonging to a community, organisation and/or group, is important for our well-being, and being socially excluded can impact negatively on our personal identity, mental health, life chances and opportunities. In attempting to understand the person's social and interpersonal world, assessors also need to consider issues relating to an individual's working life; social performance, competency and confidence; and their social engagement and social functioning. The built and natural environment also have a potential impact on the individual's well-being, as do their accommodation arrangements.

EXERCISE



1. Draw a sociogram for your own social networks and a family tree to chart your family and ancestry.
2. When you are using this approach in an assessment, how might you introduce this activity? How might you subsequently use this to understand a person's helpful and not so helpful social relationships?

CONSIDERATIONS FOR PRACTICE

1. How might you involve the family/friends in understanding the person's social and interpersonal context? What are the challenges with this?
2. What can be done if the person's accommodation proves to be unsuitable for them?
3. How could the multi-professional team work together to support the person to share an accurate picture of their social functioning?

Further Reading

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A highly influential article which is essential reading for anyone wishing to undertake social assessments in mental health care. Clearly written and comprehensive.

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6

PHYSICAL HEALTH

TERESA BURDETT



CHAPTER OVERVIEW

This chapter:

- Highlights the importance of physical assessment and physical health care to mental health practitioners.
 - Offers a usable, flexible and supportive strategy of physical assessment to inform, educate and update mental health practitioners.
 - Provides a variety of opportunities for the reader to critically reflect on their own present level of knowledge and setting.
 - Suggests how the reader may enhance their level of knowledge of physical assessment and care that they provide in their own setting and share this knowledge with other practitioners.
 - Demonstrates assessment of some commonly presenting conditions, including the interventions and strategies to undertake.
-

Introduction

Undertaking a physical health assessment with people experiencing mental health problems is vital. Appropriate assessment and care is fundamentally important as individuals with mental health issues are particularly at risk from physical health issues (Robson and Gray, 2007). This is particularly noticeable in individuals who have a diagnosis of schizophrenia or bipolar disorder, whose lifespan is on average 15–20 years shorter than the general population (Laursen et al., 2014; Miller and Bauer, 2014).

It is important that procedures to protect the service user and promote their health and safety are being applied appropriately and safely, including, for instance, appropriate infection control practices such as hand hygiene (National Patient Safety Agency, 2008; DH, 2008). In response to this, organisations will have their own specific policies and training in place to uphold these legislative and professional demands.

An Overview of Physical Assessment

Physical health has been sometimes overlooked in mental health care. Fewer than 30 per cent of all individuals with a diagnosis of schizophrenia have a yearly physical health screening (NHS England, 2016), despite their increased risks (Laursen et al., 2014; Miller and Bauer, 2014; Brown et al., 2010). Physical health assessments and subsequent care are vital to prevent long-term ill health and disability, which may exacerbate a mental condition. It is also crucial that physical illnesses are excluded before a mental disorder is suspected, as the symptoms of physical illness may appear superficially similar to a psychiatric presentation. For example, confusion arising from an acute urinary infection can mask an underlying cognitive impairment.

Conducting a Physical Health Assessment

Presented in this chapter are suggestions that may be useful for you to use when assessing physical health needs. However, whatever way you physically assess a service user, your approach needs to be: person-centred; suitable to capture all the relevant information; effective, safe, timely and responsive to the presenting issues; and appropriate to the service user and the environment in which they inhabit. The assessment needs to lead to a subsequent resolution of health concerns for the service user, such as treatment, referral and review.

You should, of course, explain what the physical health assessment entails and ensure that you have the person's consent to proceed. You should also consider where the assessment is taking place. For example, the venue should be comfortable and clean, and people should be able to discuss their symptoms privately.

Physical assessment incorporates a number of skills that we need to consider and practice each time we are involved with our service users. This includes care that is sensitive and it is vital that an assessor is able to adapt the physical assessment to accommodate the person's gender and cultural needs. This may mean, for instance, arranging non-urgent appointments so that they do not clash with days that have specific meaning for the service user.

You should also consider the use of a chaperone. This may be due to cultural or gender reasons or to the intimate nature of the assessment taking place.

Barriers to communication may involve language or communication difficulties, sensory impairment or the lack of understanding, which can impact and undermine the accuracy of the assessment made. Therefore, an interpreter may need to be arranged or information re-explained in a different format.

Initial Questions

Ensuring a collaborative dialogue is vital and your actions should work to make certain that this happens. For instance: ensure that hearing aids are working and in place; book and arrange an interpreter prior to the consultation.

It is important to start off with broad, open, global questions about how the person is feeling, for example:

- How can I help you?
- How do you feel today?
- What is causing you concerns?
- What brings you here today?

Such questions help to elicit what the person's concerns may be and will also allow you to understand their personal experience. Such a broad narrative will allow you to follow up with more direct, specific questioning so as to explore particular symptomatology. Broader questioning should also be used to gather information on a wide range of biographical data which may be of relevance in your assessment of physical health, such as:

- Age.
- Occupation.
- Previous medical history, e.g. allergies.
- Family health.
- Medication, e.g. dosage, usage, effects and side effects.
- Previous hospital admissions.
- Operations.
- Serious illnesses.
- Present conditions.
- Social activities and lifestyle factors, e.g. diet and exercise.
- Use of substances, e.g. alcohol, tobacco, drugs.

It is vital that you accurately record your consultation. Policies vary slightly in differing organisations but will require you to document the discussion, and recording your results ensures transparency of your actions and that you fulfil policy and

professional obligations (Nursing and Midwifery Council, NMC, 2015). Practitioners can vary in the degree of skills to undertake physical health assessments but everyone should be able to notice if a person is experiencing symptoms which are out of the ordinary for them (either because this is reported by the person themselves or by their family/friends) and subsequently to refer the person on to someone who can undertake a more thorough assessment. Needless to say, you should not undertake any intervention for which you have not been adequately trained or prepared.

Signs and Symptoms

Physical assessment includes taking and recording baseline observations of a person's vital signs, including pulse, blood pressure, **oxygen saturation**, temperature and respirations. Mnemonics are commonly used tools to aid structuring the physical assessment and can be helpful in directing your questioning to gain a fuller picture of the presenting issue and the service user's signs and symptoms.

An example of mnemonic is **OLDCART** (Seidel et al., 2003), which refers to:

- **Onset:** When did it start?
- **Location:** Where is it? Is it all over? Can you point to it?
- **Duration:** How long has it lasted or is it continuous?
- **Characteristics:** What is it like? For example, is the pain sharp or stabbing or a dull ache?
- **Aggravating factors:** Are there other symptoms which you feel are connected? For example, do you feel hot and sweaty as well as having abdominal pain?
- **Relieving factors:** What makes it better? For example, is sitting more comfortable than standing?
- **Treatment:** What can I/we do to help to alleviate symptoms?

Utilising another mnemonic such as Morton's (1993) **PQRSTU** can also be helpful in directing your questioning to gain a fuller picture of your service user's signs and symptoms:

- **Provocative or Palliative:** What makes the symptom/s worse or soothes the symptoms?
- **Quality or Quantity:** Ask the person to describe and define the symptom – What is it like? How often do they experience it? How many times?
- **Region or Radiation:** Where it is?
- **Severity:** On a scale of 1–10, where 1 is 'no severity' and 10 is 'extremely severe'. Does the person feel that the problem is getting better or worse?
- **Time:** Time it started? How long has it lasted?
- **Understanding:** What does the person think about their symptoms?

Using these frameworks can greatly increase your knowledge about your service user's presenting issue and ensures that a person's physical and mental health needs receive equal assessment and appropriate treatment (British Medical Association, 2014). However, these are only tools, and your own professional knowledge, and your knowledge of your service user and/or setting, will also help to form the framework of your questioning.

Head-to-Toe Assessments

When assessing the person's physical health, you may take the **head-to-toe systems approach** (see below), which ensures a systematic comprehensive approach (Bickley 2013). An overview of a head-to-toe assessment can be found in Figure 6.1.

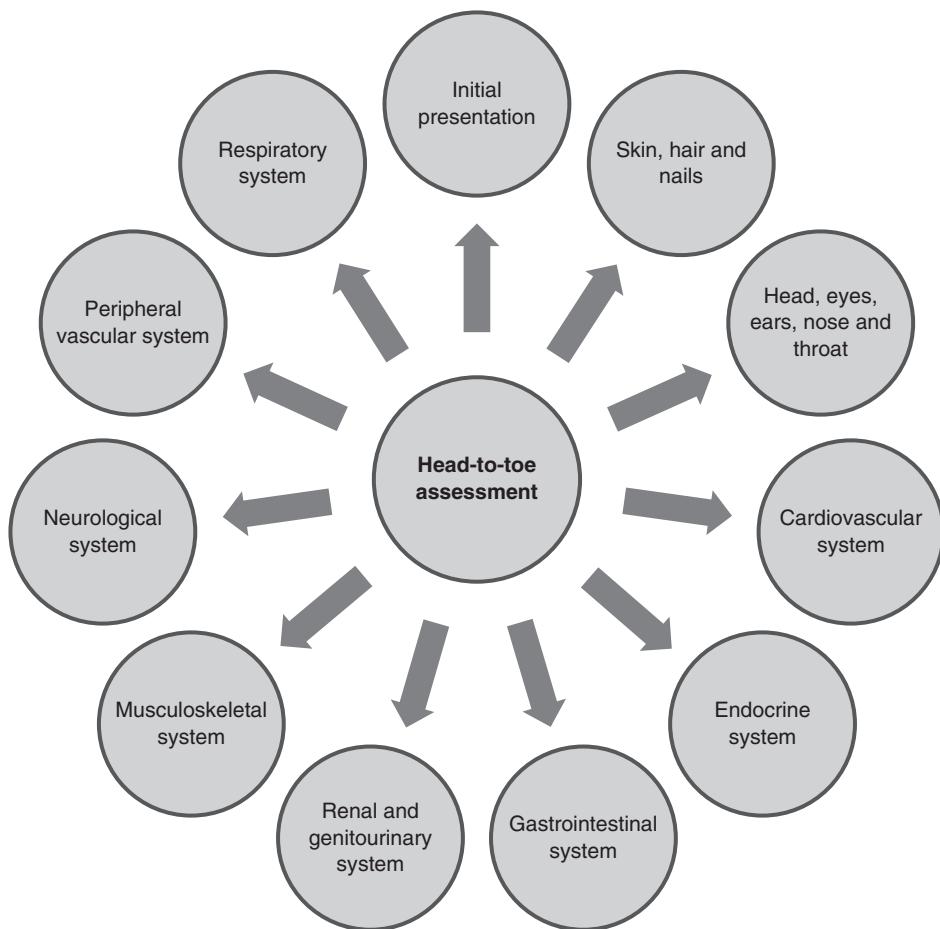


Figure 6.1 An overview of a head-to-toe assessment

Initial Presentation

Here, you will be using your observational skills to gain an initial impression of the person's physical health issue(s). There is much you can tell about the person's symptoms by their initial presentation. In asking questions, always ensure that any sensory aids that are required by the person (e.g. glasses, hearing aids) are worn so that they are able to respond. Consider, for example:

- Are there any obvious or suggestive signs of injury – such as bleeding, bruising?
- What is their facial expression like? Is it contorted or are they expressing pain?
- Are they agitated? Do they seem confused?
- Are they awake and alert? Or drowsy?
- How do they stand and hold themselves?
- What is their pallor and skin condition? Do they appear hot and sweaty? Or cold and clammy?
- Are their eyes clear or bloodshot?
- Do they appear to understand what you are asking or do they appear confused?
- What state is their clothing in – is it stained, if so, are they neglecting themselves?

Following on from the initial presentation, you may wish to consider the particular system which is first affected before moving on to consider which other systems may also be affected. Underpinning all of the assessment process is your own knowledge of the human anatomy and physiology system.

Skin, Hair and Nails

Skin review includes looking for rashes. If they are present, are they itchy? Rashes in the **flexures** could be indicative of **atopic eczema**. Larger patches or plaques on elbows and knees may indicate **psoriasis**. If moles or lumps are present, and are bleeding or have changed shape, this might be an early indicator of skin cancer.

Hair and nails are often reviewed with the skin. What is the person's hair condition like? Has there been recent hair loss? Changes in the hair and nails can often indicate illness, for example thinning hair is symptomatic of **hypothyroidism**.

Head, Eyes, Ears, Nose and Throat (HEENT)

Head

When reviewing the head, consider the size and shape, including measuring if appropriate. Has there been a history of a head injury, dizziness, light-headedness or headache? All may need further investigation or referral for a **CAT/CT scan**. For instance, a headache is a common neurological symptom, so assessment includes asking about its duration, type of ache or pain, and where in the head it is situated.

Eyes

Eyes may reveal a number of health-related issues. Physical assessment includes asking about the eye history of the service user and their family and making a visual assessment. If they use ocular aids, what are they for and when are they used? Has the person seen an optician recently and, if so, what was said?

Ears

Ears help with balance and hearing. When assessing, it is important to include asking about the person's ability to hear and if the person has noticed any changes?

Do they use aids and are they helpful? If the person has earache, then the mnemonic **OLDCART** is useful. If there is discharge, a sample may need to be taken, but on visual inspection, what does the discharge look like? What colour is it? Does it look infected or is there blood? The sample will need to be sent for analysis. This may aid with any subsequent treatment.

Nose

Have there been any nosebleeds recently or discharge? Is their breathing affected? Is there a nasal infection or upper respiratory tract infection evident?

Throat, Mouth and Neck

Are there any complaints of difficulty in swallowing? Is there any evidence of an allergic reaction? What is the colour and shape of the tongue like? Is it normal? Does the person wear dentures? Is there any dental pain? Is there swelling present in the neck? Is the person holding their neck in an unusual position (**torticollis**)? Are they complaining of pain?

The Cardiovascular System

Cardiovascular episodes or incidents are elevated as much as three times amongst individuals who have a diagnosis of schizophrenia when compared with the general population (Jindal et al., 2005; Robson et al., 2008; Chang et al., 2011). Cause for concern here may incorporate a wide variety of symptoms, including chest pain (which may indicate a **myocardial infarction** or **MI**), palpitations, **oedema** or shortness of breath, including **dyspnoea**, **orthopnoea** or **paroxysmal nocturnal dyspnoea**. All of these may be of concern and such presentations may be life-threatening, so be prepared to act swiftly if needed.

The Endocrine System

Endocrine glands secrete hormones directly into the blood and include the thyroid and pituitary. A number of symptoms may be evident in endocrine disorders. They may be diffused and have different onsets, some over many years. Taking a full medical history and investigating the presenting symptoms is paramount to make sense of what may otherwise be a random array of symptoms. Taking baseline observations may reveal changes. The pulse is often elevated (**tachycardia**) when **hyperthyroidism** (**thyrotoxicosis**) is present. **Hypertension** is present in **Cushing's syndrome**, recorded weight and height and extrapolating the **Body Mass Index (BMI)** may be helpful in indicating **polycystic ovary syndrome (PCOS)** and **Cushing's syndrome**. Weight loss may indicate hyperthyroidism and **diabetes mellitus**.

Urinalysis is an important initial observation and cannot be underestimated. It is a simple and inexpensive assessment (Krogsbøll et al., 2015) and provides very useful diagnostic information about a person's health (Merenstein et al., 2006; Gronhoj Larsen et al., 2012). Urinalysis may, for instance, reveal **proteinuria** in hypertensive renal damage and **glycosuria** in diabetes mellitus. Further investigations may include

blood tests to investigate specific complaints, for example calcium is high in **hyperparathyroidism**; imaging, including **ultrasound** of the thyroid, parathyroid, ovary, testis and **Magnetic Resonance Imaging (MRI)** of the pituitary and pancreas, may be necessary.

Diabetes mellitus is an endocrine disorder and is more common in the mental health service user group (Sernyak et al., 2002; Smith et al., 2008). This can be either type 1 diabetes (where the person is dependent on insulin) or type 2 diabetes (diet-controlled, with or without medication). Assessment of diabetes consists of a routine approach, baseline observations and recording BMI, fluid assessment, input and output, urinalysis (Krogsboll et al., 2015) and blood tests. Common symptoms include **polyuria** and also **nocturia**. Signs of diabetes may include a relentless thirst as the person tries to consume more liquid. Recent weight loss may be suggested by a person's clothes being noticeably baggier and a reducing BMI.

Referral is required and both short- and long-term care and patient education is vital to reduce the secondary complications of diabetes mellitus. These include macrovascular disease (WHO, 2016) and sexual dysfunction (Phillips and Phillips, 2015).

Diabetes that is usually well controlled by the service user may become unstable in the event of deterioration in their mental state.

CASE SCENARIO 6.1 ADRIAN

Adrian is 27 years of age and has type 1 diabetes. Recently, he has been acutely unwell with a virus. There is danger that his blood sugar levels could become unstable. Adrian should be assisted to care for himself and maintain his own diabetes, depending on how he is feeling. Factors to control his diabetes include testing his glucose levels every 2–4 hours throughout the 24-hour period. Adrian should be encouraged to take glucose foodstuffs such as fruit juice and soup if he is finding eating difficult. His urine should be tested every time he voids for the presence of ketones, which are a product of fat-burning. As Adrian is taking fluids and his glucose levels are stable (6–15 mmol/l) and there is no presence of ketones in his urine, this demonstrates that his diabetes is being kept within manageable limits whilst he is unwell.

The Gastrointestinal System

The gastrointestinal system has a number of functions, including ingestion, digestion of food products and excretion of waste products. Symptoms of gastrointestinal disorders may include abdominal distension, abdominal or flank pain, altered bowel habits, heartburn, indigestion, nausea, vomiting and/or weight loss. Each symptom will need to be investigated and the use of the mnemonics (OLDCART or PQRSTU described above) may be useful here for a thorough approach.

Abdominal distension may be associated with obesity but if a person has lost weight and abdominal distension is present, it may be an indicator of a gastrointestinal disorder. Abdominal distension may also be due to **ascites** and this always requires further investigation.

Additional assessment requires recording bowel habits, taking a stool sample, assessing and recording dietary intake, BMI and monitoring weight. Urinalysis is an appropriate assessment as is assessing skin discolouration. The presence of **jaundice** is an indicator to act upon. Any acute abdomen symptoms require prompt referral and urgent review.

The Renal and Genitourinary System

The renal and genitourinary system includes the kidneys, urinary tract and reproductive organs. Signs and symptoms that may be cause for concern include pain, discharge from the penis or vagina and frequent voiding.

Sensitivity is required due to the nature of the areas being discussed, including taking a sexual history and/or examination. Ngwena (2011) suggests that individuals with mental health issues may have reduced awareness of sexually transmitted diseases and are therefore increasingly vulnerable to a genitourinary disorder. Hence the enhanced need for appropriate assessment by practitioners caring for, and providing support to, mental health service users.

Urinalysis is a fundamental assessment tool in a genitourinary disorder which may indicate changed kidney function, and the presence of blood in the urine or protein may indicate an infection or **glomerular disease**. Further investigations include abdominal X-ray, ultrasound scan, blood tests and investigation of any discharge. Flank or back pain may indicate kidney disease or urinary tract infection.

The Musculoskeletal System

The musculoskeletal system consists of bones, joints and muscles. Symptoms of a musculoskeletal disorder may include locking of joints, nodules, pain, stiffness, swelling and weakness. Assessment consists of a routine approach, including a full history as well as any trauma and history of injuries. Baseline observations need to be taken and recorded, including an X-ray of the painful area, assessment of pain and appropriate referral, for instance to a rheumatologist.

Urinalysis may detect protein, which may indicate **rheumatoid arthritis**, and X-rays may detect factures; **ultrasonography** may detect effusion or synovitis. Joint aspiration may detect raised **white cell count**, which may indicate infections.

The Neurological System

The neurological system is a complex system that may well require specialist assessment and treatment. Symptoms of neurological disorder may include cerebrovascular accident, dizziness and headache, loss of consciousness, loss of sensation, speech impairment, syncope (fainting), tremors and weakness. **Epilepsy** is one of the most common neurological conditions (Ogden, 2015).

A neurological assessment consists of completing baseline observations as described below. Physical assessment includes identifying areas of weakness or

stiffness. Blood tests and **nerve conduction studies** may also be required. A CAT/CT brain scan may indicate **subarachnoid/intracranial haemorrhage**.

An assessment of the level of consciousness can be facilitated by using the AVPU scale, namely:

- **A:** Is the person awake or alert?
- **V:** Are they responsive to your voice and/or commands?
- **P:** Are they responsive to a pain stimulus?
- **U:** Are they unresponsive?

In assessing orientation, it is common to consider:

- Person (knows their own name).
- Place (knows where there are).
- Time (knows the day and date).

Another level of orientation is that of *purpose* – does the person know that they are being examined and why you are examining them?

The role of the mental health practitioner includes being alert to the possibility of neurological disorders, responding to the service user's presenting issues, offering support and reassurance appropriately, and referral as appropriate once an issue has been identified.

The Peripheral Vascular System

Pain in the legs or cramping pains is not uncommon. Assessment consists of checking for swelling in the limbs, oedema, colour of the limbs, evidence of ulceration, temperature of the limbs and recent medical history such as surgery or bed rest which may have increased the likelihood of **deep vein thrombosis (DVT)**. Deep venous thrombosis is relatively common, with one individual in every thousand being diagnosed with a DVT (Scottish Intercollegiate Guidelines Network, 2010). It is potentially life-threatening and the role of the mental health practitioner includes assessment, offering adequate pain referral and prompt referral. Subsequent medical actions may include checking for the presence of the pulse in the femoral, popliteal dorsis pedi and posterior tibial artery and conducting a **Doppler ultrasound scan**.

The Respiratory System

The respiratory system includes the upper respiratory tract and the lungs. Mental health service users are four times more likely to die from diseases of the respiratory system than the general public (Health and Social Care Information Centre, HSCIC, 2013).

People may present with symptoms including a cough, excess or discoloured sputum, pain, breathing difficulties and **cyanosis**. Assessment includes asking about their

smoking and occupational history and baseline observations including respiration rate. A sputum sample may need to be taken and any cough over three weeks old needs referral: a **chest X-ray** is usually required.

Activities of Daily Living (ADLs)

Activities of Daily Living (ADLs) are those things we normally do in daily living, including any daily activity that we perform for self-care (see Table 6.1). The ability or inability to perform ADLs can be used as a practical measure of ability/disability whilst people are experiencing mental health problems and can be helpful in understanding the person's ability to care for themselves in the face of medical conditions or physical challenges (Barker, 2004).

Table 6.1 Activities of daily living

Personal appearance	Dressing oneself, cleanliness and appropriateness of clothing, ability to launder clothes
Personal hygiene	Bathing or showering, washing hair, dental hygiene, manages menstruation, use of toilet and toilet hygiene
Household	Housekeeping and domestic-living skills, cooking and food preparation, cleaning, tidying, gardening, decorating or doing household repairs
Functional mobility	The ability to undertake activities independently, such as getting in and out of bed or a chair; to undertake self-care actions (moving from one place to another while performing activities)
Eating and drinking	The ability to meet own dietary and fluid-intake needs
Sexual functioning	Changes in sexual expression; difficulties

Some helpful questions in understanding a person's ADLs include:

- What's your appetite like?
- How are you eating?
- Is there any change in your weight?
- How are you sleeping?
- What time do you get to sleep and what time do you wake up?
- Do you sleep right through or wake up in the night?
- After you've woken up, do you get back to sleep?
- What time do you eventually wake up in the morning?
- Is there any change in your interest in sex?
- Are you less interested in sex than usual?
- Is there any change in how often you have your bowels open?
- Do you experience constipation?
- Is there any change in your energy levels?
- Do you have more or less energy than usual?

Screening and Health Promotion

People with mental health problems are more vulnerable to physical ill health than the general population (HSCIC, 2013; Keyes et al., 2010). However, mental health service users often receive less health promotion advice than the general population (Hardy et al., 2013; DH, 2006). Parity of esteem, which was enshrined in law in 2014 by the Health and Social Care Act, will only be achieved between physical and mental health when such disparities are addressed. Hence the even greater need for health promotion to be offered to this population group.

In undertaking a physical assessment as part of an overall psychosocial assessment, it is likely that the opportunity to discuss health promotion will arise. This may, in turn, raise awareness of issues when considering a case conceptualisation and when formulating needs and goal statements.

There are a number of factors to consider when offering health promotion to individuals who have mental health issues. For instance, breast cancer rates are higher and bowel cancer rates are twice as high in individuals who also have a diagnosis of schizophrenia than in the general population (Disability Rights Commission, 2006). Also, when co-morbid physical conditions are diagnosed, care is often poorly managed (Lawrence and Kisely, 2010; Robson et al., 2008).

In mental health care, assessment of physical health tends to occur only when the person presents with specific symptoms or when a pre-existing complaint is known, but it is vital that a proactive approach is taken and that broader health promotion practices are routine. This may occur opportunistically, such as offering smoking-cessation advice when a person identifies a need to stop smoking. However, health promotion practices also need to be organised and arranged, including offering yearly health screening. All male service users should be offered health promotion information on testicular examination and prompt referral should be encouraged as required (NICE Guidance, 2014). This is important as, according to Prostate Cancer UK (2016), more than 10,800 men a year die of testicular cancer. All female service users need to be offered gender-specific health promotion information, for instance regarding breast care, breast self-examination, mammograms and cervical smears.

Annual Health Checks

To optimise the physical health of individuals with mental health illness, Robson et al. (2008) recommended annual health checks that should be inclusive and comprise physical assessment. However, there is still clear evidence that the physical health of the mental health service user population is below the general population, especially in individuals with long-standing mental health issues such as schizophrenia (Brown et al., 2010; Lawrence and Kisely, 2010). Nevertheless, some new initiatives in Cheshire (Cole, 2015) and Bradford (Dale, 2015) are demonstrating that, in some areas, this imbalance may be reducing. Cole (2015) demonstrates an increased uptake of health screening from 6 per cent to 94 per cent.

However, health promotion is not a once-a-year stand-alone venture. Health promotion needs to be offered, both routinely and as a bespoke service. Areas of

health promotion to discuss may include activity and exercise, dental care, diet and nutrition, medication, sleep, sexual health, substance use and ocular health.

Activity and Exercise

There are significant physical and mental health benefits of being active and exercising (Reid et al., 2010). These benefits are of additional importance in individuals with mental health issues as they often have poorer physical health outcomes. Health promotion activities may include providing information on the benefits of physical exercises and also the potential additional risk to their health of being inactive. Guidelines suggest weekly 150 minutes of moderate intensity activity (UK Chief Medical Officers, 2011). Advising people of what is available to them in their community may enable them to achieve these suggested guidelines. Enhancing access to facilities and supporting the mental health service user's aims may play a significant part in increasing their own health, both physical and mental.

Dental Care

Dental care should be a service offered to all mental health service users as they tend to have higher levels of tooth decay than the general population (Kisely et al., 2015). Providing information about dental care and hygiene and ensuring access to dental services may reduce the discomfort of poor teeth and enhance an individual's self-esteem.

Diet and Nutrition

A healthy diet can improve both physical and mental health (NHS England, 2016). Hence, maximising opportunities to promote the diet and nutrition of mental health service users is vital as they tend to have a poorer diet than the general population (McCreadie, 2003). A poorer diet raises the risk of other health issues such as coronary heart disease (Emberson et al., 2003) and may also compound the impact of mental health problems (Peet, 2004). Such health-promoting activities may include offering education about an appropriate healthy diet and weight, recording BMI and recording dietary intake. Giving information about local services that help with, for instance, weight loss, is also useful, as is signposting available services and enabling access to them by the mental health service user.

Medication

Health promotion includes ensuring that mental health service users are informed about the purpose and benefits of their medication and the contraindications, too. There are also other risks to consider. For instance, there is a link between antipsychotic medication (such as olanzapine) and **hyperlipidaemia**,

which increases by five times the risk associated with cardio- and cerebrovascular disease (Gatineau and Dent, 2011; Koro et al., 2002). Weight gain is also associated with the newer antipsychotics (Bak et al., 2014; Gatineau and Dent, 2011), which also increases the risk of physical disorders such as type 2 diabetes (Citrome and Yeomans, 2005). Therefore, promotion around eating healthily is of additional importance to mental health service users.

Sleep

Adequate sleep is a building block for good health (National Heart, Lung and Blood Institute, 2012). However, a poor sleeping pattern may impact on an individual's health (Luyster et al., 2012). Sleep may be disrupted by lifestyle actions such as television and computer use, medication being taken to improve mental health, or by cigarette smoking (Liu et al., 2013). Health promotion education, including a baseline assessment of the individual's sleep pattern as well as discussing the benefits of good sleep and sleep-enhancing strategies, may be beneficial. Such signposting for better sleep may well help mental health service users to sleep better and consequently function at a higher level.

Sexual Health

Health promotion requires sensitivity, tact and cultural competence (Leininger, 1999) and, due to the increased risks for mental health service users, the topic of sexual health needs to be discussed. The sexual health of the service user is often ignored (Volman and Landeen, 2007) and as psychiatric medication often alters sexual function, it has been identified that this is a factor behind non-adherence (Higgins et al., 2006). Psychiatric medication dampens sexual desire and impacts on erectile function. The weight gain associated with psychiatric medication causes physical health issues and reduces self-esteem. Antipsychotic medication has also been associated with an enhanced rate of osteoporosis in this group (Halbreich and Palter, 1996). Increased risk-taking and a reduced knowledge base leads to an increased risk of HIV and sexually transmitted disease (Ngwena, 2011). Signposting to services and referral and also offering support and education, for instance regarding breast care and monthly self-breast examination and testes examination, are vital and health education is therefore additionally beneficial to mental health service users.

Substance Use

The impact on mental health service users' physical health due to alcohol and drugs use is profound and up to 60 per cent of individuals diagnosed with schizophrenia may abuse substances (Citrome and Yeomans, 2005; also see Chapter 10). The use of drugs and alcohol may interact with neuroleptic medication that may lead to an

increased risk of suicide and violent behaviour (Vose, 2000). Such usage may impact on physical health, and a loss of inhibition leads to increased risk-taking behaviour and enhanced risk of sexually transmitted disease and HIV (Ngwena, 2011).

Mental health service users tend to smoke more than the general population (McCloughen, 2003). The reasons for smoking are complex, including habit, addiction and relaxation (Robson and Gray, 2007). However, there is a significant amount of data that demonstrates the profound effect that smoking has on physical health and mortality (NICE, 2015; Ezzati and Lopez, 2003).

Health promoting actions consist of discussing the present situation with the mental health service user and including the potential impact that their actions are having on their physical health. It is also useful to assess the level of alcohol being consumed, the drugs being taken and the cigarettes being smoked and why. There are clear guidelines for the support strategies available, including referral and appropriate signposting, which can be tailored to the individual once a thorough assessment has been completed.

Ocular Health

Individuals' use of health services is affected by a variety of factors and the use of ocular services are no different (Donoghue, 1999). Promoting the ocular health of the mental health service user includes being aware of potential visual changes, signposting to ocular services, enabling access to ocular services and offering support and assistance. This may include encouraging the mental health service user to attend appointments, wear glasses and instil eye drops. However, mental health service users do have specific risks to their eye health, including an increased risk of cataract due to some antipsychotics which can cause a loss of vision (Marder et al., 2004). Chlorpromazine and prochlorperazine, for example, have been identified as increasing the risk of developing cataracts (Ruíz-Gómez et al., 2000). Consequently, guidelines (Marder et al., 2004) suggest being aware of visual changes in mental health service users and acting on such changes, including asking yearly about blurred vision and the quality of distance vision. Mental health service users should have yearly ocular examinations if they are over 40 and every two years if they are under 40.

Chapter Summary

In this chapter, we explored how to conduct a general physical health assessment, but we also considered those specific areas where the physical health of the mental health service user may be particularly vulnerable. Strategies offered in the chapter to achieve this include person-centred assessment, reviewing symptoms, treating symptoms and conditions using mnemonics and a head-to-toe systems strategy. We have also highlighted factors which may undermine physical health (such as a lack of exercise, poor diet, smoking and so on) and the need for appropriate health promotion strategies in mental health care, whether opportune or planned.

EXERCISE



May is a 65-year-old woman being cared for at home by twice-daily carers and her family, and has become increasingly confused, agitated and distressed over a period of two days. She is complaining of pain in her pelvis and lower back. Her sleep has deteriorated and she is falling more frequently. Her family are exhausted but are under the impression that it was her mental health that was deteriorating. Consider:

1. How would you structure an assessment of May's physical health?
2. What physical health problems might May be experiencing?
3. Why might concerns over her mental health overshadow her physical health?

An outline answer is given at the end of this chapter.

CONSIDERATIONS FOR PRACTICE

1. Revisit the skills and knowledge contained in this chapter and reflect on the implications for your own personal and professional development. How might you address any deficits that you have highlighted? Are there any issues that you would like to include in your appraisal/personal development plan?
2. How might mental health services ensure that they routinely screen for physical health conditions? Is there anything else that your service could do to promote psychosocial health?

OUTLINE ANSWER TO EXERCISE (MAY)

In May's case, it is important to be open to the potential of a physical issue being the cause of her sudden deterioration. A head-to-toe assessment would be appropriate as she is presenting with issues affecting a number of systems (e.g. musculoskeletal, neurological). The use of OLDCART or PQRSTU to understand the overall experience of symptoms would be helpful.

The rapidity of onset of her confusion and agitation, along with pain in her pelvis, is suggestive of an infection (possible urinary tract) that needs exploring. It would be vital to assess her fluid input, urinary output, amount, frequency, colour and smell of her urine. A urinalysis should be conducted alongside a full physical health assessment. We should not assume that confusion and agitation is 'simply' due to May's age. Such a misdiagnosis can be due to a number of factors, such as ageist views about older people or to a lack of knowledge or experience about physical health on the part of the practitioner. It may also be due to diagnostic overshadowing, in which physical symptoms are interpreted in terms of existing mental health conditions or diagnoses (Jones et al., 2008).

Further Reading

Bickley, L.S. (ed.) (2013) *Bates' Pocket Guide to Physical Examination and History Taking*, 7th edn. New York: Wolters Kluwer/Lippincott Williams and Wilkins.

A comprehensive guide to physical examination and history taking and which is a handy size to carry around with you.

Douglas, G., Nicole, F. and Robertson, C. (2009) *Macleod's Clinical Examination*, 12th edn. London: Churchill Livingstone Elsevier.

A comprehensive guide to history taking and both general and systematic examinations within a variety of patient populations. This book is filled with useful photographs and diagrams to aid diagnosis and enhance assessment and care.

Marieb, E.N. (2014) *Essentials of Anatomy and Physiology*, 11th edn. San Francisco, CA: Pearson Education.

Anatomy and physiology can often be an area where mental health practitioners feel that their knowledge is deficient. This useful aid has an understandable writing style and use of tools to enhance learning.

Rushforth, H. (2009) *Assessment Made Incredibly Easy: Adapted for the UK*. New York: Wolters Kluwer/Lippincott Williams Wilkins.

The title says it all. A guide to the aspects of health assessment presented in a format that is easy to read and follow.

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7

HISTORY TAKING

REUBEN PEARCE



CHAPTER OVERVIEW

This chapter:

- Provides a contextual overview of recording a comprehensive history.
 - Discusses the specific communication skills required to sensitively explore a service user's history.
 - Demonstrates a systematic approach to exploring a history in partnership with the service user.
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Introduction

It is vital that health care staff are able to understand how a service user's current presenting problem fits into their previous experiences. This chapter seeks to explore the person's history, which may have predisposed or increased vulnerability to mental distress and ongoing difficulties they might experience.

History taking is an important component in aiding development of a case conceptualisation and informing subsequent interventions with a service user. The history will normally be taken at an appropriate point at which the service user feels able to revisit their past. The purpose of taking the history is to gather the information necessary to better understand the lifetime of the service user and the impact of this on their biological, psychological and social functioning. Effective history taking is an important clinical skill to learn, most effectively developed by ‘doing’.

SERVICE USER VOICE

I have had both good and bad experiences of nurses discussing my history with me. The time it was bad was because I was feeling very anxious, having just been admitted to hospital for the first time. The nurse just kept firing questions at me and was reading the questions off a bit of paper. He was asking really personal stuff about my childhood and even my sex life. He didn't seem to pick up on my distress and appeared more interested in getting all the answers he wanted as quickly as possible. I noticed that he kept looking at his watch, too, I knew that the ward was busy and so decided just to tell him what I thought he wanted to hear. It actually left me feeling worse than I did before I saw him because it made me start thinking about how rubbish my life was at that time. On the following admission a few years later, I had a much better experience – the nurse really took their time and I could tell they actually cared as they went at my pace and picked up on the things that were particularly hard for me to talk about. The thing I think was most important was that they were genuinely interested in me, I knew they wanted to help me.

The History-Taking Interview

The history-taking interview is a conversation with a deliberate purpose. It differs from a social conversation in that the practitioner is responsible for the content and flow of the interaction, while the service user is the focus of the discussion. The interview must take place within a specific time frame. The content and process of the interview will vary according to the emotional state of the service user and the context in which the interview takes place.

The aim of history taking is to obtain a comprehensive idea of the service user's experiences over their lifetime, with a focus on their biological, psychological and social functioning. The criteria to be addressed in a comprehensive history-taking session are summarised in Figure 7.1.

It is vital to get off to a good start when taking a history by making sure that the environment is comfortable and the service user has an idea of what to expect (Mackinnon et al., 2015). It is important to remain mindful that the discussion is likely to bring up a number of sensitive issues. Therefore, always remember that the well-being of the service user comes before your own need to gather the information you require.

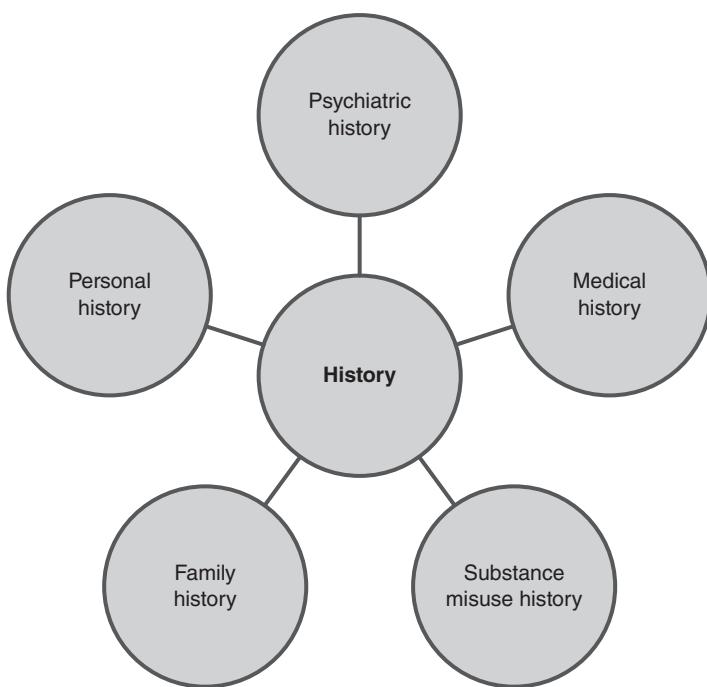


Figure 7.1 The comprehensive history

To aid the process, the following may be helpful to remember at the start of the session:

- Introduce yourself fully.
- Explain who you are and the purpose of the session.
- Put the service user at ease and build a rapport.
- Inform the service user of timings of the interview. How long will it take, roughly?
- Inform them that you may need to take notes.
- Explain confidentiality issues.

Psychiatric History

Information concerning past psychiatric conditions must be obtained in order to better understand the current episode and to aid case conceptualisation. Psychiatric conditions may be a single event, or there may be intermittent episodes, or the condition may be chronic and unrelenting, and the course of the illness may improve or deteriorate over time. Remember that the service user's understanding of their problem may be different from the formal diagnosis and it is important that you understand their perception of the condition and how they might have changed over time. This will then help shape any **psychoeducational** interventions that might be

necessary in the future. Corroborative evidence such as previous notes can often be helpful, especially in cases of multiple episodes when it can be difficult to piece together a full picture.

It can be easy to get lost in long accounts of past admissions if these are frequent and this can take some time (Bowers et al., 2009). It may be useful to arrange another date to discuss issues around previous experiences with services if the service user so wishes and keep to the basic facts such as rough dates and length of admissions, treatment given and follow-up arrangements (Aquilina and Warner, 2004).

EXPERT VOICE

‘ It is important that you explore in detail any previous diagnoses or contact with any psychiatric or other mental health services. Record (as far as possible): dates of illness, symptoms, diagnoses, treatments, any hospitalisations, outpatient treatments, any compulsory treatment under the Mental Health Act 1983/2007:

- Don’t forget to establish whether the service user has had episodes of illness for which they have sought help.

Medical History

The practitioner should ascertain significant previous illnesses, injuries and treatments received (see Chapter 6). It is also important to ask about drug allergies and past and present side effects of medication. The service user’s beliefs about their medication can give useful insight into what they believe is wrong with them. Remember to ask about side effects and adherence and bear in mind possible drug interactions (Bickley, 2013). It is important to ask, not just about current and previous prescribed medication, but also over-the-counter and other alternative therapies that the service user may have tried or may be currently using. Make a chronological list of all major physical illnesses, long-term conditions and treatments. There are many physical health conditions that can impact on mental health problems, for example head injuries and chronic pain are often likened to depression and low mood (Aquilina and Warner, 2004).

Substance Misuse History

Studies have shown high co-morbidity of mental ill health and alcohol or substance misuse. Cause is difficult to discern, as alcohol and drug misuse may precipitate an episode of mental illness or may represent a person’s attempt to cope with a pre-existing mental health issue. The details here are vital and so, if a service user does disclose that they are using a substance, it is necessary to explore in depth their use and relationship to the substance (see Chapter 10; and Mackinnon et al., 2015). Remember to establish the duration, frequency, amounts and route they use to take

the drug. Find out whether the amount/frequency is increasing, and how do they finance the activity? Establish whether they have had periods without using the drug. What are the person's own views on their drug usage? The practitioner should also obtain a history of the caffeine, alcohol and nicotine use. It is important to be aware that some drugs, such as nicotine, may impact on the efficacy of prescribed medication (Taylor et al., 2012).

Family History

Families play a huge role in the recovery process and so obtaining a comprehensive history of the family set-up is crucial. The family history should give you a good indication of the service user's family relationships. Find out which members of the family they have felt close to, and why. Equally, reasons for discord within the family should be explored. Bear in mind social, psychological and genetic risk factors for mental illnesses, and remember to ask about family psychiatric history (Jones, 2010). It can also be helpful when taking the family history to include some reference to cultural tradition, socioeconomic background, family interests and aspirations. When exploring family relationships, it can be useful to draw a family tree (see Chapter 5), recording age, health, occupation and quality of relationship. When exploring the history of psychiatric conditions in family members, don't forget to include alcohol and substance misuse, deliberate self-harm and suicide. An often overlooked area is domestic violence in the family: this can have a severe impact on the development and well-being of a person into adulthood. Finally, include important family events such as death, divorce, separation and the service user's feelings about these events (Mackinnon et al., 2015).

Personal History

The personal history is an account of the service user's infancy, childhood and adolescence through to adulthood. It may provide clues to the origin of current behaviours, for example childhood mental disorders, temperament and style of interpersonal relationships may have remained into adulthood. Personal history is important as it helps you to understand what has led to your service user becoming the person they are (Buckley et al., 2005).

SERVICE USER VOICE

We had a lot of issues in my family growing up that we never talked about, my dad was depressed from when I was young, he never managed to hold down a job for long and had problems with alcohol. This meant that my mum was always working and we never got to do much as a family. I used to feel envious of my friends at school when they talked about holidays they had or going clothes-shopping with their mum. As we didn't have much money, I would be embarrassed of my clothes and got bullied quite a lot by other

girls and had trouble getting to know boys. My dad once came to the school and had been drinking, he fell over in front of everyone and other parents were staring. I could see other children whispering to each other. I had never had the opportunity to talk about these things before I saw a mental health nurse following a period of anxiety and depression. Just being able to talk through them with someone who recognised how difficult it had been was a huge relief. What really made a difference was that they genuinely seemed to be interested in my story and wanted to help me work through my problems.

It is easiest to work through the personal history in chronological order, remembering that some of the information may have been gathered earlier on. The key areas to explore when taking a personal history are as follows (also see Figure 7.2).

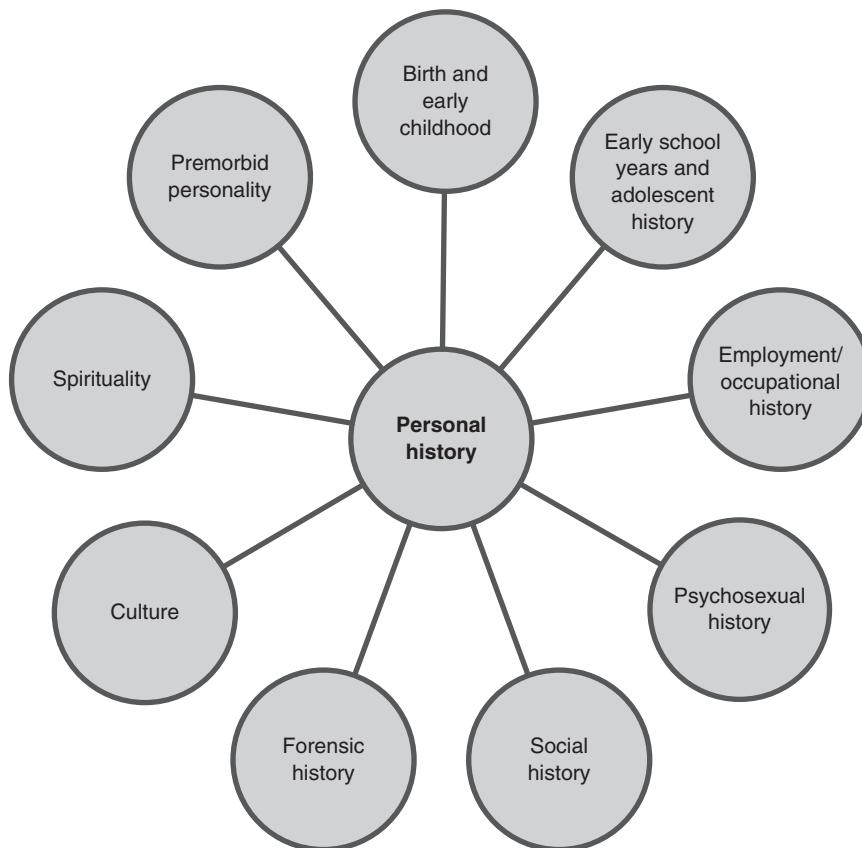


Figure 7.2 The personal history

Birth and Early Childhood

Difficulties in the early years of a child can have a huge impact on our ongoing development into adulthood. It is therefore important to explore all significant

events from birth to adolescence. Birth complications, for example, can have an impact on those initial weeks with the mother and, in more severe cases, can cause lasting physical and neurological issues. Complications with the mother, such as post-natal depression, may have an impact on secure attachments being developed. It is important to remember, however, that all human beings respond differently to their environment and what may have a huge impact for one person may have had little impact on another. This is why it is crucial to remember to always view each case on its own unique terms (Aquilina and Warner, 2004).

To aid structure, it can be helpful to record the information chronologically. Work through the developmental milestones of the person from birth to the onset of the current illness. Begin with recording the date and place of birth. It can be helpful to establish what the family social, economic and emotional circumstances were at this time, including the parents' health and marital relationship. In terms of the birth, find out whether it was full term and normal. Also, try to establish whether the service user was breast- or bottle-fed and if feeding was normal.

Importantly, find out whether the service user met those early developmental milestones within the typical time frames – walking, talking, weaning and toilet training. Establish whether they are aware of any early infections that impacted on their development. Record whether they report on any bedwetting, night terrors, sleep walking, fingernail biting, thumb sucking or stuttering – please note that these are not necessarily diagnostic of mental ill health, however, combined together and with other patterns, they may demonstrate some level of anxiety/stress during the person's formative years.

It is rare that we will remember anything before our fourth year and so we are often calling on memories given to us by our parents for those very early years. The years between birth and school 0–5 are widely recognised as crucial in shaping our emotional development (Reder and Lucey, 2014). Establish whatever you can from the service user about their family circumstances, physical, emotional and social development as well as physical health. Find out how they got along with their siblings and other children their age. How did they remember the atmosphere in the home, what was their relationship with mum and dad? The aim is to have a detailed picture of those pre-school years, including any significant event that may have influenced their progress in growing up (Jones, 2010).

It is not uncommon for a service user to ask 'How are these questions relevant?' and so it can be helpful to explain how you want to get a full picture of their life from birth to the present day and how the very earliest experiences may have an impact on our life later on.

Early School Years and Adolescent History

Much like the early years, it is important to continue to get a detailed picture of the school years from age five years through secondary school and adolescence (Carlat, 2004). Work through in chronological order, recording events during the primary, secondary and further education years. Take into account relationships with family members, peers, friends and teachers at school. Did they experience bullying? Did they feel they 'fitted in' – if not, why? What were their achievements during this

period – both personally through interests and hobbies and also academically? For example, were they high achievers at school/further education? Did they engage in the education system or did they dislike it – for example, could they be disruptive, have difficulty concentrating, play truant, were they in fights with peers? How were the circumstances at home through their adolescence (Reder and Lucey, 2014)?

SERVICE USER VOICE

‘ It was weird going through all my childhood and teenage years with the CPN (community psychiatric nurse). Initially, it felt a bit uncomfortable and I was wondering what it had to do with the problems I was seeing the CPN about. As the meeting went on, though, I actually found it really helpful, I had never really gone back through my life like that and we started to see certain patterns that had happened throughout my life. In meetings with my CPN afterwards, we were able to use the information to help me better understand myself and stop blaming myself as much for things that had happened in the past. I learnt that not everything that happened to me was my fault, and that there are some things that are out of your locus of control in your life. I feel much more in control of my life now. ’

Employment/Occupational History

It is essential to establish the service user’s past and present level of function in work. A sporadic or chaotic employment history may indicate emotional instability or frequent episodes of mental illness. It may also offer information in terms of occupational resilience and coping strategies. It is often useful to look at occupational history next to relationship history, for example it may demonstrate difficulties in establishing or maintaining relationships. Work-related stress may have precipitated the illness or high levels of stress at home may have impacted on work life. The impact of hospital admissions or other forms of treatment may have impacted on the service user’s function at work or at school (Mackinnon et al., 2015). Furthermore, difficulty with employment, for example finding work, may further exacerbate low self-esteem and other components related to a sense of well-being and a happy home life, relationships and opportunities for fulfilment (DH, 2011).

Psychosexual History

A tactful approach must be employed when discussing the person’s sexual history. It may be necessary in some circumstances for a person of the same gender to interview the service user, should they feel uncomfortable (Levine, 2006).

A sexual history is helpful for a number of reasons. First, it can indicate a service user’s ability to make and maintain intimate relationships and capacity to love and be loved. It can also highlight the ramifications of the impact in the early years through childhood sexual abuse and other negative experiences.

Important areas to consider are the service user's onset of puberty, their first sexual encounter and their thoughts and feelings at the time in relation to this. The practice of safe sex, number of sexual partners and sexual preference are all areas to sensitively explore, if the service user feels comfortable in doing so. It is crucial as a practitioner that you are mindful of your own values and beliefs when asking about such personal subjects so that you are able to be clear in your own mind that you are not passing judgement (Aquilina and Warner, 2004). A service user will very quickly pick up on embarrassment, disapproval or cultural/religious judgement projected by you, which could then lead to distress in the service user. This is especially the case if a service user discloses that they have experienced childhood sexual abuse, rape or that they themselves have had sexual feelings towards children. In terms of sexual feelings towards children, there would be a number of risk factors to consider (Mackinnon et al., 2015), such as whether the person has the current intention of acting out such feelings and that children might be at risk. If so, you must follow relevant policies within your organisation to ensure that the appropriate people and/or agencies are notified.

Social History

Larger social networks tend to promote recovery (see Chapter 5). The practitioner should inquire about the service user's family and household members. Explore whether the service user feels satisfied with their social role at this point in life. Determine the service user's wider previous social network, such as clubs and religious organisations they have belonged to, and how this might be different from their current social situation. Their living situation is also integral to the assessment, as many of life's most potent stressors are environmental in origin. It is often difficult to ascertain whether a person's social problems have precipitated or resulted from a mental illness (Jones, 2010). Consider homelessness – did mental health problems lead to the person becoming homeless, or did the homelessness subsequently cause or exacerbate a mental condition (Gonzalez and McLoughlin, 2014)?

Forensic History

A forensic history is concerned with establishing any recent or past offending behaviours. This can help in getting a clearer picture of triggers, events, links and patterns of behaviour which can aid assessment with regards to the person's current presentation (Aquilina and Warner, 2004). This is likely to be an area that the service user will have difficulty in disclosing and talking about. It can also be a difficult issue for you as a practitioner to ask about and so it will be useful to introduce the subject and why you are going to ask about it. An initial question might be something like: 'Have you ever done anything that could have got you into trouble with the police?' Should the answer be 'yes', then ask for details of actual arrests, charges and imprisonments as well as events where the person could have faced charges if they had been found out. If you only ask about whether someone has been in trouble with the police, then it may not capture regularly offending for which they have yet to be caught.

It is very possible, of course, that the person may not disclose this. Service users may be anxious about confidentiality for fear of being reported to the authorities. It is therefore good practice to explain how confidentiality works. This means that the service user is aware that you may have to contact relevant agencies should they disclose a serious past, present or potential future crime such as serious violence towards other people or sexual abuse of minors (Carlat, 2004).

Culture

Ethnicity, race, social class and language should be included in the cultural assessment. One's cultural upbringing can significantly influence the development and expression of mental disorders (Fernando, 2010). For example, members of certain groups are likely to present with more somatic complaints. The efficacy of different treatment modalities and beliefs regarding the cause and treatment of mental illness may also vary among cultures and must be considered when developing a treatment plan. However, the mental health practitioner must avoid stereotyping individual people on the basis of ethnic, racial or social group membership.

Spirituality

Spirituality is an often neglected aspect of a psychosocial assessment. However, a service user's lack of sense of spirituality may have a tremendous impact on illness and recovery (Mackinnon et al., 2015). If the service user declares that they do not follow an organised religion or are atheists, alternative sources of strength, hope, comfort and meaning in life should also be explored as part of the spiritual assessment. Some service users feel that spiritual expression, however that is manifested, decreases their sense of aloneness and despair. Gaining insight into the service user's religious beliefs and practices and any associated satisfactions and/or conflicts will be useful in planning interventions.

SERVICE USER VOICE

I have had some awful experiences with mental health services over the years, especially when being admitted into hospital. I am 55 now, and have been diagnosed with schizophrenia since my early 20s. I never recognised until I was in my 40s that I had this illness and was maybe in denial or something. It helped when I moved to a new area and the mental health team there seemed a lot more culturally aware. Where I was before, they didn't seem to care much and could be very judgemental of my West Indian heritage – I saw them as not understanding me. I mean this in no disrespect but they were of a very middle England, Christian background, which I got nothing against but they were talking to me about things they had no idea about and trying to tell me what I should and shouldn't think about life. Where I am now, the nurses and doctors respect my values and also helped me to find ways of coping when the demons come.

I think what has helped is that they were actually interested in me as a person and valued what my beliefs on things were, in a way I think it has helped them, too, to better understand people like me and they have helped me understand what mental illness is and that it's not something to be ashamed of but something I need to manage to live a happier life.

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Premorbid Personality

Unless you have previous knowledge about what the service user is usually like already, it is difficult to fully understand how their illness or current problems have affected them. In asking about premorbid personality, the information from a family member or friend can be particularly helpful. Think about coping styles, interests and activities and how the person usually relates to other people (Aquilina and Warner, 2004). This, along with the rest of the history that you have recorded, will help build a better understanding of an individual's coping skills. Coping skills are mechanisms that people use to manage internal and external stressors. Discerning the service user's characteristic pattern of coping helps to identify the coping mechanisms that may be used in the current crisis situation and those that require further development. Coping skills may be 'adaptive' or 'maladaptive' (Carlat, 2004). Adaptive skills include the ability to engage social support systems and perform relaxation exercises in times of stress. Previous patterns in using alcohol or self-harm to cope in a maladaptive effort to cope with psychological pain should be explored.

Chapter Summary

The history-taking process should be collaborative, recovery-focused and person-centred. This chapter stresses the importance of positive engagement and being mindful that you will be exploring some potentially sensitive areas of an individual's life. The chapter moves on to discuss the skills involved in recording a person-centred, systematic and comprehensive history. Through this, we are better able to build a fully informed case conceptualisation in order to support our service users through the recovery process.

EXERCISE



Using the above information, catalogue your own personal history:

1. What are some of the challenges for you in doing this?
2. Consider what might be some of the challenges in taking a history from another person.

CONSIDERATIONS FOR PRACTICE

1. An assessment of a person's history can be a long and complex process. Consider how you might best achieve this. If the person is known to services, do you feel you need to revisit historical information that might have been well recorded (such as the person's place of birth, educational history, forensic history)?
2. Do you think you can ever truly obtain an accurate historical picture of a person's life? What might some of the barriers and biases be when looking back at a person's life?
3. How might you engage the person's family/personal network in building a historical picture of the person's life?

Further Reading

Aquilina, C. and Warner, J. (2004) *A Guide to Psychiatric Examination*. Norwich: Pastest.

Written with the help of tutors and students, this practical guide is invaluable for everyone working with people with mental health problems, and is an aid to conducting efficient and comprehensive psychiatric assessments. The book contains a detailed review of a general psychiatric assessment and has practical guides on assessments in 11 specific problems and four groups of people.

Fernando, S. (2010) *Mental Health, Race and Culture*, 3rd edn. Basingstoke: Palgrave Macmillan.

This book offers a unique analysis of the impact of race and culture on contemporary issues in mental health. Drawing on extensive international experience, the author challenges the traditional ideas that inform practice in clinical psychology and psychiatry in order to promote new and alternative ways of thinking.

Mackinnon, R., Michels, R. and Buckley, P. (2015) *The Psychiatric Interview in Clinical Practice*, 3rd edn. Arlington, VA: American Psychiatric Association.

This book presents the psychiatric interview in the context of the enormous and ongoing progress that has been made in biological and descriptive psychiatry. In addition, it emphasises the shift in the social relationship between service user and clinician, recognising that the therapeutic alliance has become the foundation of all medical treatment efforts and that service users are now better informed and seek active involvement in treatment decisions. The text reflects this growing equality and supports the clinician's efforts to nurture the relationship for optimum therapeutic outcomes.

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8

MENTAL STATE EXAMINATION

CAROLINE ATTARD



CHAPTER OVERVIEW

This chapter:

- Provides a detailed description of what a mental state examination (MSE) consists of and what skills and knowledge mental health practitioners need to conduct one.
 - Explores how an MSE can contribute to therapeutic engagement with a service user.
 - Provides examples of useful questions to use in an MSE.
-

What is a Mental State Examination?

A mental state examination (MSE) is an assessment of the mental state of a service user at a given time. It reflects the subjective report and experience of the person as well as the objective observations and impressions of the mental health practitioner at the time of the interview. Traditionally, an MSE uses a common format and language to record information, which may be understood across different services and professions (Gelder et al., 2012), but this may not be so meaningful or easily understood by a service user or their friends and family. The goal of an MSE is to help the person

share their experiences of their mental health in order to ensure that appropriate assistance can be given and that any risks are addressed accordingly.

A mental state examination is used to:

- Establish a baseline of a person's current mental health and behaviour.
- Provide a platform for a shared understanding about the person's experiences about their mental health.
- Facilitate and evaluate changes in mental health over time.

In addition, the information obtained enhances the therapeutic alliance between the practitioner and service user. Like any skill, the MSE is one which is enhanced through practice, clinical supervision and constructive feedback.

An MSE involves the systematic appraisal of the appearance, behaviour, mental functioning and overall description of a person. It reflects a 'snapshot' of a person's psychological functioning at a given point in time. An MSE is an important component of the psychosocial assessment of a service user. Most mental health practitioners intuitively perform many parts of an MSE every time we interact with or observe others.

Rapport-Building in Undertaking an MSE

Taking the time to establish rapport with a service user before initiating an MSE is very important. Acknowledging the service user's feelings is both important for the success of the interview and for any ongoing engagement with treatment (Jordan Halter, 2014). Mental health practitioners need to listen closely to what the service user has to say and to ask for clarification or examples, if needed. Showing empathy to the service user's distressing thoughts and beliefs will help in working collaboratively with the service user towards developing a shared understanding of the problems and symptoms in question (Gamble and Brennan, 2006).

The Importance of Listening in an MSE

Listening is the ability to accurately receive and interpret messages in the communication process. Listening is key to all effective communication. Without the ability to listen effectively, messages and signals may be misunderstood, communication breaks down and the sender of the message can easily become frustrated or irritated (Harrison et al., 2004).

Of all the communication skills that a mental health practitioner should aim to master, listening sensitively and respectfully should be the top priority. There is an assumption that, as a mental health practitioner, one is already good at listening. However, service users and families have reported that they have been misquoted and misunderstood (DH, 2009). Many service users also report that mental health professionals repeat and duplicate assessments, which is frustrating for them (DH, 2011). Therefore, the service user should always be at the centre of an MSE examination, which should be coordinated between team members.

Listening means paying attention, not only to the person's narrative, but also the way in which it is told through the use of language and voice, and how the person uses his or her body. In other words, it means being aware of both the person's verbal and non-verbal messages (Clarke and Walsh, 2009). Your ability to listen effectively depends on the degree to which you perceive and understand these messages.

A good listener will listen, not only to what is being said, but also to what is left unsaid or only partially said. This is particularly important in an MSE. For example, a service user might answer the question 'How are you feeling?' with 'I am okay' but his non-verbal communication might suggest otherwise – looking down on the floor, minimal eye contact, looking particularly sad, worried or anxious. There is an incongruity (see below) here that clearly needs exploring. Effective listening involves observing body language and noticing inconsistencies between verbal and non-verbal messages.

How to Conduct an MSE

Psychiatric terminology and medical diagnostic classifications used in mental health care can be daunting but it is not necessary for mental health practitioners to have a detailed knowledge of all of these in order to complete a baseline MSE. What is essential is for the practitioner to have an understanding of the basic concepts used in an MSE (see Figure 8.1). A key skill for the mental health practitioner is being able to notice and recognise the basic presentation of a service user, helping them to share their experiences.

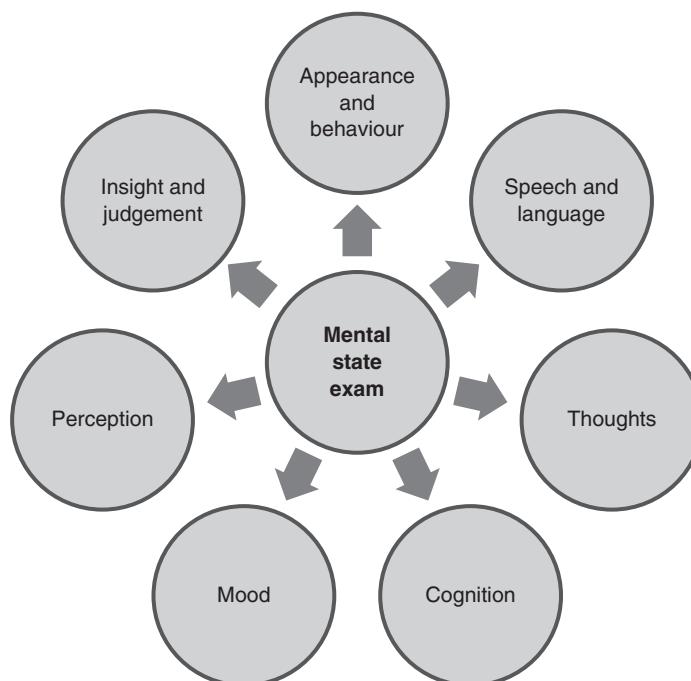


Figure 8.1 A framework for structuring a mental state examination

Open-ended questions are essential for gathering relevant information on a person's mental state (O'Carroll et al., 2007). For example, 'How are you feeling today, Emily?' is preferable to 'Is your mood still low, Emily?' This gives the service user a chance to talk about their experiences and concerns whilst allowing the practitioner an insight into the person's experience (Schultz and Videbeck, 2013).

It is important to note that the MSE should not be a series of questions but an evaluative process based on the mental health practitioner's observations and interactions with the service user. If broad mental health issues are identified during the course of an MSE, then more direct, clarifying and specific questioning about the service user's experience may be required. Moreover, the use of more in-depth evidence-based assessment tools (see Chapter 3) such as the Brief Psychiatric Rating Scale (BPRS) (Overall and Gorham, 1988) or Auditory Hallucination Rating Scale (Haddock, 1994) may be helpful to gather more focused information and, again, with the aim for a shared understanding.

Over time, the mental health practitioner will develop his or her own style of interviewing. It is important that the practitioner feels comfortable with the style that they have adopted so that questions do not seem awkward or forced and keep the service user at the centre whilst a therapeutic engagement is achieved.

Background to Taking an MSE

Taking an MSE is a core skill for mental health practitioners (Simms, 2015) and is best learned by practice and repetition. The MSE should be service user-focused and a common error is to see the assessment purely as an information-gathering exercise. Each step covered in the MSE should help the mental health practitioner make sense of what is going on for the service user.

Structuring an MSE

The framework in Figure 8.1 will help you develop the areas that you need to look out for whilst doing the MSE. The framework keeps the service user in the centre and aims to develop a greater understanding of their experience. There is no correct order in which to discuss these areas and it is most likely that the interview will not be sequential. It is best facilitated as a narrative, with the person sharing their experiences as they come to mind. For example, if someone has not been sleeping, this may be the first thing they tell you when you sit down to talk with them. This may be the most important issue for them at that time, so it is natural that they would want to draw your attention to it. It is important to take notice of this when it arises and, if you enquire about it later, acknowledge that it has already been said, for example: 'You said earlier you haven't been sleeping, can you tell me a bit more about that?'

It is not always appropriate to ask all the questions all the time. Sometimes, it can be better to leave gaps to fill in later, especially if service users are suspicious and paranoid or acutely distressed. Some of the MSE can be gathered from speaking to a family member or a friend.

Appearance and Behaviour

A person's appearance can provide valuable information about their mental state. Observations of the person's appearance and behaviour takes place from the first meeting and throughout the interview (Simms, 2015) and should be described whilst maintaining a non-judgemental approach and attitude. Mental health practitioners need to consider the person's:

- Eye contact and rapport: Is the service user able to maintain eye contact? Are you able to build a rapport?
- Clothing: Is attire appropriate for the context?
- Hygiene: Are there any indications that there may be problems with grooming or personal hygiene?
- Facial expressions: Are there signs that the service user is responding to the interview? Do expressions portray emotions?
- Movements: Are there any signs of movements being slow?
- Signs of arousal: Are there any signs of either panic or anxiety? Are they agitated or excited?
- Affect: Do they seem sad? Happy? Anxious? Worried? Are their emotional responses appropriate?

So, overall, how does the service user look? Consider the person's age, gender, race/ethnicity, build, hairstyle and colour, grooming, posture, level of hygiene, mode of dress and apparent level of health.

When we talk about a service user's *affect*, we are referring to how people convey their mood by their behaviour. A 'normal' affect, within reason, would be described as reactive and appropriate such as when a person laughs at a joke or cries when sad. However, it is imperative that the mental health practitioner documents this in an objective and non-judgemental manner in order to avoid bias and ensure that any record is accurate, fair and respectful.

An example of an objective report of a person's appearance is as follows: Mrs Smith is a 27-year-old Caucasian single woman who is slightly overweight for her height of approximately 5 ft, with minimal clothing of shorts (jeans), T-shirt and flip-flops – considering that it is cold outside – and a poor level of hygiene is also evident. During the interview, her eye contact was poor, with her constantly looking at the window. She seems in good health, however her clothes seem small for her stature and age.

Descriptions of appearance in an MSE should include any prominent or unusual physical characteristics (shaved head, tattoos, etc.), height and weight (obesity or thinness), posture, grooming, hygiene, level of eye contact, apparent age in relation to chronological age, facial expression in relation to thought content, and anything unusual such as clothing which is inconsistent with the time of day or season, or unusually applied clothing or make-up.

Appearance and behaviour during the interview can also provide valuable insights into the person's social and interpersonal functioning. It is therefore essential that consideration is given to the service user's attitude to both the mental health practitioner and to the assessment/interview processes itself. It is also important that you understand that this may influence your judgement and content of information obtained, and may pose special challenges. This is especially important during the development

of the therapeutic relationship as this may impact on the ability to objectively report on the MSE findings. The service user's behaviour towards the practitioner may be described using terms such as cooperative, uncooperative, frank, deductive, defensive, evasive, guarded, hostile or threatening. Any changes in behaviour throughout the interview, as well as the level of rapport established, should also be recorded. For example, Mrs Smith seemed suspicious and angry towards me and asked, 'Why do you want to know everything?' and was at times uncooperative during the session and refused to answer some of the questions. At times, she asked rhetorical questions and insisted that I share personal information before she would proceed.

It is important that the assessment is culturally sensitive and that a person's appearance and behaviour is seen in the context of what, for the person, may be culturally appropriate behaviours (Simms, 2015). Judgements about mental state should also always consider the developmental level of the person and age-appropriateness of the noted behaviour(s) (*ibid.*).

In assessing psychomotor behaviour, the practitioner is observing the person's actions and coordinated activity involving the arms, hands, fingers and feet. This also includes all non-verbal behaviour evident during the interview, and this can reveal information regarding a person's mood, energy level, muscle strength, coordination, general medical condition and potential adverse effects of medication (Morrison, 2008). The documentation of activity and behaviour in the MSE should include abnormalities in the level of activity, any involuntary motor activity or behaviour, and any excessive, repeated or distinctive activity or behaviour. It is important to describe the actual behaviour shown, so, instead of recording 'appears anxious', it is important to be specific and a record of 'constantly wringing hands or tapping foot repeatedly' is therefore preferable.

Speech and Language

When assessing the *content* of speech, we are interested in what the service user actually says (see below). We are also interested in examining the *way* in which the person communicates. That is, how does the service user verbally express himself/herself?

In assessing the person's ability to communicate verbally, the assessor is noticing the rate, rhythm and fluency of speech, all of which may be affected by severe and enduring mental health problems (Simms, 2015). We should consider the person's speech pattern and examine, in particular:

- *Rate* – rapid, pressured (fast), slow, retarded (slow motion).
- *Volume* – loud, whispered, quiet, monotone, varied.
- *Rhythm* – clear, hesitant.
- *Tone* – angry, irritated, monotone.
- *Quantity of information* – poverty (lack of) or pressure of speech, mute/silent.
- *Quality* – stutter, slurring or any atypical qualities.

Consideration should also be given to the absence of speech or inability of the person to speak.

Thoughts

Thoughts can be considered in terms of *form* (that is, how one's thoughts are organised) and *content* (that is, what one is actually thinking about). Obviously, we cannot directly access the person's thoughts, and we can only understand what a person is thinking through their speech. Note that we all often edit our thoughts before expressing them in speech, although facial expressions and body language might betray what we are really thinking.

Form

The sequence of our thoughts may illustrate difficulties in the way in which our thoughts are organised (Mackinnon et al., 2006) and might suggest a breakdown of normal thought processes. For example:

- *Thought block*: The flow of thought stops abruptly. On occasions, it is possible to witness this where a person may stop what they are saying halfway through the sentence and be unable to continue for a period.
- *Flight of ideas*: Is particularly seen when a person is in an over-excited state, where there are rapid associations made by the person between each thought and where there is a shifting of ideas.
- *Incoherent/illlogical*: Disorganised or senseless speech.
- *Derailment*: Unrelated or loosely connected ideas.
- *Tangentiality or loosening of association*: Unrelated or incomplete replies.

While the form of a person's thoughts may often be inferred by directly listening to their verbal communication, there are some helpful questions that you may wish to ask a person about the form of their thinking which may be particularly helpful, for example:

- Do your thoughts seem faster than normal?
- Do you ever have the experience of when your thoughts suddenly stop?
- Do you ever feel that your mind is suddenly wiped blank and you have no thoughts at all?
- Do you often start a sentence and then forget what you are going to say? How often does this happen?

Content

Here, we are interested in the content of a person's beliefs and, in particular, the experience of people who may experience *delusions*. A delusion is an unshakeable idea or belief that is out of keeping with the person's educational, cultural and social background and which is held with extraordinary conviction and certainty (Simms, 2015). This may not make any sense to the assessor, but we need to try to understand what these beliefs mean to the service user.

The most helpful response to a service user's delusional beliefs can be to address the emotion or feeling that is behind them (which can be terrifying or upsetting for

the individual), rather than to the content. Sometimes, practitioners can worry about reinforcing delusions or strange ideas by asking about them. However, the role of the mental health practitioner is to develop a shared understanding of the service user's experience, rather than to pass judgement on the content.

Delusional beliefs can be extremely distressing to the individual and can present in many different ways, including beliefs of being persecuted, having bizarre strange thoughts which are out of keeping with the person's cultural background, grandiose ideas (where the person might feel that they are unduly important in some way), self-referential thoughts (that is, the tendency for people to believe that information is related to themselves), and delusions of control (the belief that other people are controlling their thoughts and/or actions or that external parties have manipulated their thoughts). Other examples include:

- *Thought withdrawal*: The experience of thoughts being removed by a third party. Does the service user feel that their thoughts are being taken away, wiped blank or that the thoughts are removed so that they are not there anymore?
- *Thought insertion*: The opposite to thought withdrawal, whereby thoughts are experienced as alien, not arising from oneself but being placed there by a third party.
- *Thought broadcast*: This is when the service user may experience their thoughts being communicated publicly by TV or radio, for example, or that anybody can hear their thoughts.
- *Passivity*: This is the sense that the person feels that they are being controlled by an external source to themselves, whether this is physically, emotionally or cognitively.

There are some helpful questions that you may wish to ask a person about the content of their thinking, for example:

- Has anything strange or unusual been going on?
- Do you feel that there is anything special about yourself that makes you different from other people?
- Are you sure that this is happening or do you feel that you might be imagining it?

We are also interested here in whether a person has any thoughts to harm themselves or others, which will be discussed more fully in Chapter 9.

Cognition

Cognition refers to the mental processes of attention, concentration, knowing and thinking, including aspects such as memory, awareness and reasoning. This could be inferred from their vocabulary, level of education and how easily they recall important personal information and dates. Unless you detect a problem, for most people you can briefly screen the following areas (Folstein et al., 1975):

- Orientation for time, person and place.
- Registration – Ability to repeat new information such as a name and address.

- Recall – Repeating the new information five minutes later.
- Concentration and attention – You can check this by asking the service user to spell ‘WORLD’ backwards or serial sevens or simply ask how their concentration is?
- General knowledge – Name of the prime minister, recent news items.

The purpose of asking the above questions is to ascertain whether or not the person is alert and orientated to time, person and place. You may be able to infer these during the interview and, in which case, do not ask the questions if it is obvious. Listen carefully to the service user to avoid unnecessary irritation or agitation of multiple questioning.

Mood

Our mood is reflective of our emotional state. Do people feel sad, happy, apathetic, anxious, angry, excited? In a mental state examination, the person should be encouraged to describe how they are feeling in their own words. If not spontaneously reported, the practitioner should ask about mood and whether how they are feeling is typical for them. It is also important to note when the service user’s mood is relatively ‘normal’ to the situation, age and circumstances.

Simms (2015) states that a person’s mood may be further characterised in terms of its ‘stability’, ‘reactivity’ and ‘duration’:

- *Stability*: Refers to the consistency of the mood, particularly over the course of the day. That is, does a person’s mood fluctuate? Are they brighter in the morning or evening?
- *Reactivity*: Refers to whether or not a person’s mood changes in response to external events or circumstances.
- *Duration*: Refers to the persistence of a particular mood, measured in hours, days, weeks, months or even years.

Some helpful examples of how to ask appropriate questions related to mood include:

- How do you generally feel most of the time?
- What is your mood like?
- How would you say you feel generally – happy, sad, frightened, angry?
- Is there any pattern to how your mood changes through the day?
- Is there any time of the day when you tend to feel better or worse?
- Do you tend to feel worse in the evening?
- Are you able to get enjoyment from anything?
- Do you still enjoy activities that you used to enjoy?
- If something nice happens, do you cheer up a bit?
- Do you find yourself crying a lot?
- Would you say that you’re more cheerful than usual?
- What’s your view of the future?
- Do you think that things will get better or worse?

- Do you hope that things might get better?
- Is there any possibility that things might get better?
- Do you see any possibility at all that things might get better, even a little bit?

Further questions about appetite, sleep and general functioning (see Chapter 6) can help in the screening for low mood, excitable states, and other issues such as psychosis. It also gives the practitioner a guide to the person's overall functioning and areas in which they may wish to have further help.

A service user's affective state consists of several components, which are objectively observed and cannot be elicited by direct questioning. It should be monitored throughout the interview, and its congruence with thought content should be noted. Gelder et al. (2012) explain that written description of affect in the MSE examination should be characterised in terms of its range, change pattern, intensity and appropriateness, as explained below:

- *Range*: A practitioner who is conducting an MSE assessment needs to refer to the variation in emotional expression observed throughout the interview. It is characterised as 'full' (normal variation in emotional expression) or 'constricted' (limited variation in emotional expression). 'Blunted' affect is a reduction in the intensity of an individual emotional response.
- *Change pattern*: Refers to the rate of change of emotional expression. It is characterised as 'stable' (normal rate of change) or 'labile' (rapid change in emotional expression, without external stimuli).
- *Intensity*: Refers to the strength of emotional expression. It is characterised as 'average', 'flat' (complete lack of emotional expression) or 'blunted' (reduced intensity of emotional expression).
- *Appropriateness*: Refers to congruence of affect and thought content, i.e. a happy thought tends to produce or reflect a happy mood. A service user's mood and affect should be congruent with each other. Incongruence can be observed when a person expresses an inconsistent emotion with what they are talking about (i.e. laughing when talking about a loved one's death).

Perception

Screening for perceptual disturbances is critical for detecting serious mental health problems such as psychosis, cases of severe anxiety and mood disorders. These include *hallucinations* and *illusions* in the case of psychosis, and *dissociative experiences* (see below), which may be experienced in trauma, substance abuse, anxiety and other emotional disorders (Gelder et al., 2012). Perceptual disturbances may be disturbing or frightening, so it is important for the mental health practitioner to be aware of them and notice related symptoms, as described below:

- *Dissociative experiences*:
 - Derealisation: Feeling that the world or one's surroundings are not real.
 - Depersonalisation: Feeling detached from oneself, or feeling that you are observing yourself from the outside.

- **Illusions:** The service user perceives things as different to usual, but accepts that they are not real, or that things are perceived differently by others.
- **Hallucinations:** These are sensory experiences in the absence of an external stimuli which seem absolutely genuine to the person.

Hallucinations are indistinguishable from 'reality' for the person and can affect all sensory modalities – sight (visual), smell (olfactory), touch (tactile), hearing (auditory) and taste (gustatory) – although auditory hallucinations are the most common (Carlat, 2005). Olfactory hallucinations can also be a sign of physical health problems (such as epilepsy) that may require investigation and, whilst visual hallucinations can occur amongst people who have been recently bereaved and people living with Lewy Body Dementia, they can also be present in delirium from organic causes, substance use and withdrawal.

Command hallucinations occur when the person experiences voices telling them to do something (Simms, 2015). These should be investigated carefully as this can be a significant risk issue because the service user may feel that they have to respond to the command. It is important that the practitioner notes the degree of fear expressed by the service user, whether they feel compelled to act on what they are hearing and how able they feel to ignore the instruction. *Third person hallucinations* are those where the service user may experience a running commentary on their actions and this can be very intrusive, for example: he is trying to sleep, he's making a cup of tea, he's trying to read a book.

Some helpful examples of how to ask appropriate questions related to perception include:

- Do you ever hear voices when there is no one else around?
- Do you ever hear things that other people don't hear?
- Do you ever hear anything strange?
- Where do you think the voices come from?
- Are the voices in your head or outside? Are these thoughts in your mind or sounds that you would hear with your ears?
- Do you recognise any voices?
- How many voices are there?
- Do they talk to you or do they talk to each other about you?
- Do they ever talk about what you are doing?
- Do they repeat your thoughts or comment on your thoughts?
- Do your thoughts ever sound loud, as if somebody next to you could hear them?
- Do the voices tell you to do things?
- Do you see things that other people don't see?
- Do things ever smell strange or taste strange?
- Do you ever feel things touching you?
- Do you feel things changing inside your body?

Insight and Judgement

During the MSE, the mental health practitioner should also consider if the service user has any *insight*. When we talk about insight, we are referring to the service

user's capacity to recognise his/her own problems and mental state. When we talk about *judgement* in the MSE, we are referring to the service user's capacity to make sound, reasonable, reasoned and responsible decisions to maintain their health and protect their own safety and those of others (David, 1990).

Families and Friends

If during an MSE, a service user is found to be significantly unwell, it is recommended that they are asked if they would like a family member or another to be contacted for support and assistance. If it is assessed that a service user's judgement is significantly impaired (and they refuse any assistance from others), it may be appropriate to contact the service user's registered next of kin. If the service user refuses for you to speak to a family member due to confidentiality, you are bound not to give out any information, but there is no reason why you should not ask the person's family and friends about how the person's mental state has been recently.

Challenges with MSE

You may need to ask some questions which may be challenging, especially if you are not experienced in carrying out an MSE. You might find that the service user does not want to talk about a particular topic or glosses over things. Some skilful techniques you can use in these circumstances include:

- Normalising statements: 'Often, when people are that down, they feel like they can't carry on ... Have you ever felt like that?'
- Pointing out behaviours: 'You seem distracted and you keep on looking outside of the window, Mrs Smith, is there anything or anyone outside?'
- Reassuring statements: 'You seem very scared. Is there a reason and can I do anything to help?'

Sometimes, service users may be reluctant to be interviewed for a variety of reasons. It may be that their mental state makes them suspicious of your motives, or frightened to disclose information. In these circumstances, it is important for the mental health practitioner to emphasise that they want to help without giving false reassurances. Promises should not be made that cannot be kept, for example: 'Don't worry, I won't tell anyone.' The mental health practitioner needs to be mindful of his/her own safety, professional and legal obligations and trust their instincts. If the practitioner feels threatened, then it is best to remove themselves from the situation and seek help from a more experienced colleague or the team. It might help to leave a particular line of questioning for a time and move on to more neutral information-gathering until the service user feels more relaxed.

Another potential problem during an MSE is that of the over-inclusive patient, who wants to tell you details about every aspect of a situation, for example about the dress their sister wore at her wedding and the engraving on the groom's cufflinks. The practitioner may need, tactfully, to interrupt this monologue, and bring the service user

back to the point, or change tack entirely if this fails. The practitioner can interrupt and be firm without being rude.

Think about good ways of phrasing difficult questions here, such as:

- Thanks for telling me about the wedding but I wonder if we could now focus on how your day was yesterday?

Chapter Summary

In this chapter, we have explored how to conduct an MSE in detail, making sure that the service user is at the centre of the assessment. We have looked at what skills and approach the mental health practitioner needs to have to successfully conduct an MSE. Mental health practitioners are in an excellent position to use the MSE towards a shared understanding of the problems presented and to develop a therapeutic relationship. Assessment can be a therapeutic tool when used skillfully: it can give the service user a real opportunity to talk about how they have been feeling, and the mental health practitioner can hope to increase their understanding of the service user's experience.

EXERCISE



In this chapter, we have consciously avoided using medical terminology and psychiatric diagnoses wherever possible. Our position is that we prefer to develop a shared understanding about people's experiences as part of a negotiated, meaningful case conceptualisation, rather than gather evidence for a diagnosis that is then applied to a person. There are some people who go further than this and believe that psychiatric diagnoses are 'dangerous' labels that disable and disempower the person. Others argue that diagnoses are 'desirable' and help to ensure that the person receives the best treatment:

1. Where do you stand?

CONSIDERATIONS FOR PRACTICE

1. Mental health practice in the UK is often medically dominated and the use of psychiatric terminology and diagnosis is widespread. How would you develop your knowledge in this area, should you wish to?
2. Assessing a person's mental state requires considerable skill and sensitivity. Consider what skills you may need to develop to support your practice.

Further Reading

Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice-Hall.

Written at a time when mental health services comprised large psychiatric institutions, Goffman's book is an essential read for sociologists and mental health practitioners alike. It remains relevant in the context of the ongoing debate about the place of psychiatric diagnoses in modern person-centred, mental health care.

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9

RISK ASSESSMENT

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CHAPTER OVERVIEW

This chapter:

- Describes and defines risk assessment and emphasises the importance of risk assessment as a tool for enabling the management of risk through collaborative assessment and safety planning, rather than risk prediction.
 - Reiterates the importance of engagement and service user involvement in the risk assessment process.
 - Describes and discusses the need to consider risk in its broadest context, i.e. risks posed to the individual as a result of having a mental health problem, including physical health, stigma, social situation, employment and finance which need to be tackled to minimise long-term risk.
 - Gives an overview of assessing risk in key risk areas, namely suicide/self-harm, violence and self-neglect.
-

Introduction

Risk assessment and management is a fundamental component of mental health care practice (DH, 2007). The majority of relevant literature addresses either the efficacy of risk assessment tools in predicting outcomes or the links between conditions and behaviours and risk, for example Brown and Langrish (2011), Daffern (2006), Singh et al., (2011) and Snowden et al., (2009). Much of the risk literature focuses on catastrophic risk – i.e. suicide, self-harm and violence – the prediction of this risk and its importance in deciding on both the treatment plan, and the level of care and restriction required to manage it (DH, 2007; Langan, 2010; Leitner and Barr, 2006).

Whittington and Logan (2011) argue that mental health services predominantly consider these catastrophic risks and that the view that these risks can be predicted and managed is the dominant paradigm. However, this is problematic. Langan (2010) argues that the aim of risk assessment should not be to attempt to see into the future and predict actual outcomes. The Royal College of Psychiatrists (RCP, 2008) concur, arguing that risk assessment has, even when skilfully conducted, limited value in predicting risk incidents. The Royal College of Psychiatrists argue that risk assessment should be seen as a part of an overall assessment of the person's current situation. Whittington and Logan (2011) feel that this disparity has led to conflict as to what risk assessment is, and how to balance risk management and treatment, with a tension between patients' freedom and rights and the protection of the individual and the public. They assert that viewing risk in terms of prediction and prevention has led to clinicians focusing on the risks that individuals present to themselves and others to the detriment of helping people to plan to minimise and control the risks they face in everyday life. The intent behind risk assessment may be to protect people, but the way in which this is carried out, they argue, stigmatises people and focuses on the negative (*ibid.*).

Despite clinical guidance (DH, 2007) emphasising the importance of collaboration with service users in risk assessment and management planning, Boardman and Roberts (2014) argue that organisations' approaches to risk management may at times be perverse, and actually getting in the way of an individual's recovery. Whittington and Logan (2011) suggest that suicide, self-harm and violence dominate the risk assessment process because these are the most anxiety-provoking. This, they argue, presents clinicians with a difficulty in engaging and empowering the service user to be collaboratively involved in the risk assessment process and in decision-making about care and treatment, and that this lack of engagement has a detrimental effect on the management of risk. The Royal College of Psychiatrists (2010) support this view, arguing that risk assessment has come to dominate practice and is based on an incorrect view that people's behaviour can be predicted and on what they refer to as the rise of a 'blame culture', which has led to a tick-box culture of defensive practice; and, while helping staff to feel protected, this ultimately takes time away from talking to and supporting service users.

This view is echoed by Leitner and Barr (2011), who argue that the clinician's primary task should be to work with service users in order to support their well-being, rather than framing their relationships in terms of risk, which they argue is detrimental to recovery.

Defining Risk Assessment

Safety is at the centre of all good health care. This is particularly important in mental health but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk. (DH, 2007: 3)

Risk assessments must consider what the risk factors may be in any given situation in a consistent, reliable way. It is important to note that, while we cannot predict and prevent all adverse incidents, we can – and still have a duty to – identify potential risks with service users and work with them and their families to manage and try to avoid potential adverse outcomes.

An overview of the factors that should be considered in a risk assessment, discussed later in this chapter, can be found in Figure 9.1.

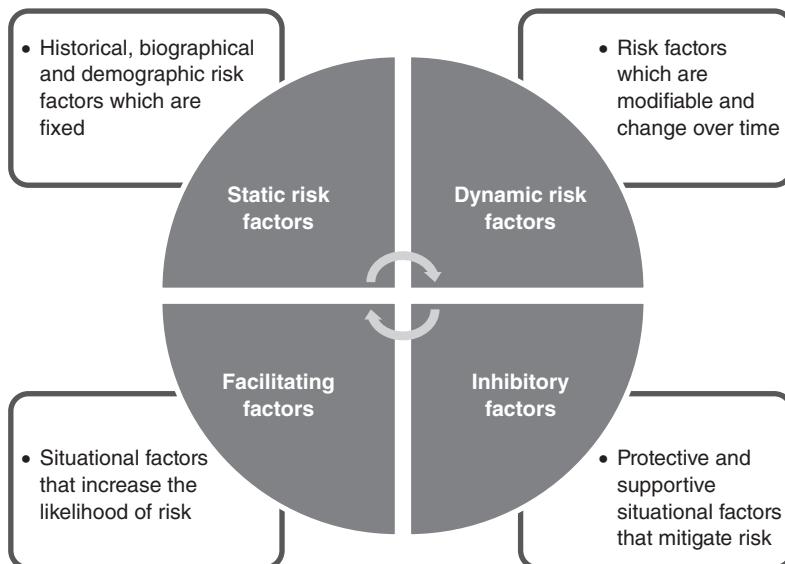


Figure 9.1 An overview of risk factors

Static and Dynamic Risk Factors

Best practice in risk assessment and management involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience, and clinical judgement. (Department of Health, 2007: 5)

In any assessment of risk, consideration must be given to those variables (or factors) that increase (or, indeed, decrease) the likelihood and/or frequency that a risk may materialise. The Department of Health identifies a risk factor as: 'A personal characteristic or

circumstance that is linked to a negative event, and that either causes or facilitates the event to occur' (ibid.: 13). Risk factors can help us to predict what types of risks are potentially present and may be categorised as *static* or *dynamic* (see Table 9.1).

Table 9.1 Static and dynamic risk factors

Static risk factors	Dynamic risk factors
These are factors that are known to be associated with increased risk which do not change. These include historical indicators, for example a history of suicide attempts, family history of completed suicide/suicide attempts, violence or childhood abuse. These factors will always be present, although their relevance will vary across individuals and over time.	These are factors that change over time, for example the misuse of alcohol or drugs. These factors may be aspects of the individual or of their environment and social context or indeed all of these. Examples of this are: attitude and beliefs of carers, financial status, living arrangements, social deprivation, and current mental state. These factors may change over time and are therefore more amenable to management. Dynamic factors may change slowly (stable factors) or rapidly (acute factors): the impact of these factors on the level of risk may be short lived or longer term.

Source: DH (2007)

There has traditionally been a focus on considering static risk factors in risk assessment, for example age, gender and history of risk incidents. While these factors are undoubtedly extremely important in the consideration of risk, they must be viewed in the context of dynamic factors. By definition, static factors will not change (although their meaning to the person may shift over time), and, yet, professionals often focus on these, from which the level of current risk for service users may be derived. Dynamic factors such as housing, finances, social situation and employment are often more amenable to effective interventions, and by intervening in these areas, health care professionals can work collaboratively with the service user and their friends and family to effectively manage potential risks and thus avoid harm.

However, in making a risk assessment, we are interested, not only in the type of risk factor(s), but also the frequency, magnitude, duration and likelihood of a risk event, and the extent and impact of potential harm (for the individual, for others, including vulnerable groups, and for the community), if the risk should materialise. This will, in turn, influence the nature and extent of risk management plans or, indeed, if any action needs to be taken – sometimes, it might be considered that an intervention by services might actually increase or precipitate a crisis, thereby leading to a risk event that may not have otherwise occurred. If it is decided that no direct action needs to be taken by mental health services, practitioners should consider whether any other services may be of assistance or should be informed, for example their GP, housing departments or adult social care.

Inhibitory (Protective) Factors

Inhibitory or protective factors are those variables that may inhibit or mitigate risk – either in terms of the magnitude, frequency, duration of the risk event or the likelihood

that it may arise at all – and must be taken into consideration in any risk assessment. These factors are likely to include internal resources that an individual is able to draw on – such as coping abilities, insight, the person's belief in their abilities (self-efficacy), knowledge, hopefulness, motivation and so on – and external resources – such as support from communities, family and friends, engaging in prosocial activities, employment, sufficient income to satisfy needs and so on.

It is also vital for any risk assessment to consider the person's access to well-trained, motivated and compassionate health care staff who are easily accessible and responsive at a time of crisis for the individual and their family and friends.

Types of Risk Assessment

The *Best Practice in Managing Risk* (DH, 2007) guide identifies three types of risk assessment approaches. An 'unstructured clinical approach' takes the form of an unstructured conversation. It is not systematic and is therefore less reliable. This method is not recommended as the basis of a formal risk assessment, but may be helpful to open up initial discussions about the service user's experiences and possible areas to explore using more structured approaches.

An 'actuarial approach' tends to focus on static factors known to be statistically associated with increased risk. For example, statistically, people who have self-harmed in the past, are at a higher risk of suicide. Actuarial risk assessments apply mathematical/statistical modelling to look at trends of particular risk events within populations and is of value in placing people in particular risk categories for the likelihood of an adverse event happening. However, as they are based on *population* data – that is, the association of identifiable demographic and other static characteristics of individuals and circumstances with particular risk events – and do not take into account dynamic and personal factors, they are not sensitive in predicting that the event will or will not occur in an *individual* case.

A 'structured clinical approach' is the preferred method of assessing and subsequently managing risk because it combines the use of a structured method of assessing risk with the use of actuarial information in order to assess clearly defined risk factors, risk triggers and ameliorants of risk, and makes use of:

- Clinical experience and knowledge of the service user.
- The service user's view.
- The views of carers and other professionals.

Suicide

Suicide is a complex phenomenon representing 'the end point of a complex history of risk factors and distressing events' (HM Government/DH, 2012: 4). In 2014, the Office for National Statistics reported that there were 1775 road deaths in the UK; in the same period, 6122 people took their own lives (ONS, 2016).

Suicide is a leading cause of premature death in the UK and the UK suicide rate was 10.8 deaths per 100,000 population in 2014 (*ibid.*). The *National Confidential*

Enquiry into Suicide and Homicide (NCE) (University of Manchester, 2014) reports that between 2002 and 2012, out of the total suicides in England and Wales, 28 per cent were by people who had been in contact with mental health services in the 12 months prior to their death – an average of 1248 per year. In the mental health service user population, the most used methods of suicide are, in decreasing order: hanging (41 per cent), overdose (26 per cent) and jumping (15 per cent) (*ibid.*).

In 2016, the suicide definition was revised to include deaths from intentional self-harm in children aged 10 to 14. However, the number of deaths from suicide in this age group is very low (ONS, 2016).

Risk Factors for Suicide

Risk factors thought to be associated with suicide, some of which are discussed below, can be found in Table 9.2.

Table 9.2 Risk factors for suicide

Demographic factors	Male Middle age (especially those aged 45–49 years old) Low socioeconomic status Unmarried, separated, widowed Living alone Unemployed
Background history	Deliberate self-harm (especially with high suicide intent) Childhood adversity (e.g. sexual abuse) Family history of suicide Family history of mental illness
Clinical history	Mental illness diagnosis (e.g. depression, bipolar disorder, schizophrenia) Personality disorder diagnosis (e.g. borderline personality disorder) Physical illness, especially chronic conditions and/or those associated with pain and functional impairment (e.g. multiple sclerosis , malignancy, pain syndromes) Recent contact with psychiatric services Recent discharge from psychiatric inpatient facility Psychological and psychosocial factors Hopelessness Impulsiveness Low self-esteem Life event Relationship instability Lack of social support Co-morbid drug and/or alcohol misuse

Current context	Suicidal ideation Suicide intent Life stressors Suicide plans Availability of means Lethality of means
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Source: Adapted from DH (2007) and ONS (2016)

Previous History

Features of the individual's previous history that may be associated with an increased risk of suicide are *static* risk factors (that is, not amenable to change). This historical context helps to establish the current baseline risk of suicide for the individual. These factors include:

- History of self-harm (people who self-harm have an increased risk of attempting suicide).
- History of suicide attempts, including recent incidents.
- History of mental disorder and admissions to mental health facilities.
- Personality traits.
- Childhood adversity.
- Family history of suicide.

It is very important to understand the nature and context of previous suicide attempts, if present, as there is evidence that people tend to repeat patterns when suicidal. Risk is increased where previous attempts have occurred. Here, the assessor should note:

- Triggers and context for previous attempts.
- The level of intent to commit suicide at the time and the person's subsequent view of this attempt (e.g. remorse, lack of emotion, sense of failure).
- Past methods for attempting suicide.
- Perceived and actual lethality of chosen method.
- Attempts to avoid detection.
- Any final acts (e.g. leaving a suicide note).

Risk is also increased in the context of escalating frequency and severity of self-harming behaviour, help-seeking behaviour (e.g. frequent presentation to services) and substance misuse.

Gender

Men complete suicide more frequently than women in a ratio of about 3:1 (University of Manchester, 2014); and, in 2014, it was recorded that 76 per cent of all suicides were males, compared to 24 per cent females (ONS, 2016). In 2014, the

male suicide rate was 16.8 male deaths per 100,000, compared to 5.2 female deaths (*ibid.*). While the male suicide rate in the UK in 2014 decreased (from 17.8 to 16.8 deaths per 100,000 population), the female suicide rate has increased (from 4.8 to 5.2 deaths per 100,000 population) (*ibid.*).

Age

Middle-aged men are at the greatest risk from suicide (*ibid.*). Suicide rates in older men aged 60 to 74 years and those aged 75 and over have decreased steadily since 1981. In 2014, the highest suicide rate in the UK in 2014 was amongst those aged 45 to 59 (23.9 deaths per 100,000 for men, compared to 7.3 deaths per 100,000 population) (*ibid.*). Since 2007, the suicide rate in the 45–59 age group has been increasing. Suicides by 10–29-year-olds have consistently been the lowest rates.

Marital Status

There is a clear link between marital status and suicide, and being unmarried has consistently been found to be a risk factor for suicide, whereas marriage seems to have a beneficial effect (Griffiths et al., 2008). Lesbian, gay and bisexual people have an elevated risk of suicide (HMG/DH, 2012).

Ethnicity

There is no consistently clear evidence of the link between ethnicity and suicide risk (Hawton et al., 2005b).

Life Events

There is no doubt that current life-event stressors in our lives increase the likelihood of suicidal ideas and attempts. This has long been recognised, with the Holmes and Rahe's (1967) Social Readjustment Scale attempting to quantify the risk of such stressors and capturing the compounding nature of such stressors (see Chapter 5). The factors are *dynamic* variables and include:

- Psychosocial stress – such as relationship difficulties, conflict and marital break-up, employment and work-related stress, severe financial difficulties and debt, family relationships, role changes, accommodation troubles such as inability to make mortgage repayments, evictions.
- Social and community stresses – such as stigma, prejudice, harassment and bullying, can all contribute to increasing an individual's vulnerability to suicide.
- Recent losses – such as redundancies, bereavements and severe financial difficulties.
- Recent life events and anniversaries.
- Imprisonment.

Of the total number of people who killed themselves between 2008 and 2011, 45 per cent were unemployed (University of Manchester, 2014). Barr et al. (2012) provide evidence linking the recent increase in suicides in England with the financial crisis that began in 2008. English regions with the largest rises in unemployment have had the largest increases in suicides, particularly among men.

In general, there is no evidence that people who have served their country in armed conflict are at higher risk of suicide. However, people who leave the armed services in their early 20s seem to have an elevated risk of suicide (two or three times greater risk) compared with people who have not served (HMG/DH, 2012).

Mental Health Problems

People with mental health problems represent one of the most important high-risk groups for suicide. It is worth noting that almost all the patients in contact with specialist mental health services are at increased risk compared with the general population. Current mental health problems are a significant factor in increasing risk of completed suicide (University of Manchester, 2014). Psychiatric conditions that can increase the risk of suicide include depression (Hawton et al., 2005a), bipolar disorders, schizophrenia, personality and childhood disorders (McLean et al., 2008). Some psychiatric symptoms are particularly implicated such as insomnia, anorexia, low mood, negative cognitions (such as anergia, anhedonia, motivation, poor concentration, problem-solving deficits), agitation and psychomotor restlessness, psychotic symptoms including delusional beliefs and command hallucinations. However, Hawton et al. (2005a) found a lesser or reduced risk of suicide amongst people experiencing hallucination but there appears to be an elevated risk amongst people diagnosed with schizophrenia and personality disorders at the initial diagnosis (McLean et al., 2008).

Other mental health-related issues that increase the risk of suicide include:

- Current suicidal ideation, intent and active plans (with access to means; see below).
- Feelings of hopelessness and helplessness.
- Recent admission and discharge to/from mental health services.

Substance misuse increases the risk of suicide attempts and subsequent death by suicide. The risk of suicide from alcohol misuse is greater among women than among men (*ibid.*), and the suicide risk is higher for those who use opioids and intravenous drugs than that for alcohol.

It also seems that fears of relapse and a deteriorating mental health and non-compliance with treatments plans – including any failure to attend appointments and the level of engagement – are also associated with an elevated risk of suicide (Hawton et al., 2005a).

A lack of hope for the future is a key predictor of suicide risk and an important aspect of assessing for the risk of suicide. Questions here include, for example:

- Do you have any hope for the future?
- Have you got anything to look forward to at the moment?
- Do you think you will get through this?

Physical Health

There is a well-documented link between suicide and long-term, chronic, debilitating and painful diseases (HMG/DH, 2012). Living with long-term conditions can also increase the risk, and those with three or more long-term conditions are seven times more likely to develop depression, a known risk factor for suicide. Some treatments used to manage long-term conditions, such as insulin, provide easy access and lethal means for overdose. With some diseases, such as coronary heart disease and chronic obstructive airways disease, there is a higher suicide risk on, or immediately following, confirmation of the diagnosis (*ibid.*).

Protective Factors against Suicide

Protective factors promote resilience and mitigate the risk of suicidal behaviour. Clearly, timely access to effective mental health and voluntary services which can support the suicidal individual have significant impact on reducing risk. Psychological factors such as hopefulness, optimism, clear reasons for living, positive future thinking and optimism are all protective against suicide attempt among those with depression (McLean et al., 2008). Problem-solving and coping skills may be protective against suicidal behaviour among those who have attempted suicide. Social support, such as positive family relationships, connectedness and marriage have also been linked with lower rates of suicide. Employment has a protective effect against suicide, possibly due to collegiate social working relationships and a more favourable financial position.

Participation in religion and religious observances has often been cited as a protective factor against suicidal behaviour (Perlman et al., 2011). However, it is not clear if this is due to the support that may be offered by the religious community or possible moral sanctions against suicide.

Assessment of Current Suicide Risk

In assessing a current suicide risk, the service user should be asked directly about suicide but it is vital that this is done sensitively and compassionately. There is no evidence that doing so increases the risk. When assessing the risk of suicide, it is important to consider the history of the service user (see Chapter 7), alongside the static and dynamic risk and protective factors (outlined above) contributing to the current presentation. In assessing the current level of risk, it is vital that the assessor considers three key areas: ideation, intentions and plans.

1. Assess Ideation

Has the service user had any current thoughts of ending their life or of suicide?

Questions can be direct, indirect or normalising.

Direct questions ask about suicide in a frank and open way, for example:

- ‘Have you been thinking of killing yourself?’

This questioning style can be appropriate in many situations because it is clear and unambiguous. However, such direct questioning may seem rather insensitive and threatening, which may discourage the person from discussing their current feelings and, at such times, ask the question in a modified form. These *indirect* questions imply or lead to the subject of suicide, for example:

- ‘Have you been thinking of ending it all?’
- ‘Have you felt like harming yourself recently?’

This questioning style may seem more gentle and can be useful in broaching a sensitive subject but it can lack clarity. It is important therefore to follow up such questioning to clarify ideas of suicide, for example:

- ‘Do you mean that you have thoughts of suicide?’

Normalising questions bring up the subject of suicide in the context of the situation, for example:

- ‘You must be very stressed at the moment, sometimes people in this situation think about killing themselves. Is this something you’ve considered?’

It is also important to assess the frequency and intensity of the suicidal thoughts. The thoughts may be occasional and fleeting in nature, or may be frequent, strong, overwhelming thoughts that would indicate an increased risk. It should be clarified if the thoughts come from an internal source (i.e. the individual’s own thoughts) or if there is any evidence of command hallucinatory experiences indicative of a psychotic disorder.

2. Assess Intentions

If thoughts of suicide are present, does the person intend to act on them?

If a person has suicidal ideation, then it is important to assess their intention to commit suicide. Direct questions that may be helpful as a starting point for a conversation about the intent include:

- Do you think you will act on these thoughts?
- Do you think you will kill yourself?

The Pierce Suicide Intent Scale (Pierce, 1977) can be useful as a structured assessment of a recent apparent suicide attempt. The aim is to understand the circumstances surrounding the attempt, as shown in Table 9.3.

Table 9.3 Pierce Suicide Intent Scale

Circumstances		Score
<i>Isolation</i>	Someone was present at the time the attempt was made	0
	Someone was nearby or on the telephone	1
	No one was nearby	2
<i>Timing</i>	The attempt was timed so that intervention was possible	0
	Intervention was unlikely	1
	Intervention was highly unlikely	2
<i>Precautions against rescue</i>	There were no precautions taken against discovery	0
	Precautions were passive (e.g. alone in room, door unlocked)	1
	Active precautions	2
<i>Acting to gain help</i>	Someone was notified	0
	Contacted someone, but did not explicitly tell them	1
	No contact with anyone	2
<i>Final acts in anticipation of death</i>	No final acts	0
	Partial preparation	1
	Definite plans (e.g. writing a will, insurance, gifts)	2
<i>Suicide note</i>	No suicide note written	0
	Note written but torn up	1
	Presence of note	2
Self-report		Score
<i>Lethality</i>	The person thought what they did would not kill them	0
	Person is unsure that the chosen method was lethal	1
	Believed it would kill them	2
<i>Premeditation</i>	The attempt was impulsive	0
	The attempt was considered for < 1 hour	1
	Considered for < 1 day	2
<i>Stated intent</i>	Considered for > 1 day	3
	The person reports that they did not want to die	0
	Unsure	1
<i>Reaction to act</i>	Wanted to die	2
	The person reports that they are glad they have recovered	0
	Uncertain	1
	Sorry they were unsuccessful	2

Medical risk score		Score
<i>Predictable outcome</i>	Survival certain	0
	Death unlikely	1
	Death likely	2
<i>Death without medical treatment</i>	No	0
	Uncertain	1
	Yes	2

Source: Adapted from Pierce (1977)

The maximum score for the Pierce Suicide Intent Scale is therefore 25, with the level of intent/risk graded as follows:

- Less than 4 = low intent/risk
- 4–10 = medium intent/risk
- More than 10 = high intent/risk

3. Assess Plans

If thoughts of suicide and intentions are present, it is important then to consider:

- Has the person had thoughts of, or made a plan of, how they will actually kill themselves?
- If so, how detailed is the plan?
- What is the potential lethality of the means?
- Do they have access to the chosen means?
- Are they readily available?
- Have they recently written or planned a suicide note?
- Have they made any moves to distance themselves from friends and/or relatives?
- Or have they made any preparations in anticipation of dying, for example giving away property or rewriting their will?

In general, a detailed and well-prepared plan indicates a degree of thought and possible rumination on the act, suggestive of a greater risk as is the availability and lethality of means.

Any assessment of ideation, intention and plans must be understood in the context of the person's current situation, along with an assessment of the static and dynamic factors, including active mental health symptoms. It is also important to note that if a person is not disclosing thoughts, plans and intentions, it does not mean that a risk is not present.

Self-Neglect

People who neglect their own personal and household hygiene and health are familiar to mental health staff (Lauder, 2005), and it is therefore a significant issue for mental health services and an important and challenging aspect of risk assessment.

Definitions of Self-Neglect

Self-neglect is ‘a form of self-care deficit in which those self-care activities that are thought to be necessary to maintain a socially accepted standard of personal and household hygiene are not undertaken’ (*ibid.*: 46). However, self-neglect may also include a failure to adequately manage personal finances; social and interpersonal neglect; poor adherence with treatment plans; and failures of people to protect themselves from sexual, financial and property abuse (*ibid.*, 2001; Gunstone, 2003; Gibbons et al., 2006).

Self-neglect, of course, does not represent an all-or-nothing phenomenon but appears to exist on a continuum. The lower end of the self-neglect continuum may include issues such as a failure to look after one’s diet; poor dental hygiene; not proactively seeking medical attention when an illness or condition is suspected; and so on. At the other end of the continuum, *severe self-neglect* may lead to a significant deterioration in physical and mental health such as: the hoarding of potentially hazardous or toxic rubbish and animals, both alive and dead; the continual neglect of rotting food; poor personal hygiene resulting in parasitic infestations, and other infections; recklessness arising from ignoring possible dangers from poorly maintained electrical appliances; and so on (Arluke et al., 2002; Gunstone, 2003; Lauder, 2001; Gibbons et al., 2006).

Risk Factors for Self-Neglect

Mental Illness

Self-neglect has been associated with various mental conditions such as obsessive-compulsive disorders (Maier, 2004); psychosis; depression; dementia (Halliday et al., 2000; Abrams et al., 2002); stress in later life (Clarke et al., 1975); and personality disorder (Damecour and Charron, 1998; Abrams et al., 2002). Self-neglect can also be found in those with frontal lobe atrophy, which can also be associated with aggression, hostility and paranoia (Orell et al., 1989). People who live in squalor also tend to have higher rates of mental conditions, often exacerbated by a co-morbid alcohol abuse (Halliday et al., 2000).

Mental illness, then, may be a clinical precursor to self-neglect. However, the links between psychiatric conditions and self-neglect are not always clear (Lauder, 1999a) as, for example, approximately 50 per cent of people who neglect themselves in the over-60s have no clinically diagnosed mental disorder (Macmillan and Shaw, 1966; Clarke et al., 1975). Whilst psychiatric experiences and the use of sedating psychiatric medication may contribute to some people’s difficulties in coping with personal and household hygiene, finance, social interaction and concordance with treatment and so on, there is as yet no definitive evidence of a causal association between mental ill health and self-neglect (Vostanis and Dean, 1992).

Age and Gender

Significant associations may also exist between self-neglect and cognitive decline in older age (Macmillan and Shaw, 1966; Abrams et al., 2002), and this group, in particular, may experience social withdrawal (Hettiaratchy and Manthorpe, 1989), malnutrition, the hoarding of rubbish and severe neglect of personal hygiene (Clark et al., 1975).

However, self-neglect in younger adults (specifically those under 60 years of age) is poorly understood and poorly researched (Cooney and Hamid, 1995), so the self-neglect risk profile for these age groups is unclear. That is, it is not clear if there are specific risk factors for younger people with mental health problems who self-neglect that distinguish them from the general population (Lauder, 2005).

Psychosocial Factors

Psychosocial perspectives of self-neglect seek to understand and explain the phenomena rather than classify it as a symptom of some underlying mental disorder (Lauder 2001). For example, Bristow et al. (2001) found significant differences in the higher rates of self-neglect amongst admissions to inpatient mental health facilities in inner London areas compared with outer London. However, it is not clear if living in inner city/urban areas contributes to self-neglect or if people who are prone to self-neglect are drawn to those areas. Self-neglect may also occur where an individual becomes focused on, and perhaps over-involved with, the needs and welfare of others to the exclusion of their own personal needs (Fritz and Helgeson, 1998). Vostanis and Dean (1992) explored two cases of self-neglect in women aged 35 and 38. Both were unemployed and were described as having an emotionally detached upbringing from their family and relatives and no evidence of a treatable psychiatric illness was diagnosed. There were further similarities, in that both women had few contacts with friends, rejected help from outside agencies and were described as being often suspicious and quarrelsome. This supported previous findings on the social and interpersonal characteristics of those that self-neglect (Macmillan and Shaw, 1966).

However, consideration needs to be given to how assessors may interpret or perceive self-neglect (Lauder, 1999a). Social definitions and explanations of self-neglect are likely to involve individual values, culturally acceptable norms and perceptions of citizenship (Gunstone, 2003; Lauder 2001, 2005). As such, self-neglect may be perceived by assessors as a failure to engage in socially acceptable and culturally defined standards of personal and household hygiene (Lauder 2001):

people who are ‘dirty’, ‘unclean’ and ‘unhygienic’ in Western Cultures are regarded as disordered, unhealthy and to be vanquished. (Lauder, 1999b: 60)

Self-neglect, then, may be seen as a violation of prevailing social norms (*ibid.*, 2005) and, therefore, perceptions of acceptable levels of cleanliness and hygiene are likely to vary between individuals who are undertaking risk assessments of self-neglect (*ibid.*, 2001). That is, mental health care practitioners are likely to make different judgements as to what constitutes self-neglect based, at least in part, on their own cultural values (Lauder, 2001). The implications are clear: health professionals who are making risk assessments of self-neglect need to be aware of what they consider ‘normal and abnormal levels of cleanliness and hygiene’ (Lauder, 1999b: 61). Furthermore, if risk assessments of self-neglect are culturally determined (Crowe and Carlyle, 2003), then perceptions may also vary, depending on the extent to which we assume those who self-neglect *choose* to do so (Lauder, 2001). That is, whether we believe that a person’s perceived self-neglect is an intentional decision on the part of the self-neglecting individual (Gibbons et al., 2006) or whether we assume that self-neglect results from the unintentional consequences of circumstances that are beyond the person’s control (*ibid.*), such as experiencing mental health problems or cognitive decline.

Risk Assessment of Self-Neglect

There is a clear need for the early identification of self-neglect, not only so that early preventative action may be taken, but also because self-neglect may be part of a 'relapse signature' which might be suggestive of a service user's deteriorating mental state (Lauder, 1999a; Gunstone, 2003). Therefore, the regular monitoring of those at risk for nutrition and dietary intake, physical health status, self-care and hygiene, along with treatment concordance, is essential (Tierney et al., 2004).

Unfortunately, self-neglect may go 'undetected until either a pattern of behaviour is observed by health care personnel or the individual is acutely hospitalised in a state of severe neglect' (Gibbons et al., 2006: 11). However, Gunstone (2003) highlighted the significant problem that exists in the application of actuarial risk assessment tools, in that most have been developed for research, and do little to meet the everyday needs that emerge in individual cases. Some global or symptom-specific assessments, such as the Camberwell Assessment of Need (Phelan et al., 1995) or the Expanded Brief Psychiatric Rating Scale (Lukoff et al., 1986), may be helpful to indicate or describe a health care need.

Any risk assessment of self-neglect will need to develop an idiosyncratic profile of an individual, including details of the specific areas of neglect (such as poor hygiene; animal hoarding; lack of proper disposal of potentially hazardous or toxic rubbish; the continual neglect of rotting food; social and interpersonal neglect; poor adherence with treatment plans; recklessness; and failures of people to protect themselves from sexual, financial and property abuse). However, the assessment must also include details of the person's: culturally imbued beliefs surrounding the importance of hygiene and other factors; their ability to respond to their own perceived need; a clear baseline for their 'usual' standards of hygiene and variations from this baseline; and factors which might underpin a movement away from this baseline (Lauder, 1999a).

Violence

Risk Factors for Violence

The Health and Safety Executive (HSE, 2006) suggest that individual risk assessments of violence should be completed and regularly reviewed as part of the care planning process. The assessment should consider:

- The mental, emotional and physical condition of the person.
- The effect of medical conditions or ingestion of drugs, alcohol or medicines.
- Their stress levels.
- Whether they have a history of challenging, violent or aggressive behaviour.
- Whether they consider others a threat.

The factors should not be seen in isolation, but as complex, multiple interacting variables that contribute to increasing the likelihood of violent behaviour, such as family history, personal stressors (such as loss, marital break-up or bereavement), and socioeconomic factors (such as financial problems, debt and accommodation difficulties). We must not assume that the following variables are unique to this

group and we must be aware that variables that increase the likelihood of violence in the general population will also affect those experiencing mental health problems. Risk factors thought to be associated with violence, some of which are discussed below, can be found in Table 9.4.

Table 9.4 Risk factors for violence

Demographic factors	Male Young age Socially disadvantaged neighbourhoods Lack of social support Employment problems Criminal peer group
Background history	Childhood maltreatment History of violence First violent at young age History of childhood conduct disorder History of non-violent criminality
Clinical history	Psychopathy Substance abuse Personality disorder Schizophrenia Executive dysfunction Non-compliance with treatment Anger Impulsivity Suspiciousness Morbid jealousy Criminal/violent attitudes Command hallucinations Lack of insight Current 'context' Threats of violence Interpersonal discord/instability Availability of weapons
Psychological and psychosocial factors	

Source: DH, 2007

History of Violence

People who have acted violently in the past are more likely than others to act violently in the future. Past violence is the single best predictor of future violence (Monahan et al., 2001). An exploration of the previous violence needs to be undertaken, with particular

attention being paid to establishing any patterns and the circumstances surrounding past violent events – including triggers, stressors, health issues, contexts, motivations and so on. The risk of violence also increases with exposure to familial violence during childhood, parental physical abuse or criminal activity by a parent.

Age and Gender

Younger people tend to act more violently than older adults. Men tend to act more violently than women, with the latter, tending to direct violence towards family members at home (*ibid.*).

Socioeconomic Stress

Poverty and homelessness are widely thought to increase the risk of violence. However, recent research found no associations between childhood family income and subsequent violent criminality (Sariaslan et al., 2014).

Personal Stress

Being assaulted in the past year increases the risk of violence by the victim. People who have lost their job and/or experienced marital break-up or separation are more likely to become violent.

Mental Disorder

People experiencing hallucinations that command a violent act and those who are generally suspicious and angry may be more likely to become violent than people who do not experience these symptoms. Some forms of personality disorders (such as borderline personality disorder, antisocial personality disorder, conduct disorder), particularly where the person experiences emotional detachment, are strongly associated with violence. The MacArthur Violence Risk Assessment Study (Monahan et al., 2001), however, found that a diagnosis of a major mental disorder (especially schizophrenia) was associated with *lower* rates of violence overall.

Substance Use

The use of substances can be emotionally destabilising and can trigger violent behaviour by impairing judgement, exacerbating paranoid and hostile symptoms and reducing inhibitions. It is not surprising, therefore, that people who have a **dual diagnosis** are many times more likely than patients with a mental disorder alone to become violent (Monahan et al., 2001).

Risk Assessments of Violence

An appraisal of the various risk assessment tools for violence is outside the scope of this book but it is important to acknowledge that the predictive accuracy of any risk assessment tool varies, depending on the skills of the assessor and how they are used. In general, they tend to identify low-risk individuals with high levels of accuracy, but they should not be relied on for use as sole determinants of future violence (Fazel et al., 2012).

The use of some of these tools are restricted to specific occupational groups (e.g. psychologists) and may require formal training before they can be used, which may incur a charge, as might the purchasing of a licence for their use. For example, the HCR-20 (Version 3) (hcr-20.com) consists of 20 items, dividing risk assessment into historical factors, clinical factors and risk management factors. These indicate relevant issues in a service user's past history, evaluating the presence of contemporary dynamic issues in risk, and possible future risk management requirements. Each item is coded on a three-point scale ('absent', 'possibly present' or 'definitely present').

Violent People or Violent Situations?

The risk literature often portrays violence as a phenomena stemming from *within* the individual suggestive of a personality trait or a pathological symptom of an underlying 'disease'. As we have seen from the above discussion, risk assessments tend to focus on the dispositional, historical and clinical features of a violent individual reacting to a particular context. Risk assessments of violence, however, may involve a wider appreciation of the environmental, contextual, interpersonal and situational factors than the study of a decontextualised individual. That is, violence does not occur in isolation and we must recognise that stressful situations and contexts can provoke angry or possibly violent behaviour and that such reactions may not be reflective of a person's 'disposition' (McGrory and Trenoweth, 2008). Duxbury (2002) and Duxbury and Whittington (2005) also argue that the environment, both built and social, and organisational activities within inpatient services can impact on violent behaviour.

For Megargee, 'the degree of danger that an individual represents to himself or others varies markedly as a function of a number of variables' (1976: 5). Megargee proposed a formula to account for the complex interplay of intra-, inter-, situational risk factors and those protective variables that mitigate risk. These include:

- Risk factors that facilitate violent acts:
 - An individual's motivation to become violent (Mx).
 - The individual's past history of being reinforced for violent behaviour (H).
 - Factors within the situation which may facilitate violence (Sf).
- Risk factors that inhibit violent acts:
 - Factors which inhibit (I) violent act (a) against a victim (x) (Ia.x).
 - Factors within the situation which may inhibit violence (Si).

Megargee (*ibid.*) suggested that, when the inhibitions were stronger, there would be less likelihood of violence:

$$Mx + H + Sf < Ia.x + Si$$

and, where factors leading to violence were stronger than inhibitions, then violence would be more likely:

$$MX + H + Sf > Ia.x + Si$$

This model gives consideration to the patient's previous violent behaviour; incentives and disincentives to become violent; possible targets of the violent behaviour; and protective factors.

Megargee (*ibid.*) suggests that it is important to consider staff factors (Sf) that may also facilitate or inhibit violent behaviour. Negative staff-patient relationships, limit setting and controlling practices because of policy and organisational demands may also trigger episodes of violence (NICE, 2015). It has also been suggested that assessments of risk need to take into consideration the emotional and psychological state of the assessor. Tardiff, for example, suggests:

a patient may be viewed as more dangerous than he actually is because of staff anxiety that is projected onto the patient. (1988: 543)

Similarly, there tends to be less violent behaviour in services that have well-trained and experienced staff working well together with good leadership and high morale (Royal College of Psychiatrists, 1998); and there tends to be more violence associated with services where there are staff who are inexperienced, poorly trained and authoritarian (Morrison, 1990; Lipscomb and Love, 1992). Furthermore, the assessment of violent, or potentially violent, behaviour needs to consider the environment in which the assessment takes place (which may be stressful and noisy). The presence of the individual who is making the assessment, and their actions, may increase or decrease the display of violent behaviour and, in turn, they may be personally affected by the risk, either emotionally or physically.

The National Institute for Health and Care Excellence (NICE) guidelines for *Violence and Aggression: Short-Term Management in Mental Health, Health and Community Settings* confirm that violence and aggression:

depends on a combination of intrinsic factors, such as personality characteristics and intense mental distress, and extrinsic factors, such as the attitudes and behaviours of surrounding staff and service users, the physical setting and any restrictions that limit the service user's freedom. (2015: 4)

Therefore, it is evident that skilled risk assessment and management of violence and aggression must consider the intrinsic factors mentioned above but also the extrinsic factors such as clinical leadership and staff training, attitudes and behaviours, including: an ability to engage with service users and a person-centred approach to care; the involvement of people in their care; the recognition of escalating aggression and de-escalation to reduce the likelihood of violence; and ensuring that service users are offered appropriate therapies, physical activities and leisure pursuits (*ibid.*).

Safeguarding

While a full discussion of *safeguarding* is outside the scope of this book, it is important to highlight those issues that are particularly relevant to the psychosocial assessment process. Safeguarding is defined by the Care Quality Commission (CQC) as protecting people's health, well-being and human rights, and enabling them to live free from harm, abuse and neglect. This means that you may need to act upon some of the information that you are given in a psychosocial assessment, particularly where issues of risk are being discussed or where there are concerns of abuse, harm or neglect of vulnerable adults or children. If you are concerned about any information that you have received, then you should discuss this with the appropriate safeguarding lead or designate within your service. If there is no safeguarding lead, and you are concerned about a vulnerable child or adult, then you should contact the social care department at the appropriate local authority. If this is not possible, then you can contact the CQC on 03000 616161 or enquiries@cqc.org.uk. For further information, see the CQC website at: www.cqc.org.uk/content/safeguarding-people.

Chapter Summary

In this chapter, we have described and defined risk assessment and discussed the importance of risk assessment as a tool for enabling the management of risk through collaborative assessment and safety planning. In the risk assessment process, we should try wherever possible to involve and engage the service user. We have illustrated the principles of risk assessment by giving examples of three common areas in mental health care – suicide/self-harm, self-neglect, and violence. Risk assessments tend to explore factors *within* the individual but we argue that the situational factors that may facilitate and inhibit risk behaviours must also be considered. That is, in undertaking a comprehensive risk assessment, there is a need to consider risk in its broadest context and to consider risks posed to the individual as a result of having a mental health problem, including physical health, stigma, social situation, employment and finance that need to be tackled to minimise long-term risk.

EXERCISE



Risk assessments can sometimes fall into the trap of only considering the risk that the person poses to themselves or other people. However, it is important to recognise that service users themselves may be at risk from others. Jot down some risk that you feel mental health service users may be exposed to:

1. How might we assess these risks?

CONSIDERATIONS FOR PRACTICE

1. What skills and values do you believe practitioners need to assess risk?
2. How might you involve the service user in the risk assessment process?
3. Risk assessments for self-neglect may not be routinely undertaken in clinical practice. Why might this be the case?

Further Reading

Department of Health (2007) *Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services*. Available at: http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_076512.pdf (accessed 10 June 2016).

An essential document for identifying evidence-based best practice principles for risk assessment and management in health care. It identifies how best to work alongside service users in assessing and managing risk, and provides a framework for multi-professional working.

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10

SUBSTANCE USE

MARY O'TOOLE



CHAPTER OVERVIEW

This chapter:

- Explores the concept of dual diagnosis and related terms.
 - Gives an overview of the common drugs of misuse and their effects on mental health.
 - Identifies the key components of a comprehensive assessment of a person with concurrent mental health and substance misuse problems.
 - Highlights how brief interventions, including motivational interviewing, can form part of the assessment.
-

Introduction

Substance misuse is a broad term that refers to the harmful use of any psychotropic substance, including alcohol and either legal or illicit drugs. Substance misuse is generally (although not always) regarded as a problem if there is evidence of

dependence (NICE, 2011). For a person to be considered dependent on a drug (including alcohol), they will have a strong desire or sense of compulsion to take the substance, with significant difficulties in controlling substance-taking behaviour in terms of its onset, termination or levels of use. They will experience a physiological withdrawal state when substance use has ceased or been reduced, and this will vary according to the characteristic withdrawal syndrome for the substance. There will be evidence of tolerance (the person will require increasing amounts of the substance in order to achieve the same effects). Generally speaking, there will be progressive neglect of other activities or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects. The person is most likely to persist with substance use, despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use or drug-related impairment of cognitive functioning.

Dual Diagnosis

The term *dual diagnosis* has been used to describe varying combinations of physical, psychological or developmental conditions. However, for the purpose of this chapter, it is a term that has been used to describe people who experience coexisting mental health and substance use problems.

It is known that most misused substances increase dopaminergic activity in the brain (Koob and Volkow, 2010), and that mental health conditions such as schizophrenia and psychosis are characterised by an increase in dopaminergic transmission (Howes and Kapur, 2009). Most antipsychotic medications work by blocking dopamine receptors and therefore reducing dopamine activity, so, it can therefore be concluded that substance misuse is likely to increase symptoms of psychosis (such as hallucinations and delusions) and compromise the therapeutic effects of the antipsychotic medication.

Substance Misuse and Mental Health

Psychosis is a term used to describe a group of severe mental health disorders characterised by the presence of delusions and hallucinations that disrupt a person's perception, thoughts, emotions and behaviour. The main forms of psychosis are schizophrenia (including schizoaffective disorder, schizophreniform disorder and delusional disorder), bipolar disorder or other affective psychosis (NICE, 2011).

It is estimated that 40 to 50 per cent of people diagnosed with psychosis misuse substances at some point in their lifetime (NICE, 2011; Cleary et al., 2010), which is approximately double the rate seen in the general population. Levels of substance use that would be considered not particularly harmful in people without psychosis could have a significant impact on the mental health of an individual who has experienced, or is currently experiencing, psychotic symptoms. Indeed, substance misuse can be harmful without dependence among people with a coexisting psychosis.

People with coexisting substance misuse have a higher risk of relapse and hospitalisation, and have higher levels of unmet needs compared with other inpatients with psychosis who do not misuse substances (NICE, 2011; Hughes, 2006).

The reason that is most frequently cited for substance use in people with psychosis is as a way of coping with symptoms. However, for a third of people with psychosis, this amounts to harmful or dependent use (NICE, 2011). The outcome for people with psychosis and coexisting substance misuse is worse than for people without coexisting substance misuse, partly because the substances used may exacerbate the psychosis and partly because substances often interfere with pharmacological or psychological treatment.

Mental health problems and symptoms can frequently occur in individuals who use drugs. The symptoms vary according to the drug used and the route of administration. Most drugs will have detrimental effects on a person's mental state and may exacerbate already existing mental health problems. In addition, substance use is also associated with partial or non-adherence with medication, further increasing the likelihood of relapse (Mutsatsa, 2011).

Substance misuse among individuals with psychiatric disorders is associated with significantly poorer health and social outcomes than for individuals with a single disorder (NICE, 2011; Cleary et al., 2010). These are summarised in Table 10.1.

Table 10.1 Health and social outcomes for dual diagnosis

Health or social outcome	Example
Worsening psychiatric symptoms	Effects of stimulant drugs on psychotic symptoms; effects of alcohol on depressive symptoms
Poor physical health	Liver damage; HIV and other blood-borne viruses; poor nutrition; smoking-related conditions
Poor medication adherence	Non-adherence due to potentially chaotic lifestyle; drugs may interfere with pharmacological action of prescribed medication
Homelessness/rooflessness	Lack of income, stability and generally chaotic lifestyle
Lack of engagement/drop out from services	Lack of coordination between addictions and mental health services; chaotic lifestyle; stigma; reluctance to engage due to fear of recrimination
Family problems	Family estrangement; stigma
Increased contact with criminal justice system	Increase in acquisitive crime to pay for drugs/alcohol

A Complex Relationship

The relationship between psychosis and substance use is complex, as it is often unclear whether the individual is experiencing psychosis as a result of substance misuse or whether they are using substances as a consequence of their psychosis. Indeed, many individuals would argue that their substance use can serve to ease their symptoms, whilst others have proposed that substance use can exacerbate those symptoms. Evidence suggests that substance use, intoxication, withdrawal and dependence may all lead to, or exacerbate, mental health symptoms. Conversely, mental health problems may lead to substance use and dependence (DH, 2002; Crome et al., 2009).

Historically, there has been much discussion around the concept of ‘true’ dual diagnosis. However, as Crome et al. (2009) suggest, individuals may present during an episode of intoxication or withdrawal; may be dependent on one or more substances; and may suffer from more than one mental health symptom or condition. The question of whether a person is experiencing ‘true’ dual diagnosis is therefore largely meaningless for service users who may be excluded from help as a result. In addition, a preoccupation with ‘what comes first’ is unhelpful and the aim of any treatment plan should be to treat the person holistically.

Four distinct relationships within dual diagnosis have been recognised (DH, 2002; Crome et al., 2009), and these are summarised in Table 10.2.

Table 10.2 Relationships within dual diagnosis

-
1. Mental conditions precipitating or leading to substance misuse (e.g. a person with severe anxiety is prescribed a benzodiazepine. The person begins taking four-times the prescribed dose to alleviate symptoms. The person becomes dependent)
 2. Substance misuse worsening or altering the course of a condition
 3. Intoxication and/or substance dependence leading to psychological symptoms
 4. Substance misuse and/or withdrawal leading to psychiatric symptoms or conditions
-

Common Substances of Misuse

Substances have often been categorised according to their effects on the body. So, for example, cocaine, crack cocaine and amphetamines are categorised as stimulants. Alcohol, benzodiazepines, cannabis and opiates such as heroin would be categorised as sedatives. Acid, LSD and ecstasy are categorised as hallucinogens. However, it is important to note that these are slightly nebulous categories because drugs can react in different ways for each individual, particularly if they are mixed with other drugs and/or alcohol.

Table 10.3 summarises some of the key mental health problems and symptoms associated with some of the common drugs of misuse.

Table 10.3 Drugs and their associated mental health problems

Drug	Associated mental health problems
Heroin (and other opiates)	Anxiety, depression, suicidal ideation, overdose, personality disorder
Cannabis	Anxiety, restlessness, thought disorder, paranoia
Cocaine, crack cocaine	Psychosis, persecutory delusions, paranoia, depression, sleep disturbance
GHB (gammahydroxybutrate) and GBL (gammabutyrolactone)	Sedative (very dangerous when mixed with alcohol) disinhibition, confusion, paranoia
Ecstasy (MDMA)	Anxiety, panic, paranoia, psychosis
Amphetamine	Thought disorder, hallucinations, paranoia, restlessness, sleep disturbance

New Psychoactive Substances (Legal Highs)

A more recent and worrying development is the advent of new psychoactive substances (NPS, formerly known as ‘legal highs’). NPS are compound substances which produce similar effects to other illegal drugs such as cocaine, cannabis and ecstasy. These substances were banned on 6 April 2016 under the Psychoactive Substances Act 2016. Prior to the ban, they were very easily available and affordable online or in legal high shops. Today, possession of an NPS is not an offence, but possession with an intent to supply can lead to seven years imprisonment and/or a fine. NPS are constantly being developed and manufactured and, as such, very little is known about their potency, adverse effects and long-term effects as research is still in its infancy. NPS have already been linked to numerous emergency hospital admissions and some deaths.

As with other drugs, NPS can be described according to their effects. The three main categories of NPS are stimulants, sedatives and hallucinogens, and they generally come in the form of pills, powders, liquids or smoking material. There is wide variation in the appearance of these substances and their names. They are often presented in brightly coloured packaging with interesting names (clockwork orange, white pearls). However, this does not reflect the fact that they are a highly potent and potentially dangerous psychoactive substance, further increasing the risk of harm as potential users will not necessarily realise the risk they are taking.

NPS are normally taken as a pill, snorted, smoked or injected. The same risks are associated with injecting NPS as with injecting any illegal drugs. For example, any drug that is injected direct into a vein will hit the blood stream rapidly and the effect will be immediate. If little is known about the NPS and its potency, then this is a very risky practice as the drug may reach harmful, or even fatal, levels in a matter of seconds. There are also the additional risks associated with the injecting process, such as blood clots and abscesses and transmission of blood-borne viruses such as HIV and hepatitis C.

Many of the effects of NPS have been described as similar to those of other illegal substances. Table 10.4 summarises some of the key mental health problems and symptoms associated with NPS.

Table 10.4 New psychoactive substances (NPS, formerly known as ‘legal highs’) and their associated mental health problems

Type of NPS	Effects	Associated mental health problems/adverse effects
Stimulant (e.g. BZP, mephedrone (meow meow), MPDV, NRG-1, Benzo Fury, MDAI, ethylphenidate)	Act like amphetamines, cocaine, ecstasy. Makes user feel overconfident and disinhibited	Can induce feelings of anxiety, panic, confusion, paranoia; can cause or exacerbate psychosis. User may feel low for a time after use

Type of NPS	Effects	Associated mental health problems/adverse effects
Sedative (e.g. etizolam, pyrazolam and flubromazepam)	Act like cannabis, benzodiazepines, GHB/GBL. Reduces inhibitions and concentration, slows down reactions and makes user feel lethargic, forgetful or physically unsteady Can also cause unconsciousness, coma and death, if mixed with alcohol and/or with other sedatives	Can induce feelings of anxiety, particularly after stopping Withdrawal can be dangerous and may require medical attention
Hallucinogenic (e.g. 25i-NBOMe, Bromo-Dragonfly)	Act like LSD, magic mushrooms, ketamine. Can cause strong hallucinatory reaction (trip) Some NPS create strong dissociative effects, which make user feel like their mind and body are separated	Can cause confusion, panics and hallucinations ('bad trips'); erratic behaviour; risk-taking; self-harm; impaired judgement

Cannabis and Psychosis

Cannabis is the most widely used illicit substance in the UK and frequent use of cannabis is about twice as likely amongst young people. Recent figures indicate that nearly 5.3 million 16–24-year-olds have used it in the UK in the last year (Royal College of Psychiatrists, 2014). There has been much debate with regard to the link between cannabis and psychosis, and research over the last 10 years it has been suggested that it can have serious consequences for some people, particularly those who are genetically vulnerable to developing a psychotic illness.

In recent years, a stronger form of cannabis known as 'skunk' has become popular. It has a much higher concentration of THC (tetrahydrocannabinol), the main active ingredient, than other more traditional herbal varieties. For many people, the effects of smoking cannabis are quite pleasant and can make the user feel relaxed and happy. However, when higher amounts are consumed, it can have the opposite effect by increasing anxiety. Other effects include confusion, hallucinations, anxiety and paranoia. In some people, these effects last a few hours but others suffer longer-term consequences.

Evidence suggests that people with mental health problems, including depression and psychosis, are more likely to use cannabis or have used it for long periods of time in the past. Regular use of the drug has appeared to double the risk of developing a psychotic episode or long-term schizophrenia (Patton et al., 2002; RCP, 2014). A key question within this field of research is whether cannabis causes depression and schizophrenia or whether people with these disorders use it as a medication? Indeed, there does seem to be a clear link between early cannabis use and later mental health problems in those with a

genetic vulnerability, particularly when cannabis is used by adolescents. It has been suggested that the reason that adolescents are particularly vulnerable is that the brain is still developing in the teenage years and up to the age of about 20. Heavy use of cannabis may interfere with neural development resulting in long-term psychological effects.

Alcohol and Depression

Alcohol consumption has long been linked to depression or low mood. Indeed, it is known that regular drinking lowers the levels of serotonin in the brain – a chemical that helps to regulate mood (RCP, 2013; DH, 2012). Excessive alcohol consumption may be either a cause or a consequence of depression. A person may use alcohol to alleviate feelings of anxiety and depression; as tolerance to alcohol increases, so will consumption. Furthermore, alcohol is likely to interrupt the pharmacological action of anti-depressants, thus reducing their effectiveness. People who consume excessive alcohol are more at risk of suicide and self-harm (Raistrick et al., 2006).

Assessment of Substance Misuse

A comprehensive and thorough assessment is essential for individuals presenting with coexisting mental health and substance use problems. Before considering assessment in any detail, it is important to highlight that despite successful national campaigns pioneered by organisations such as Mind and Rethink, there is still considerable stigma and lack of understanding associated with mental health problems as well as substance misuse. Indeed, stigma and lack of understanding can even occur within health care settings and between health care professionals. Individuals who have both conditions may well encounter discrimination as a result of this (NICE, 2011). Social isolation, stigmatisation and social exclusion are likely to be common experiences, as well as generally poor provision in some areas and for some groups of people (Crome et al., 2009). Moreover, a person seeking help may experience feelings of shame and fear.

It is vital, therefore, that we convey a non-judgemental attitude and that the assessment is conducted collaboratively with the service user and families (if appropriate) in an atmosphere of warmth, empathy and respect. Effective written and verbal communication is vital for a person with coexisting mental health and substance misuse problems. This applies to communication between health care workers and service users and their family (if appropriate) and also between health care professionals. Service users and their family should have a clear plan in place with regard to whom they need to contact in a crisis or indeed a routine situation.

Information Gathering

An assessment of a person with coexisting mental health and substance misuse problems should be comprehensive and cover each area of a person's life in as much detail as possible.

There are a number of key areas that should always be included in any assessment and these are summarised in Table 10.5.

Table 10.5 Assessment of person with coexisting mental health and substance misuse problems

Current substance-misuse related physical health problems	Blood-borne viruses (HIV, hepatitis C) Circulatory and wound problems (relating to frequent injecting)
Substance misuse related offending behaviour	Criminal record Pending court cases
Accommodation	Including history of homelessness Stability of current living arrangements
Current substance misuse	Particular substance(s) used Quantity/pattern of use Route of administration Duration of current level of use Cigarette smoker? Supply issues
Past substance misuse	History of substance misuse General impact on their life and health Previous treatments Previous experience/responses to treatment
Current alcohol use	Drink of choice? How many units/drinks? What time do you start/stop? Withdrawal symptoms? Ever had seizures?
Current view of treatment	Treatment preferences/goals Personal strengths and weaknesses Readiness to change their substance use/motivation

The assessment may need to take place over several meetings to gain a full picture of the person and their needs. This will also help to develop trust and promote engagement. Indeed, a person may not be able to endure an assessment session that lasts longer than an hour. However, it is worth noting that this service user group will often lead quite chaotic and complicated lives and, as such, it is important to keep in mind that the initial assessment may be your only contact with that person. It is important, therefore, to maximise your time and take opportunities for brief interventions – this will be discussed in more detail in the following section. If the service user agrees, then discussion and collaboration with family members and supportive friends is also useful.

As well as obtaining detail with regard to substance use, it is important to explore with the service user situations or states when he or she is vulnerable to drug use and to explore alternative coping strategies. If possible, it is beneficial to encourage the service user to make links with symptoms of their mental health problem and effects of the drug. For example, the service user may wish to think about the effect of the drug on symptoms such as hallucinations or low mood.

Assessment Tools and Approaches

There are a number of assessment tools in existence for substance misuse as well as mental health, and their uptake and use vary nationally. Most substance misuse assessment tools will assess severity of dependence and levels of use (Opiate Treatment Index, Darke et al., 1991; AUDIT, Babor et al., 1992; CAGE, Ewing, 1984); whilst most mental health tools will focus on symptoms and side effects of medication (PHQ-9, Kroenke et al., 2001; LUNERS, Day et al., 1995). There are no widely recognised tools designed specifically for dual diagnosis.

Standardised assessment tools should only ever be used in conjunction with a comprehensive face-to-face assessment and should be viewed as additional information to complement the main assessment. Assessment tools are useful for giving a baseline and also to monitor any changes in a person's symptoms, substance use or severity of dependence. A self-assessment tool may be useful for initial engagement with a person and may serve as a guide or a structure for further in-depth assessment.

Timeline

Using a timeline (see Chapter 4 for more details) can be really simple but very effective, particularly for individuals with coexisting mental health and substance misuse problems. The service user can mark key points in their life along a timeline (see Figure 10.1).

For example, when they first noticed that they were unwell; when they were prescribed medication and which type; when they first started using each substance; when their symptoms were worse or better. You and the service user can then look at whether there are any links in events. For example, the service user may notice that when they were using less alcohol, their mood seemed more stable. The service user who uses cannabis may make links between increased use and exacerbation of symptoms or even hospital admission.

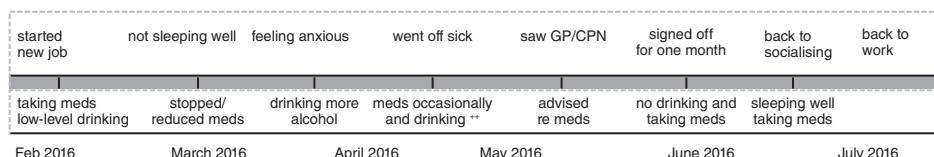


Figure 10.1 Example of a timeline

Diary

A diary is also a really useful way of tracking thoughts, feelings and behaviours, particularly in terms of drug taking and/or alcohol consumption. Your service user should be encouraged to keep a daily diary (written or electronic) and record as much information as possible on each day:

- What type(s) of substance is used (including alcohol).
- How much of each substance.
- What time of the day did you start using?
- What time of the day did you stop (or did you ‘crash out’)?
- Who were you with, or were you alone?
- Where were you? (At home? In the pub? At your mate’s house?)
- How did you feel before you started using on that day?
- How did you feel while using? (Happy, sad, voices? Good or bad thoughts? Angry? Bored?)
- How did you feel the next day?

The service user can then bring their diary to your next meeting and use this to explore patterns in behaviour and potential consequences of substance or alcohol use on their mental and physical health. This can also be a really good way of providing insight into reasons and situations that may lead to using.

Decisional Balance Chart (Pros and Cons Chart)

A decisional balance chart (pros and cons chart, decision matrix) can be a useful way of exploring the good and not so good aspects of substance use. It can be as simple as writing a list on a piece of paper or a more complex arrangement. This can be done during an assessment/session and you can encourage your service user to think of the advantages (or pros) of continuing to use a substance versus the disadvantages (or cons) of usage. This can be an excellent starting point for a brief intervention or helping the person to think about addressing substance misuse issues. If, at assessment, the individual appeared determined and ready to make changes, then they may be referred to the appropriate service.

Brief Interventions

The assessment process provides an ideal opportunity for opportunistic brief interventions. For example, a person who is experiencing depression may be drinking well above the recommended limits of alcohol but be unaware of the potential harm on his physical and mental health. He may not have had the opportunity or inclination to discuss this with any health care professional previously. Similarly, a person with schizophrenia may smoke cannabis to help him relax but be unaware of the potential for cannabis to exacerbate psychotic symptoms. Even highlighting the issue in a non-judgemental and supportive manner may help that person to

begin to think about their drinking behaviour and begin to take steps to change. Simply raising a person's awareness with regard to the link between alcohol and mood (or cannabis and psychosis) may be enough to start that person thinking about changing their behaviour.

Assessment of Withdrawal

Withdrawal from substances can be very distressing for the user, and potentially life-threatening in the case of alcohol. It is therefore important to recognise if a person is withdrawing (either deliberately or inadvertently) from a substance to which they are physiologically addicted.

Alcohol Withdrawal

Acute alcohol withdrawal occurs if a dependent drinker suddenly stops drinking. Symptoms can begin as soon as two hours after the last drink and can persist (in mild form) for weeks. Symptoms can range from mild anxiety and shakiness to severe symptoms such as seizures and **delirium tremens** (so-called DTs), both of which are potentially life-threatening. The symptoms of DTs include confusion, tachycardia and a high fever, and occurs in 1–5 per cent of cases.

Assessment of Alcohol Withdrawal

Alcohol withdrawal can be assessed using the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) (Sullivan et al., 1989). This is a 10-point questionnaire, using a combination of objective and subjective observations about the person's withdrawal symptoms. The scale can be repeated frequently (hourly in the first 24 hours and then 4-hourly) and the person's score can then be titrated against the dose of medication given to facilitate withdrawal (usually diazepam or chlordiazepoxide).

Opiate Withdrawal

Opiate withdrawal occurs if a dependent opiate user stops using. Untreated, it can last for up to a week, peaking after 3–4 days. Although highly unpleasant, opiate withdrawal is not considered a life-threatening condition. Opiate overdose, however, is. Generally, the signs of opiate withdrawal include sweating, running eyes and nose, sneezing, yawning, restlessness, insomnia, gooseflesh, dilated pupils, flushing, shivering, muscle twitching, pains in muscles and joints, nausea and vomiting, abdominal cramps, diarrhoea, tachycardia, raised blood pressure (BP) and low-grade fever.

Assessment of Opiate Withdrawal

Opiate withdrawal can be assessed using the Clinical Opiate Withdrawal Scale (COWS) (Wesson and Ling, 2003). This is an 11-item scale, designed to be administered by a clinician. Its purpose is to rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time. Scores for the complete scale can be used to help clinicians determine the stage or severity of opiate withdrawal and assess the level of physical dependence on opioids. Symptoms of withdrawal can be treated with buprenorphine (Subutex) or methadone – doses can be titrated according to severity of withdrawal within the first 24 hours.

Reviewing Changes

Whilst a detailed and comprehensive assessment is important at the start of a person's treatment journey, it is vital that any changes are reviewed regularly with regard to both mental health and substance use. A regular review is also a further opportunity for brief intervention if a person is difficult to engage. This is summarised in Table 10.6.

Table 10.6 Reviewing changes

Personal circumstances	Changes in accommodation (homelessness) Benefits still being paid? Changes in family circumstances (estrangement)
Substance misuse	Is the person taking more of a particular drug to achieve the same effect (change in tolerance level)? Are they using a different route of administration (smoking, injecting)? Are they drinking more/less alcohol?
Mental health	Have they added or omitted a drug to their drug-taking routine? Have they developed symptoms (paranoia, low mood) or have things improved? Are they still taking prescribed medication?
Physical health	Any changes to risk of self-harm/harm to others? Development of physical health problems (blood-borne viruses, diabetes, altered liver function) Evidence of withdrawal syndrome? Interaction of drug with prescribed medication?

Chapter Summary

There are a number of commonly misused drugs that have a detrimental effect on mental health. Links have been made between psychosis, cannabis and novel psychoactive substances, as well as alcohol and depression. The rate of substance

misuse amongst people with mental health problems is higher than that seen in the general population – for example, 40–50 per cent of people with psychosis misuse substances at some point in their lifetime, which is approximately double the rate seen in the general population (NICE, 2011).

People with coexisting mental health and substance use problems will often experience a significant number of negative health and social outcomes, as well as a high level of unmet needs, and will benefit from a comprehensive, collaborative and sensitive assessment of their needs.

The assessment process provides an ideal opportunity for opportunistic brief interventions. A number of practical tools can aid the assessment and information gathering. In this chapter, we have explored substance misuse and the concept of dual diagnosis. We have given an overview of the common drugs of misuse and given some detail with regard to specific effects on a person's mental health. We have identified the key components of a comprehensive assessment of a person with concurrent mental health and substance misuse problems, highlighting the importance of communication, information gathering, ongoing review and the use of standardised assessment tools. We have also demonstrated how brief interventions can form part of the assessment.

EXERCISE

CASE STUDIES



ANGELA

Angela has been diagnosed with severe anxiety and has been prescribed diazepam (5 mg, three times a day) for two weeks to help alleviate her symptoms so that she may engage in a course of **cognitive behavioural therapy (CBT)**. After two days on diazepam, Angela is feeling a lot less anxious and really likes the slightly detached feeling she is experiencing. She receives a call from the GP, telling her that, unfortunately, she cannot start her CBT for another two weeks due to high demand in her area. The GP is happy for Angela to continue on the diazepam and encourages her to engage in an online programme to help with her anxiety. Angela does not really feel she benefits from the online programme but she is becoming increasingly reliant on the diazepam and gradually increases her dose (without consulting the GP). Angela finds that she is able to obtain a further supply of diazepam online (grey market) and is now taking four times her original prescribed dose.

Reflect on this case study and consider the following questions:

1. According to the Department of Health categories, which type of dual diagnosis does this represent?
2. What are the challenges when working with Angela?
3. Why is the practitioner's attitude important in the assessment process?

CHARLES

Charles was diagnosed with schizophrenia in his early twenties. Now 33, he has had a number of admissions to hospital and, until recently, has been feeling relatively well

and living independently for the last year. Charles hears voices, which are often relentless and persecutory in nature. He is prescribed olanzapine (10 mg daily), which he sometimes believes to be effective, although would rather not have to take medication at all and will quite often miss a dose. Charles smokes cannabis regularly (around four or five joints a day, generally from 3 p.m. in the afternoon and throughout the evening). Smoking cannabis normally makes him feel relaxed and helps him sleep and, although he still hears the voices, they do not bother him so much if he has had cannabis. Charles has recently split up from his girlfriend of 10 years, which was a major blow for him. Since then, he has been smoking more cannabis (up to seven joints a night) and also drinking alcohol (strong lager and some vodka). In the last week, Charles has reported some quite worrying intrusive thoughts relating to his neighbours – he has started to believe that they want him to leave and are recording his every move. His voices have become relentless again and his sleep is disturbed. He is still willing to meet with his community nurse, with whom he has a good relationship.

Reflect on this case study and consider the following questions:

1. What do you know about the link between cannabis and psychosis – can you find any current research relating to this area?
2. How might alcohol affect Charles's mental health?
3. How might you be able to help Charles – what steps might you take to try and raise his awareness with regard to the link between cannabis and psychosis and possible solutions?

CONSIDERATIONS FOR PRACTICE

1. What are the signs that a person may have been using drugs and/or alcohol?
2. What are the challenges you might encounter when working with service users who use new psychoactive substances?

Further Reading

Drugwise: www.drugwise.org.uk/ (accessed 25 June 2016).

Drugwise is an excellent resource, frequently updated with topical, evidence-based and non-judgemental information relating to drugs, alcohol and tobacco.

National Institute for Health and Care Excellence (NICE) (2011) Clinical Guideline 120 [CG120]: *Psychosis with Coexisting Substance Misuse: Assessment and Management in Adults and Young People*. Available at: guidance.nice.org.uk/cg120 (accessed 10 October 2015).

This is a comprehensive overview of the key issues relating to substance misuse and psychosis – it is definitely worth familiarising yourself with this guideline.

National Treatment Agency: www.nta.nhs.uk/ (accessed 23 June 2016).

Now part of Public Health England, the National Treatment Agency has lots of information on its website about drugs and the various treatment options available.

Talk to Frank: www.talktofrank.com (accessed 1 July 2016).

An excellent guide to substance use, including an A-Z of all substances and the different slang terms in use. It also includes photos of what the drug looks like and details on the physical and psychological effects.

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11

STRENGTHS AND MENTAL WELL-BEING

STEVE TRENOWETH



CHAPTER OVERVIEW

This chapter:

- Considers those factors that assist in protecting an individual from psychological harm and in promoting mental health following a crisis.
 - Discusses factors that are related to an individual's mental well-being, satisfaction and happiness, and help the person to **flourish** and give a sense of meaning and purpose to their lives.
 - Outlines the general approaches to the assessment of mental well-being and the classification of an individual's strengths, abilities and talents.
 - Considers specific issues of hope, self-efficacy, resilience and positive relationships.
-

Introduction

Psychosocial assessments should consider not only the difficulties and challenges that a person may be facing in their life, but also those factors that help them to cope with and manage their current troubles. It is important, therefore, to take account of and

understand both a person's positive and negative experiences (Westbrook, 1976). In this chapter, we discuss those factors that seem to *protect* individuals from psychological harm and promote their mental well-being and satisfaction with life.

In psychological terms, *strengths* are broadly those features of ourselves and/or our environment that are the capital which we can draw on to *protect* us in times of adversity. Like personal wealth, some people are richer in such capital than others.

As we saw in Chapter 4, the Stress Vulnerability model (Zubin and Spring, 1977) reminds us of the factors which impact on our ability to cope with challenging circumstances in our lives. In this model, exogenous stressors (such as bereavements, divorce, marriage, childbirth and so on) may precipitate a crisis, and may pose challenges for an individual's ability to cope and adapt to such stresses and subsequently readjust their lives. An individual's vulnerability to stress varies with the extent of the level of *inborn* (for example, the genetic and 'internal environment' of the individual) and *acquired factors* (for example, trauma, drug and alcohol use and so on). Such factors may *pre-dispose* us to mental distress. Factors which are seen to be helpful and protective to the individual (such as our coping abilities, helpful beliefs, positive relationships and social networks, personal strengths and talents) can reduce our vulnerability to psychological and psychiatric distress at times of adversity and promote resilience. Likewise, factors that are unhelpful (such as maladaptive coping mechanisms, social isolation and so on) can increase our vulnerability at times of stress and may lead to a crisis for a person's mental health and well-being. Amongst vulnerable people, a failure to cope and adapt to such stresses may place their mental health under strain and increase the likelihood of exacerbation of their condition or a relapse.

In this chapter, a number of tools and tests are described and the reader is encouraged to research further to identify other tests which may also be suitable for use in particular cases.

Strengths

What are strengths? For Park et al., our character strengths are 'positive traits reflected in thoughts, feelings, and behaviours' that are associated with mental well-being (2004: 603). Strengths are the personal and **social capital** that support our *resilience* and our ability to *cope* at times of uncertainty, *protecting* us from psychological harm, and thereby allowing us to 'flourish'. An individual who is 'flourishing', in this sense, may be seen as someone who is *thriving* in their world. The person may feel that they are in charge of their lives, with a sense of *autonomy*, and that they believe that they have the personal and social resources and abilities to be *resilient* and *cope* with life's troubles. There might be a sense of *personal accomplishment*, *environmental mastery* (that is, an ability to feel in control of our lives and situation) and *personal growth*. A person may feel that their *talents*, *knowledge* and *skills* are strengths in that they provide *opportunities* for them to meet their *aspirations* or pursue their personal *interests* (Reeve, 2009).

Mental Well-Being

Mental well-being is a complex and multidimensional concept. It is generally considered, however, that our mental well-being is subjective and comprises happiness,

hope and optimism and life satisfaction, positive psychological functioning, resilience to adversity, autonomy and a sense of control over one's life, self-awareness and acceptance, and supportive and interpersonal relationships. Mental well-being facilitates our personal growth and supports a personally satisfying life, which is purposeful and meaningful, and capable of reaching its full potential (Ryff and Keyes, 1995; Stewart-Brown and Janmohamed, 2008; Jenkins et al., 2008).

For the World Health Organization (WHO), health is 'not merely the absence of disease or infirmity' (1946). It further defines mental health as:

a state of well-being in which the individual realises 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. (*Ibid.*)

However, there often exists confusion over what the term 'mental health' actually means (Stewart-Brown and Janmohamed, 2008). Many people now prefer the term 'mental well-being', defined by the mental health strategy for England *No Health without Mental Health* by the Department of Health as:

A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment. (2011: 90)

These definitions recognise the personal and subjective nature of one's experience of mental health and well-being. A person with a positive sense of mental well-being may be satisfied with their life overall and also feel physically healthy. It also reflects feelings of security and our ability to function, cope within, and make a contribution to society, recognising the social nature of our functioning as human beings.

An individual's personal sense of mental well-being is therefore likely to be associated with their construing of positive satisfying, interpersonal relationships in their lives (Viney, 1981, 1983). Furthermore, a person who feels that they have a positive sense of mental well-being may also have a sense of self-reliance, with feelings of personal competence, self-efficacy and agency, and may perceive themselves as having self-determined intentions, plans and goals, which they feel are within their grasp (Viney, 1986). They may express a positive sense of striving or trying to achieve these goals, and an ability to overcome or influence others or the environment (Westbrook and Viney, 1980; Viney, 1981).

People who have a positive sense of mental well-being often describe a sense of purpose and meaning in their lives. There is an acceptance of their life, along with its highs and lows of life's events. People may describe a sense of resilience, in that they may have relevant skills, abilities and resources to cope with and bounce back after adversity.

Conversely, people may perceive themselves as lacking self-determination, in that they express feelings of helplessness, with a lack of personal agency and feelings of being a victim of circumstance. They may describe a sense of being controlled, forced, prevented by, or at the mercy of, things which are outside of their influence (Westbrook and Viney, 1980; Viney, 1981) or that they have little hope of being able to reach their goals.

For Carol Ryff (1989; Ryff and Keyes, 1995), psychological mental well-being is a multifaceted concept embracing:

- Self-acceptance (a positive attitude towards one's personal history and current self, acknowledging and accepting one's abilities and limitations).
- The establishment of positive, warm, close, supportive and trusting interpersonal relationships (including an ability to compromise; have empathy and compassion for others; and have an understanding of the ebb and flow of human relationships).
- A sense of self-determination and autonomy (including an ability to be assertive and judge one's self by personal standards).
- The ability to master complex environments (including a sense of personal competence in managing one's personal world).
- Having a purpose in life (including a sense of personal meaningful goals and reasons for living).
- Ongoing development as a person (including being open to new experiences and self-improvement).

The components of mental well-being are summarised in Figure 11.1 and discussed below.

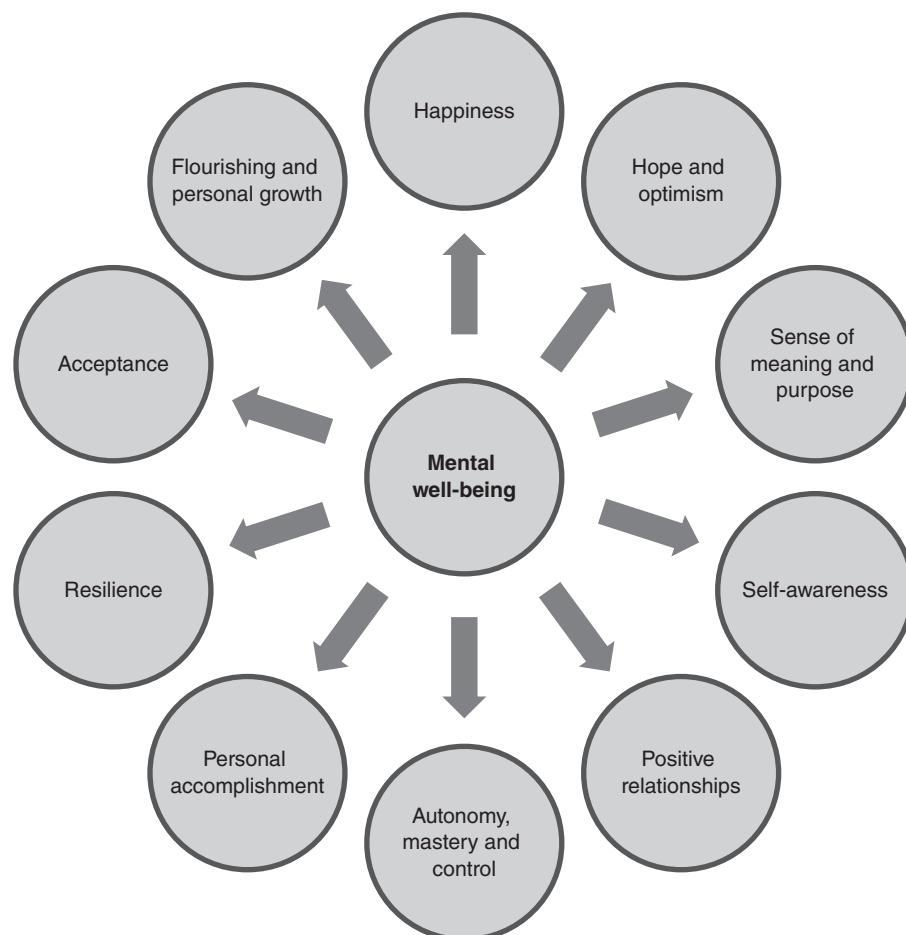


Figure 11.1 Components of mental well-being

Assessing Protective Factors

In this section, we will discuss some of those factors that help to protect the individual.

Strength-Focused Conversations

While there are some approaches that can be used to structure discussions and assessments of an individual's perceived strengths and mental well-being, it is vital for a person to be offered the opportunity just to talk about the good things in their lives. Of course, at times of particular distress, a person may feel that their life was once more positive than it is now but such experiences are now elusive. This makes the need for such discussions and assessments to be undertaken sympathetically and sensitively.

A general conversation can help the person to express what they consider to be their personal and social capital whilst imposing a minimum amount of structure by an interviewer. This may also help the person to consider the balance between positive and negative aspects of their lives and to re-evaluate their experiences and to consider that there are a number of personal and social resources that may be available to them, but which they may have not considered.

Peter Watkins (2001) identifies a person-centred approach to 'assessment' and highlights a number of positively toned questions to help structure a general conversation about strengths and well-being (Table 11.1).

Assessing Strengths

Attempting to identify an individual's strengths and abilities is a challenge as people often find it is easier (and quicker) to describe their perceived weaknesses (Snyder et al., 2011). This is also a challenge perhaps for mental health practitioners who are most used to assessing psychological deficits (Peterson and Seligman, 2004).

There have been a number of approaches that have attempted to assist people to identify their strengths, abilities and talents, such as personal diaries and reflective journals in which the person is encouraged to give a positive and negative appraisal of their responses to situations and events for later discussion with an interviewer. There are also a number of rating scales that have been developed. For example, the Clifton Strengths Finder (Buckingham and Clifton, 2001; available at: www.strengthsfinder.com for purchase) is a self-report questionnaire that identifies 34 strength themes such as *communication* (the ability to put one's thoughts into action), *restorative* (being able to resolve challenges) and *analytical* (understanding reasons and causes).

Other self-report questionnaires include the only free, online and psychometrically valid measure of strengths in the world, referred to colloquially as the VIA Survey (VIA Inventory of Strengths, or for young people, the VIA Youth Survey).

Table 11.1 A strengths-orientated conversation

What in your life do you find inspiring?	What sort of help do you think you need?	Could you say a little about the good things in your life, the things that are OK?
<ul style="list-style-type: none"> • What are some of the things in your life that give it meaning? • What sorts of experiences have brought a sense of joy or peace to your life? • Where do you go/what do you do when you want to find a sense of peacefulness? 	<ul style="list-style-type: none"> • When you've felt like this before, what has helped you most? • Is there anything you can do to help yourself to get through this? • Who do you turn to if you need help? • How do you think I/we can help? • What would help you the most at the moment? • What makes it easier for you to cope? • Is there one thing that would possibly be helpful now that we can work on? 	<ul style="list-style-type: none"> • What are the things in your life that you get satisfaction from? • What are some of the things that you enjoy/are interested in? • What are you good at? What would the person who knows you best say that you are good at? What would they say are your good points? • What are some of the things that you've done that you are proud of? • Who are the people who are important in your life? • Have there been times when other people have had to rely on you/when you've helped others out? • Tell me about a time in your life when you felt happy. • What's the best job you've ever had? What sort of work would you like to do? • How do you look after yourself/stay well? • How do you relax? • What's kept you going through all the difficult times? What helps? What do other people do that helps? • What are some of your hopes for the future? • If I met you a few years back, what would I have noticed about you that would be different from now?

Source: Adapted from Watkins (2001)

The VIA Survey comprises 120 questions, takes approximately 15 minutes and generates a personalised rank order of character strengths from 1 to 24, along with definitions. It has been translated into 34 languages and has been taken by over 4 million people. It is found at the VIA Institute on Character's website at: www.viacharacter.org. These surveys seek to reveal an individual's personal strengths (see Table 11.2). This helps people to understand their characters better and, subsequently, to take advantage of their positive personal qualities in enhancing their everyday life (Snyder et al., 2011).

Of the strengths identified in Table 11.2, it seems that hope, zest for life, gratitude, love and curiosity are the ones which are most substantially related to satisfaction with one's life (Park et al., 2004).

Table 11.2 The VIA Classification of Character Strengths

Appreciation of beauty and excellence (awe, wonder, elevation)	Noticing and appreciating beauty, excellence, and/or skilled performance in all domains of life, from nature to art to mathematics to science to everyday experience
Bravery (valour)	Not shrinking from threat, challenge, difficulty, or pain; speaking up for what is right even if there is opposition; acting on convictions even if unpopular; includes physical bravery but is not limited to it
Citizenship (social responsibility, loyalty, teamwork)	Working well as a member of a group or team; being loyal to the group; doing one's share
Creativity (originality, ingenuity)	Thinking of novel and productive ways to do things; includes artistic achievement but is not limited to it
Curiosity (interest, novelty-seeking, openness to experience)	Taking an interest in all of ongoing experience; finding all subjects and topics fascinating; exploring and discovering
Fairness	Treating all people the same according to notions of fairness and justice; not letting personal feelings bias decisions about others; giving everyone a fair chance
Forgiveness and mercy	Forgiving those who have done wrong; giving people a second chance; not being vengeful
Gratitude	Being aware of and thankful for the good things that happen; taking time to express thanks
Hope (optimism, future-mindedness, future orientation)	Expecting the best in the future and working to achieve it; believing that a good future is something that can be brought about
Humour (playfulness)	Liking to laugh and tease; bringing smiles to other people; seeing the light side; making (not necessarily telling) jokes
Integrity (authenticity, honesty)	Speaking the truth but more broadly presenting oneself in a genuine way; being without pretense; taking responsibility for one's feelings and actions
Judgement (open-mindedness, critical thinking)	Thinking things through and examining them from all sides; not jumping to conclusions; being able to change one's mind in light of evidence; weighing all evidence fairly
Kindness (generosity, nurturance, care, compassion, altruistic love, 'niceness')	Doing favours and good deeds for others; helping them; taking care of them
Leadership	Encouraging a group of which one is a member to get things done and at the same time maintaining good relations within the group; organising group activities and seeing that they happen
Love	Valuing close relations with others, in particular those in which sharing and caring are reciprocated; being close to people

Love of learning	Mastering new skills, topics, and bodies of knowledge, whether on one's own or formally; obviously related to the strength of curiosity but goes beyond it to describe the tendency to add <i>systematically</i> to what one knows
Modesty and humility	Letting one's accomplishments speak for themselves; <i>not</i> seeking the spotlight; <i>not</i> regarding oneself as more special than one is
Persistence (perseverance, industriousness)	Finishing what one starts; persisting in a course of action in spite of obstacles; 'getting it out the door'; taking pleasure in completing tasks
Prudence	Being careful about one's choices; not taking undue risks; not saying or doing things that might later be regretted
Self-regulation (self-control)	Regulating what one feels and does; being disciplined; controlling one's appetites and emotions
Social intelligence (emotional intelligence, personal intelligence)	Being aware of the motives and feelings of other people and oneself; knowing what to do to fit into different social situations; knowing what makes other people tick
Spirituality (religiousness, faith, purpose)	Having coherent beliefs about the higher purpose and meaning of the universe; knowing where one fits within the larger scheme; having beliefs about the meaning of life that shape conduct and provide comfort
Zest (vitality, enthusiasm, vigour, energy)	Approaching life with excitement and energy; not doing things halfway or halfheartedly; living life as an adventure; feeling alive and activated

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Assessing Mental Well-Being

The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) (available after registration at: <http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/>) is a recently developed rating scale for use amongst adults over the age of 16 years, which aims to measure mental well-being. It is a 14-item self-report scale, capturing perceptions of subjective mental well-being and positive mental health during the previous fortnight. Responses are scored on a 1–5 Likert scale (where 1 is 'none of the time', to 5 'all of the time'). Scores are summed up and the range is 14 to a maximum of 70. Higher scores are associated with greater subjective feelings of mental well-being.

Assessing Happiness

Positive mental well-being is often associated with happy, enjoyable experiences (Viney and Henry 2002). However, *happiness* is an elusive, complex and

metaphysical concept. What exactly is happiness? Are there qualities of happiness that do not vary between individuals and cultures? How do we, as human beings, ‘become’ happy? Can we ever be truly happy all the time? These questions have clear implications for any strength-focused assessment – if we are unable to be clear and to define our terms, it will not be possible to capture the phenomenon as a human experience. What is clear, however, is that happiness is a personal and subjective experience.

There is a debate between people who see happiness as a function of one’s personality (that is, relatively stable personal ‘set points’ and predispositions for happiness), or that one’s happiness is less stable, reflective of positive/negative experiences within which one finds oneself. It seems, therefore, that any assessment of happiness must consider both personality and situational variables (Snyder et al., 2011).

For Seligman (2002), true happiness is an enduring experience. This is to be compared with the pursuit of hedonistic experiences, characterised by transient, momentary and fleeting pleasures:

Momentary happiness can easily be increased by any number of uplifts, such as chocolate, a comedy film, a back rub, flowers or a new blouse. (Seligman, 2002: 45)

The type of happiness that Seligman (*ibid.*: 45) has in mind is one that is ‘authentic’ and complex, as suggested by his formula:

$$H = S + C + V$$

Where:

- H is enduring happiness.
- S is our biological, genetic *set point*, although to determine our range of potential happiness.
- C are the circumstances in which we find ourselves that can influence our happiness.
- V are those voluntary factors that we can control.

That is, lasting happiness (H) is related to our life conditions (C) and our perceived ability to influence our environment and the choices we make (V) but, crucially, that there is a happiness point (S) to which we eventually return after good or bad news (our ‘set point’).

The four-item Subjective Happiness Scale (Lyubomirsky and Lepper, 1999) is scored on a 7-point Likert scale, and helps us to understand an individual’s overall, global level of happiness or, to put this another way, whether a person is generally happy or not. The person is also invited to compare their level of perceived happiness with others and whether or not they feel that they enjoy life, regardless of what is going on around them. The average score is taken with a possible range of 1.0 to 7.0. Using this scale, it has been found that the average score for adult American participants is 4.8 with a range of 3.8 to 5.8 (Seligman, 2002). In America, at least, people perceive themselves to be generally happy!

Seligman (*ibid.*) reviewed research over 35 years and identified external circumstances that can affect our level of subjective happiness. People who live in a relatively wealthy democracy (as opposed to an impoverished dictatorship) tend to be happier; as do people who are married; those have avoided negative experiences or negative emotions; and those who belong to a religion. Money, health, level of education and race do not appear to have any effect in our subjective happiness. It appears that our subjective attitude towards such circumstances (for example, if we feel personally impoverished or are dissatisfied with our level of health or ability or the things we feel we *should* have) rather than objective criteria (such as how much money we have in the bank, fitness level and so on) which matters most (*ibid.*).

Finally, Seligman (*ibid.*) considers the influence of those factors that are under our voluntary control (the V variable in his happiness equation) which can influence happiness. Here, Seligman identifies variables relating to our satisfaction with the past (see the section below on ‘Assessing Satisfaction with Life’), present and future (see the section on ‘Hope’). With regards to satisfaction with the present, Seligman distinguishes between *pleasures* (“delights that have clear sensory or strong emotional components ... ecstasy, thrills, orgasm, delight, mirth, exuberance, and comfort”, *ibid.*: 102) and *gratifications* (personally satisfying activities which engage and absorb us, when we are in touch with our strengths). For Csikszentmihalyi (1975), happiness ‘flows’ from a positive psychological state, where our personal skills are optimally and appropriately challenged and tested by tasks in our daily lives. We become so involved and immersed in a task, which tests us, that we lose all sense of time. This allows us to learn, develop and grow as individuals and to develop a personal sense of satisfaction in accomplishment.

Assessing Satisfaction with Life

The Satisfaction with Life Scale (SWLS) (Diener et al., 1985) is a five-item self-report scale, which respondents rate on a 7-point scale:

- 1 = Strongly Disagree
- 2 = Disagree
- 3 = Slightly Disagree
- 4 = Neither Agree nor Disagree
- 5 = Slightly Agree
- 6 = Agree
- 7 = Strongly Agree

The items are described in Table 11.3.

Table 11.3 The Satisfaction with Life Scale (SWLS)

Items	Scoring
1. In most ways my life is close to my ideal.	30–35 Very High Score; Highly Satisfied
2. The conditions of my life are excellent.	25–29 High Score
3. I am satisfied with life.	20–24 Average Score
4. So far, I have gotten the important things I want in life.	15–19 Slightly Below Average in Life Satisfaction
5. If I could live my life over, I would change almost nothing.	10–14 Dissatisfied 5–9 Extremely Dissatisfied

Reproduced with permission: © Ed Diener et al. (1985)

Acknowledgement: © Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin as noted in the 1985 article in the *Journal of Personality Assessment*

The scores range is 5–35, with higher scores revealing greater levels of reported satisfaction with life. For those who score the highest range (in the 30–35 range), life is perceived as enjoyable and domains of life (such as work, family and personal development) are going well. Those with high scores may feel that their life is mostly good and may be motivated to improve less successful areas of their lives. For people whose scores are average (that is, average within economically developed countries), where most of the population live, life is generally good and there is an air of satisfaction, but there is also room for improvement. For those who feel less satisfied with their lives (in the 15–19 range), there are some small but, nonetheless, significant areas of life which are a source of dissatisfaction. This may be due to some recent, temporary changes in their lives that bring temporary dissatisfaction, which may improve. For people who express dissatisfaction or extreme dissatisfaction with their lives, life has become challenging. There may be significant problems at home or at work, or there may be significant life events such as bereavements, divorce or redundancy. Persistently low life satisfaction may indicate a chronic condition, where the person may need support to make positive changes to their lives. It might be, for example, that the individual finds it difficult to let go of an unhappy past or are unable to forgive perceived past wrongs (Seligman, 2002).

For Diener et al., a person's general satisfaction with life reflects an individual's personal evaluation of those aspects of their own life that are seen as important and 'not upon some criterion which is judged to be important by the researcher' (1985: 71). To this end, the SWLS should be seen as a general starting point for further discussions on sources of satisfaction and dissatisfaction in their life.

Assessing Hope

Hope is an important concept in modern approaches to mental health care (Kylmä et al., 2006; Cutcliffe and Koehn, 2007; Shepherd et al., 2008), and is considered the 'catalyst that facilitates behavioural change with the client'

(Hellman et al., 2013: 727). Furthermore, hope may also enhance our sense of self-compassion, skills in personal relationships and life satisfaction (Umphrey and Sherblom, 2014).

For Snyder et al., hope is: ‘goal-directed thinking in which the person utilises pathways thinking (the perceived capacity to find routes to desired goals) and agency thinking (the requisite motivations to use those routes)’ (2011: 185). So, a person who is hopeful has knowledge of their own personally valued goals, which they are motivated to strive for, and a sense of their own ability to positively and persistently work towards those goals. It also follows that hopeful people are likely to have a sense that, if one particular route to their goal is blocked or unfruitful, then they will be able to find others pathways. Furthermore, they are likely to have a zest and an optimism that their efforts to goal attainment will be worthwhile.

The Adult Hope Scale (Snyder et al., 1991) is a self-report 12-item test using an 8-point Likert scale, from ‘Definitely False’ to ‘Definitely True’, which seeks to capture an individual’s sense of hope. There are two subscales: *agency* (such as the perceived ability to pursue and achieve our personal goals); and *pathways* (such as the ability to problem-solve and pursue the things that we feel are important in our lives).

The scale has been extensively studied and used widely in research and clinical practice (Snyder et al., 1991), and is generally considered to have ‘value as a measurement tool toward our understanding of optimum human functioning’ (Hellman et al., 2013: 728).

Assessing Self-Efficacy

Self-efficacy may be seen as:

beliefs in one’s capabilities to mobilise the motivation, cognitive resources, and courses of action needed to meet given situational demands. (Wood and Bandura, 1989: 408)

In essence, then, self-efficacy may be seen as the person’s perception of their own capacity and capability to succeed in particular tasks, or ‘specific self-efficacy’ (SSE).

There have been concerns, however, that SSE may be ephemeral and unstable, being influenced by an individual’s motivation. More recently, self-efficacy has been seen as a broader concept, encompassing the person’s belief in their abilities across a wide range of situations and contexts (Chen et al., 2001). This ‘general self-efficacy’ (GSE) may develop from past successes and failures across our lifespan, and it is suggested that this, in turn, influences the perceptions of our abilities in specific situations.

The New General Self-Efficacy Scale (NGSE) (*ibid.*) is an 8-item, self-report measure that seeks to capture GSE, that is, how people view their capabilities of meeting the demands from tasks across a range of situations (see Table 11.4).

Table 11.4 Items on the New General Self-Efficacy Scale (NGSE)

-
1. I will be able to achieve most of the goals that I have set for myself.
 2. When facing difficult tasks, I am certain that I will accomplish them.
 3. In general, I think that I can obtain outcomes that are important to me.
 4. I believe I can succeed at almost any endeavour to which I set my mind.
 5. I will be able to successfully overcome many challenges.
 6. I am confident that I can perform effectively on many different tasks.
 7. Compared to other people, I can do most tasks very well.
 8. Even when things are tough, I can perform quite well.
-

Source: Chen et al. (2001: 79)

The NGSE is rated on a 5-point scale from ‘Strongly Disagree’ (which scores 1) to ‘Strongly Agree’ (which scores 5).

Assessing Resilience

Resilience is the ‘ability to bounce back or positively adapt in the face of significant adversity or risk’ (Snyder et al., 2011: 114). Of course, the issue here is to consider to what people are actually ‘bouncing back’? There is a danger of specifying what may be considered within the normal range of human functioning and we should take into account that any measure of resilience considers the individual and cultural context of individuals (*ibid.*).

For Friedli (2009), there are three broad dimensions that support resilience and confer protection at times of adversity:

- *Environmental resources:* Features of the natural and built environment that support communal capacity for resilience (not discussed in this book).
- *Social resources:* Social networks and family life that enhance resilience amongst people and communities (see below).
- *Personal emotional and cognitive resources:* That support and contribute to developing resilience amongst individuals, such as good mental health – factors which undermine personal resilience include mental distress, low levels of mental well-being and neglect of self and others and a range of unhelpful coping mechanisms and self-harming behaviours, including self-sedation and, e.g., self-medication through alcohol and drugs, high fat and sugar consumption.

Tools which seek to understand an individual’s perception of their own resilience include the Brief Resilience Scale (Smith et al., 2008) and the Connor-Davidson Resilience Scale (CD-RISC) (Connor and Davidson, 2003). These scales ask the individual to consider their ability to bounce back and recover after hard times and stressful events. The CD-RISC scale contains 25 items. There is a 5-point range of responses, based on how the respondent felt over the past month (where: 0 = Not True at All; 1 = Rarely True; 2 = Sometimes True; 3 = Often True; and 4 = True Nearly

All of the Time). The range of total scores is 0–100, and higher scores reflect greater reported resilience (the scale is available at: www.connordavidson-resilience-scale.com/index.php).

Assessing Positive Relationships

For many people, positive interpersonal relationships are assets that *protect* them from psychological harm and distress, *promote* their mental well-being and satisfaction with life and *support* resilience at times of adversity (Friedli, 2009). Furthermore, interpersonal support may protect people from significant consequences of major physical illness (Sherbourne and Stewart, 1991; Moser et al., 2012).

Our social well-being often stems from positive interpersonal relationships and social support. Danzinger (1976) identified a classification of positive relationships based on:

- *Solidarity*: A sense of belonging and interpersonal integration, social acceptance within a community and a common commitment between people and sharing resources.
- *Intimacy*: People relating to one another as sources of personal satisfaction, including kindness, altruism, love, empathy and attachment.
- *Influence*: Recognising the relevance of social status and standing within a community or group.

The Medical Outcomes Social Support Survey (MOS-SS) (Sherbourne and Stewart, 1991) is a brief 19-item test that seeks to capture the quantity and quality of companionship and affection, assistance and other types of social support. An online version can be found at: www.rand.org/health/surveys_tools/mos/social-support/survey-instrument.html and guidance on scoring the test can be found at: www.rand.org/health/surveys_tools/mos/social-support/scoring.html.

Problems with Assessing Strengths and Mental Well-being

There are, of course, many issues to consider when assessing strengths and well-being. Sometimes, it can be easier for us all to recall the qualities, skills, abilities and talents that we don't have than those that we do! This, of course, can be even more trying for people who are currently experiencing mental distress (of course, an individual who is experiencing an elated mood may also lack accuracy). Additionally, there may be gender and cultural influences that discourage discussions of such matters. At such times, discussion with friends and families may be fruitful, and indirect questioning may be helpful.

Such discussions can lead to important self-discovery that may lead to reflection and a positive appraisal of our skills and talents. The **Johari window** suggests that there are some elements of our self: to which we are blind (i.e. not known

to us, but known to others); that are hidden (i.e. known to us, but not known to others); and that are unknown (i.e. not known to us or others). The process of mental health assessment can, therefore, be potentially revelatory as the individual may become aware of those aspects of self which have been previously blind or unknown to them. Another important element of an assessment of strengths is the potential problem of capturing variables that are subjective. Self-report can be biased and is subject to errors, such as imperfect recall of previous and state-dependent memory, the tendency to recall events and experiences better when the person is in the same state as when the memories were formed. That is, happy events are best recalled when we are happy, and sad events are easier to bring to mind when we are sad.

It is generally considered that aspects of our personality are relatively stable and enduring over our adult lives, in that we return to a ‘set point’ following positive and negative experiences. Of course, this does not mean that we cannot develop new strengths and talents or hone existing ones by acquiring new skills and knowledge. However, our strengths may be compromised at different points in our lives by our life experiences and the situations, conditions and contexts in which we find ourselves, and, at such times, our personal resilience and our ability to cope with life’s problems may be compromised. There may also be a motivational component to our strengths that may be influenced by our goals in any given situation (Snyder et al., 2011).

Chapter Summary

In this chapter, we have explored factors that assist in protecting an individual from psychological harm and in promoting mental health following a crisis. We also discussed factors that relate to an individual’s mental well-being, satisfaction and happiness and help the person to flourish and give a sense of meaning and purpose to their lives. We discussed the general approaches to the assessment of mental well-being and the classification of an individual’s strengths, abilities and talents before considering specific issues of hope, self-efficacy, resilience and positive relationships.

EXERCISE



1. Do you consider yourself to be mentally healthy at the moment? What criteria are you using to judge this? What might need to happen to change how you are currently feeling about your mental health?
2. What gives your life meaning?
3. Reflect on and list those factors in your life that promote your resilience. How do you cope with difficult issues in your life? What protects you from psychological harm?

CONSIDERATIONS FOR PRACTICE

1. How could you help a person who is low in mood and/or has lost all confidence in themselves to consider their skills talents and abilities?
2. How could you encourage and support an individual to develop a latent talent, should they, of course, wish to?
3. How do we help people to develop a sense of citizenship to support their connection with community life?

Further Reading

Lopez, S., Pedrotti, J. and Snyder, C. (2014) *Positive Psychology: The Scientific and Practical Explorations of Human Strengths*, 3rd edn. Los Angeles, CA: Sage.

An excellent, comprehensive and crucially applied text that is clear and easy to read. It focuses on positive psychology but is suitable for all practitioners working in mental health, and who want to develop their skills and knowledge about working positively with service users. There are clear synergies here with the recovery approach.

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PART 3

ANALYSING AND INTEGRATING ASSESSMENT INFORMATION



12

CASE CONCEPTUALISATION

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CHAPTER OVERVIEW

This chapter:

- Provides an overview of the value of developing a case conceptualisation.
 - Highlights how the process of developing a case conceptualisation enables the use of a recovery approach and builds on the service user's narrative.
 - Identifies the central features of a case conceptualisation and presents a model for developing a shared understanding with a service user using a template based on central themes explored in previous chapters.
 - Highlights key considerations when developing the case conceptualisation with a service user.
 - Demonstrates how the case conceptualisation is used to underpin the development of strengths and needs statements and to define goals with the service user.
-

Introduction

The terms of **case formulation** and ‘case conceptualisation’ are interlinked and are often used interchangeably. However, it is important to recognise a distinction between these concepts. Whereas case formulations tend to underpin specific interventions and therapies, case conceptualisations focus attention on the person’s recovery journey in light of their personal narrative alongside findings from the assessments undertaken. Using a case conceptualisation enables both the service user and the practitioner to begin to make sense of the wider picture and begin the process of identifying needs and building on the person’s strengths.

Broadly speaking, therefore, the case conceptualisation should:

- Help to normalise a service user’s experiences.
- Offer a clear picture of the factors that may have impacted on overall health and functioning.
- Help to arrange large amounts of complex information gathered during the assessment phase.
- Use the stress vulnerability explanation to understand presenting problem/s.
- Develop a shared understanding between service user and practitioner.
- Lay the foundations for identifying strengths and needs and formulating goals.

Case conceptualisation, identifying strengths and formulating needs (Chapter 13) and goal statements (Chapter 14) are all interlinked, as represented in Figure 12.1.

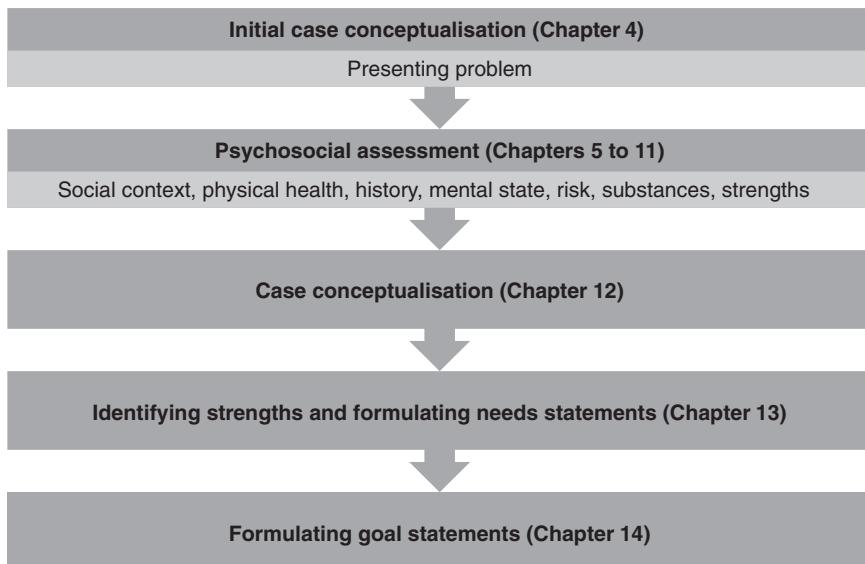


Figure 12.1 Key stages of the psychosocial approach

Key Skills in Case Conceptualisation

Developing a meaningful case conceptualisation is a skilled process, requiring considerable technical knowledge and skill in assisting the service user to begin to make sense of their experiences and work towards ongoing recovery. As discussed in previous chapters, there are therapeutic skills that are needed to ensure a person-centred approach in order to facilitate and guide the discussion. Therefore, core skills of agenda setting, communication, active listening, using reflective statements, questioning and affirmation are key to the process. The mental health practitioner needs to be mindful of attention to detail, and be able to analyse and synthesise information that has been gathered throughout the assessment process. Skills of negotiation and collaboration with the service user will ensure that the case conceptualisation develops to underpin the development of strengths and needs statements and the formulation of goals.

Preparing for the Case Conceptualisation

As with any session with a service user, consideration needs to be given to the venue within which it will take place, that is, as discussed in Chapter 2. In line with a systematic approach to the assessment process, time and consideration needs to be given to ensure adequate preparation on the part of the mental health practitioner. Using a ‘funnelling approach’ (see Chapter 2), the practitioner will have begun to draw together information that has significance to the presenting problem/s and factors that influence/impact on health and functioning. To give value to the wealth of information that has been shared during the assessment process as a whole, it is useful to sketch initial thoughts before the meeting with the service user. This ensures that all areas covered during the assessment process are given adequate consideration and ensures that there are no oversights during the initial case conceptualisation.

Introducing the Case Conceptualisation

When thinking about developing the case conceptualisation with the service user, attention needs to be given to helping the service user understand and begin to link together component parts of their experiences. It is important to revisit previous sessions and collate information gathered in a comprehensive manner.

We advise starting with a normalising rationale. Here, the practitioner uses therapeutic skills to show empathy and understanding and demonstrate sensitivity. They will help the service user to reflect on experiences and recognise that their reactions are completely understandable, and they will be mindful not to minimise the service user’s experiences and the distress that they have experienced. Throughout the case conceptualisation, the practitioner will use the information gathered during the assessment process to highlight to the service user that everyone has different aptitudes to remain well in the face of personal and environmental stressors, as suggested by the Stress Vulnerability model (Zubin and Spring, 1977). The practitioner should acknowledge the value of the service user’s cooperation with the assessment process.

It is critical to use language that conveys sensitivity towards past and present experiences and to ensure that the statements made are clear and in a language that makes sense to both the service user and yourself. For example:

Over the last few weeks, we have begun to share information and to get a clearer picture of what has been happening for you ... It has been really useful to have taken the time to understand your ideas and how you feel about what has been going on for you lately ... I know that it has not always been easy to think about things that have been distressing for you, but the thing that has struck me is that you have much strength and this has enabled you to cope with situations that most people would find difficult ... I have begun to try to draw together what I believe to be key factors that are important to you ... By using this template, we can begin to make more sense of what has been happening ... The idea behind this is that, by looking at a visual representation of all we have discussed and explored recently, it becomes easier to understand the connections between the component parts... and, importantly, how best to proceed ... I am hoping today that we can begin to get a sense of how best to proceed, alongside how best to build on your strengths ...

Case Conceptualisation Format

As can be seen in Figure 12.2, the use of a structured approach to a case conceptualisation can help draw together key information and help the service user begin a process of making sense of their experiences. Using the session to begin to bullet-point key information can prove a valuable exercise in making connections between

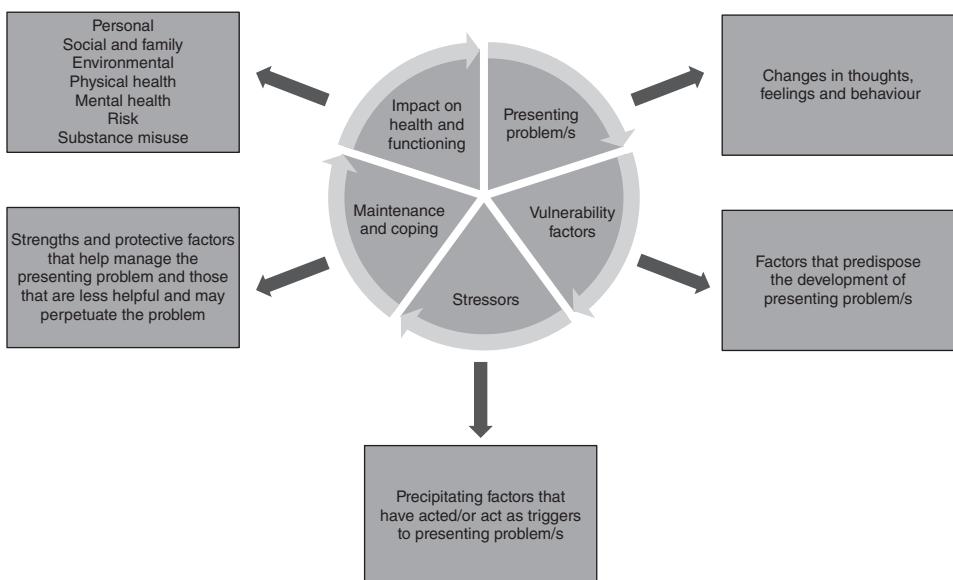


Figure 12.2 The format of a case conceptualisation

factors that have contributed to the presenting problem/s and potential areas of needs alongside strengths and protective factors. A template (adapted from the work of Birchwood et al., 1992; and Kingdon and Turkington, 2005) for your use in practice is at the end of this chapter (see Appendix 12.1).

Throughout this chapter (and the following Chapters 13 and 14), we will be looking at a case scenario involving Emily. This is a fictional person, who is a composite of many service users we have worked with which will help to illustrate and apply the key skills and techniques. An overview of Emily's case is presented in Case Scenario 12.1.

CASE SCENARIO 12.1 EMILY

Emily was a premature baby and required specialist treatment for the first month of her life. She developed a speech problem as she matured, and mentioned when completing the timeline that she did not speak until much later than her peers. She received speech and language therapy, which helped, but she can remember feeling different from her friends as she had to be taken out of class at school to receive this treatment. She remembers being bullied from pre-school age. Her father's friend sexually abused Emily as a child. Emily also attended a special school at primary school age due to her speech problems and she remembers feeling depressed from a very young age. Emily moved out of the family home after school at the age of 16 to gain more independence, however she ended up living in a hostel. This environment led her to experiment with drugs, mainly cannabis. Emily talks about the fact that she had numerous relationships with different men within the hostel environment and that these relationships were never stable or supportive. She mentioned that she never talked about her past issues or her low mood to others. She moved accommodation regularly from hostels to temporary flats. She eventually started a college course and was studying maths, English and childcare and was working part-time at a nursery, but she struggled to maintain this due to the multiple demands and eventually stopped the course and lost her job. This was around the time that she had her first episode of psychosis and ended up in hospital under section. She does not remember a lot about the circumstances leading to her admission, but she does remember not being in touch with reality and believing that her family and friends were aliens whom she couldn't trust. Emily currently lives within a supported housing project with other people who have mental health problems. She receives a monthly antipsychotic medication in the form of a **depot**, which she receives through her GP practice. Her **long-term goal** is to work with children within a nursery setting, which she did before her first episode of psychosis. Emily likes shopping, especially for handbags, and has one close friend (Sue) whom she used to go into town with but recently she has not felt able to meet up with her.

Developing the Case Conceptualisation

Presenting Problem(s)

As discussed in Chapter 4, there are various factors that can impact on a person's overall functioning and health. The presenting problem/s can include psychiatric

symptoms (changes in thinking, feeling and behaving), emotions, bodily sensations, problem behaviours. During the initial assessments, you will have begun to draw together a clear picture of the presenting problem/s and will have begun the process of helping the service user have a clear understanding of why and how the current presentation is as it is. A comprehensive picture begins to develop as consideration is given to: vulnerability factors, stressors, helpful and unhelpful coping, strengths, maintenance factors and overall functioning.

It is important that you have the correct understanding of the presenting problem. When you share the case conceptualisation, you will revisit and clarify discussions had with the service user. It is important to sketch out your initial ideas beforehand, but remember that this is collaborative in nature and it is vital that you obtain feedback from the service user. This helps to ensure your shared understandings and that any inaccuracies or misunderstandings can be corrected. For example:

- It can be difficult to think about how distressing things are/have been. Although, by trying to understand this, we can begin to think about developing a plan to build on your strengths.
- How do you feel about what I have said, Emily?
- Do you think what I have said accurately captures the situation for you?
- Is there anything that we have not included?
- As we move on to the other areas, we will begin to make connections between factors that play a role in how you have been.
- When I read this, I am struck by how distressing things have been for you and that, despite this, you have ...

Following the assessment process and the service user narrative, there will usually be a clear sense of the presenting problem. In summarising the presenting problem, it is important to use language that is simple and clear and uses the service user's own words. Therefore, rather than a list of symptoms, statements like 'feeling very low in mood' are preferential to 'depressed'. Using Emily's case as an example, the completed template box for her presenting problem(s) may look like Table 12.1.

Table 12.1 Emily's presenting problem

Presenting problem/s (changes in thoughts, feelings and behaviour)
Feeling unable to do things, having no energy and struggling to get things done
Feeling very low in mood
Spending long periods on my own and feeling very lonely, not going out much
I have ideas that I am being watched, I feel suspicious
Struggling to look after myself

Vulnerability (Predisposing Factors)

As previously discussed, a service user's mental health can be determined by a number of interactions between biological, environmental and social factors, known as

'predisposing factors', which increases a person's vulnerability to illness. Using a normalising rationale, discussion can help the service user understand how in certain conditions we can all develop difficulties and that some factors in life have increased their vulnerability to do so. Simply put, individuals with high vulnerability can develop symptoms with relatively low levels of stress, people with low vulnerability can develop symptoms with higher levels of stress, and the presence of protective factors and coping skills can influence the recovery journey. Potential vulnerability factors will have been explored as part of the psychosocial assessment process and this can include; genetic predisposition, developmental problems, anomalies in cognitive processing, substance use, head injury and childhood trauma.

It is important that you have the correct understanding of the vulnerability factors pertinent to the service user. When you share this part of the case conceptualisation, you will discuss important experiences and issues that have increased the service user's vulnerability. Therefore, sensitivity and empathy are essential to highlight the role that these factors will have played. It is important to sketch out your initial thoughts beforehand, but remember that the wording may be critical for the service user. Major events cannot be ignored but be mindful of how you deal with them during your discussions. This helps to ensure a shared understanding and convey a sense of hope and the role that resilience has played for the service user.

For example:

- In our discussions, we have talked about how past experiences have increased your predisposition/vulnerability and I have started to think about how we can summarise them to begin understanding the role that they have played. It can be hard to think about how difficult past events have been for you. By trying to understand this, though, we can begin to think about how you have coped and, importantly, how we can build on the strengths that you have.
- I am struck when I read this of how well you have coped, and that most people would have found this hard to deal with.
- How do you feel about what I have said Emily?
- Do you think what I have said accurately captures the situation for you?
- Is there anything that we have not included?

When drawing together vulnerability factors, it is important to convey sensitivity. Use skills that show understanding and do not minimise the service user's experiences. It is important to think about wording and the use of language to convey a sense of hope. Looking at a list of distressing life events can be difficult for some service users and they may prefer statements such as 'very difficult experiences to deal with in childhood' to 'sexually abused as a young child'. Using Emily's case as an example, the completed template box may look like Table 12.2.

Table 12.2 Emily's vulnerability/predisposing factors

Reaching development milestones later than peers, attended special school
Difficult experiences at school being bullied
Traumatic experiences in childhood
Early use of cannabis

Stressors (Precipitating Factors)

When discussing stressors, the service user and the practitioner explore longer-term stressors and precipitating factors and events that have led to presenting problem/s. The aim here is to use the service user's narrative to begin to increase understanding of how events/stressors have played a role in current presentation (Persons, 2012). At times of distress, it can be difficult to ascertain what events or situations are connected and how this can manifest as changes in thinking, feeling and behaviour. The discussion centres on drawing together previous discussions to highlight factors that have precipitated presenting problem/s. By doing this, you begin the process of helping the service user give meaning to experiences and highlight how this understanding can build on strengths and identify needs. As with all stages of developing the case conceptualisation, time is taken to clarify and identify important factors. As with previous examples in this section, it is critical to remember that the overall purpose is to help the service user to begin to make sense of their experiences. Attention therefore needs to be given to using a normalising rationale in discussion and how best to build on strengths to manage stressors and to build on areas of need.

For example:

- You have had a difficult time recently and I'm sure many people who have had your experiences in recent weeks would feel as you do.
- I have begun to list the recent factors that I believe have been significant for you and may have contributed to how you are feeling now.
- Recently, these are some of the things which have happened which may be related to your presenting problem ... Would you agree?

Use skills to help the service user understand events that led up to the current situation. An important part of this is to help make connections between the sequence of events and the presenting problem. By doing this, you begin the process of helping the service user give meaning to experiences, and how this understanding can build on strengths and identify needs. Using Emily's case as an example, the completed template box may look like Table 12.3.

Table 12.3 Emily's stressors/precipitating factors

-
- Starting a college course
Working in a stressful and demanding job in a nursery
Leaving your job
Stopping the college course
Arguments with family – couldn't trust them
Accommodation issues
-

Maintenance and Coping (Protective and Perpetuating Factors)

It is important to acknowledge both helpful and less helpful strategies that the service user has to manage and cope with their experiences. Helpful strategies and adaptive coping skills are likely to be protective. However, maladaptive coping skills may initially seem to be helpful but are likely to perpetuate a problem, preventing its resolution, and are ultimately likely to be unhelpful.

In line with previous discussions and assessments of the person's strengths and well-being, the practitioner helps the service user make sense of how these factors have direct links to overall functioning. It is important that the practitioner is aware that several areas need to be considered to ensure that discussions and subsequent case conceptualisation reflect the service user's narrative and the information that has been gathered during the assessment process, namely:

- Appraisal:
 - What is the service user's judgement of their protective factors?
 - How does the service user feel about the perpetuating factors?
 - How does the service user consider these factors in relation to current and ongoing health and functioning?
- Availability of coping resources:
 - What resources does the service user have access to?
 - Are they sufficient?
 - Do they have a social support network?
 - Are there any groups they can attend?
- Coping strategies:
 - What coping skills does the service user have that are helpful to ongoing health and well-being?
 - What helpful strategies is the service user using to cope and how do they feel about them?
 - What unhelpful strategies is the service user using to cope and how do they feel about them?
- Environment:
 - What is the service user's situation and their surrounding?
 - How does this impact on their protective and perpetuating factors?
- Social situation:
 - What is the service user's social situation?
 - Do they have family?
 - Do they have friends?
 - How does their social situation impact on protective and perpetuating factors?

For example:

- In our discussions, we have talked about how you have coped with your experiences and how you use a range of coping strategies to manage your ongoing health. I think we agree that there are some things you do that are really helpful and warrant further attention and others that may be deemed less helpful in the longer term. By trying to understand this, though, we can begin to think about how you have coped and, importantly, how we can build on the strengths that you have. It is also important that we think about what is available to you to support you, the important people in your life, your current situation and support network.
- How you have coped with the stressors in your life recently has been very difficult for you. We have talked through some of the ongoing stress that you have and also some of the recent events that may have contributed to your recent ... presenting problem/s.
- When I read this, I am struck by how well you have coped and that most people would have found this hard to deal with.
- How do you feel about what I have said, Emily?
- Do you think that this is a clear reflection of helpful and unhelpful factors?
- Is there anything that we have not included?

The use of language is critical to ensure that you convey sensitivity and are not critical of less helpful strategies. It is useful to gently help the service user make links between less helpful strategies and the presenting problem/s and impact on overall functioning. Helpful strategies or coping skills are those that may be useful for the service user to do more of. It is an opportunity to explore strengths and resilience, and to help the person to think about how they might capitalise on their coping skills and abilities. Using Emily's case as an example, the completed template box may look like Table 12.4.

Table 12.4 Maintenance and coping: Emily's protective and precipitating factors

Things that are helpful	Things that may be less helpful
I have friends, Sue is my best friend	I sometimes use substances if I am distressed
I am able to make friends	I can isolate myself from others and don't leave the house
I am motivated and keen to make changes and work towards recovery	Sometimes, I don't look after myself properly
I know myself and have insight into myself	Arguing with family
I have skills that I use to manage my distress and anxiety	Moving house frequently

Impact on Health and Functioning

In this part of the case conceptualisation, the service user and the practitioner consider the impact on overall health and functioning but also begin to articulate areas of need. The discussion includes exploring issues that impact on health and functioning and

reiteration of areas of concern for the service user. This begins the process of identifying initial thoughts about possible **psychosocial interventions (PSI)**. Skills used ensure that both strengths and needs are highlighted in discussions.

Potential areas to be covered include those explored throughout previous chapters. Knowledge and skills are used by the practitioner to ensure that pertinent issues are included in the case conceptualisation, and that only issues pertinent to the client are included. This provides an opportunity for discussion to add detail to discussions on strengths and needs and the journey towards recovery.

It can be useful to use the following headings to think about how to structure discussions on the impact on health and functioning. In keeping with a recovery approach, attention needs to be given to instilling hope and capturing strengths alongside needs:

- Personal:
 - What personal resources does the service user have?
 - What coping strategies do they have?
 - What motivates the service user?
 - Does the service user have insight?
 - Is there motivation to make changes?
- Social:
 - What social networks does the service user have?
 - Are they socially isolated?
 - What is their social functioning?
 - Does the service user want to build more social contacts?
- Family/relationships:
 - Does the service user have close relationships?
 - How do they feel about these relationships?
 - Are there any issues with close or intimate relationships?
- Environmental:
 - How does the service user feel about their situation, accommodation and their surroundings?
 - What would the service user like to change?
- Physical health:
 - Does the service user have any concerns about their physical health?
 - Are there any concerns that warrant attention to improve overall physical health?
- Mental health:
 - How does the service user feel about their treatment?
 - Are they experiencing side effects from their medication?
 - What coping skills does the service user have to manage their symptoms?
- Risk:
 - Are there any risk factors that need consideration?
 - How does service user feel about their risk?

- Substance Use:
 - Are there substances that the person is using?
 - How frequent? How much? With whom? When?
 - What are the reasons given for the substance use?
 - Is the person aware of the impact of the substance on their health and functioning?

For example:

- In our discussions, we have talked through a lot of issues that have begun to help us make more sense of what has been happening for you. By thinking about getting an overall picture, I have started to think about how all that we have discussed has impacted on your health and how you function. I think that this can give us a sense of areas that are going well for you and also those that perhaps we need to think a bit more about. By trying to do this, we can begin to think about what the next steps are and how to work towards recovery.
- When I read this, I am struck by how well you have coped and that most people would have found this hard to deal with.
- How do you feel about what I have said, Emily?
- Do you think that what I have said accurately captures the situation for you?
- Is there anything that we have not included?

Using the person's own language, highlight those factors that appear to impact on health and functioning. This requires consideration of key areas previously discussed, areas of concern for the service user and initial thoughts about areas that may warrant attention. This begins the process of identifying initial thoughts about the person's needs and goals as a prelude to possible treatment and interventions. Using Emily's case as an example, the completed template box may look like Table 12.5.

Table 12.5 Impact on health and functioning

Personal	I really want to get well again and this keeps me motivated. I have got a lot of insight and this is good
Social	Sometimes, I feel quite lonely and scared about making new friends. I know I have the skills, though. Sue is my best friend and a real support to me
Family/ relationships	I sometimes struggle in my relationships with my family and close relationships and this makes me feel down, and makes me feel as though it is my fault
Environmental	I like living with other people, I like to know that there are others around me
Physical health	I am worried sometimes as I don't always look after myself and know that I don't always eat properly. I don't always go to the GP and I worry about my health
Mental health	I am beginning to develop some coping skills for my anxiety and am trying to think about ways of dealing with my suspicious thoughts. I don't like taking medication but can see that it helps
Risk	When I am unwell, I can be a risk to myself as I stop looking after myself. I also feel that I am easily led when I am unwell and have ended up in situations and relationships that make me feel bad
Substance use	I have used cannabis in the past and I am worried that I may experiment with drugs again, especially if I'm feeling vulnerable

Emily's full case conceptualisation can be found in Table 12.6.

Table 12.6 Emily's case conceptualisation

Presenting problem(s)	Vulnerability factors	Stressors	Helpful coping and protective factors	Unhelpful coping and perpetuating factors
Feeling unable to do things, having no energy and struggling to get things done	Reaching development milestones later than peers	Starting a college course	I have friends, Sue is my best friend	I sometimes use substances if I am distressed
Feeling very low in mood	Attended special school	Working in a stressful and demanding job in a nursery	I am able to make friends	I can isolate myself from others and don't leave the house
Spending long periods on my own and feeling very lonely, not going out much	Difficult experiences at school being bullied	Leaving the job	I am motivated and keen to make changes and work towards recovery	Sometimes, I don't look after myself properly
I have ideas that I am being watched, I feel suspicious	Traumatic experiences in childhood	Stopping the college course	I know myself and have insight into myself	Arguing with family
Struggling to look after myself	Early use of cannabis	Arguments with family, problems with trust	I have skills that I use to manage my distress and anxiety	Moving house frequently
		Accommodation issues		

Impact on health and functioning

Personal: I really want to get well again and this keeps me motivated. I have got a lot of insight and this is good

Social: Sometimes, I feel quite lonely and scared about making new friends. I know I have the skills, though. Sue is my best friend and a real support to me

Family/relationships: I sometimes struggle in my relationships with my family and close relationships and this makes me feel down, and makes me feel as though it is my fault

Environmental: I like living with other people, I like to know that there are others around me

Physical health: I am worried sometimes as I don't always look after myself and know that I don't always eat properly. I don't always go to the GP and I worry about my health

Mental health: I feel anxious but I am trying to think about ways of dealing with my suspicious thoughts. I don't like taking medication but can see that it helps

Risk: When I am unwell, I can be a risk to myself as I stop looking after myself. I also feel that I am easily led when I am unwell and have ended up in situations and relationships that make me feel bad

Substance use: I have used cannabis in the past and I am worried that I may experiment with drugs again, especially if I'm feeling vulnerable

Closing the Case Conceptualisation Interview

Throughout the sharing of the case conceptualisation, the practitioner will use a range of supportive and therapeutic skills and knowledge to ensure that the case conceptualisation is developed in line with the service user narrative and the assessment process as a whole. The end product should provide a clear overview of the service user's experiences to date. The interview will have afforded an opportunity to identify both strengths and needs, and offer valuable insights into how best to proceed. As the session draws to a close, the practitioner needs to ensure that the service user has understood the purpose of the case conceptualisation and the value of the session is apparent to both parties. The summary should include discussion of how component parts link together and seek clarification from the service user. The practitioner should mention how forthcoming sessions will include building on strengths and needs alongside formulating goals and a plan of interventions.

Problems with Case Conceptualisations

There is a temptation when developing a case conceptualisation to overly prepare for the session and not give adequate attention to service user views. The case conceptualisation is as a result of collaboration between practitioner and service user during the assessment phase. It should not represent the practitioner's overview or understanding of the service user's experiences but instead seek to develop a shared understanding. The language used should reflect the service user's choice of words and should reflect sensitivity afforded to distressing experiences.

A template or instruction manual to guide and inform practice can be very useful. However, the practitioner needs to ensure that they feel adequately prepared for the session and that they do not overly rely on either the template or the practice suggestions made in this chapter. As practitioners, we all have different ways of conveying sensitivity towards service users and, likewise, different words that we use when talking with service users. It is always best to use a style that suits our style, rather than replicate words that we are not comfortable with. Finally, remember that the intention is to help the client begin to make sense and therefore use your judgement and be flexible in your approach.

Key Points in the Case Conceptualisation

- Acknowledge all the information that has been shared by the service user over previous sessions and how this can give a sense of how best to go forward.
- Use language that conveys sensitivity to the service user experiences.
- Use simple statements so that the case conceptualisation is clear and concise and therefore easier to make sense of experiences.
- Help the service user make connections between the different parts of the conceptualisation using stress vulnerability to normalise experiences and begin to understand both strengths and needs.

Chapter Summary

This chapter has sought to guide the practitioner through the process of developing a case conceptualisation. Using the service user's narrative and a recovery-focused approach, the case formulation is used to make sense of the service user's experiences. The chapter outlines how the wealth of information gathered during the assessment process can inform the process and make best use of the information. The chapter draws on the use of a normalising rationale to underpin the development of the case conceptualisation and highlights suggestions in the 'Considerations for Practice' section by providing example questions. Building on previous chapters, this chapter demonstrates how the case conceptualisation is used to underpin the development of strengths and needs statements and to define goals with the service user. Finally, a template and practice examples are used throughout the chapter, with reference to a case scenario to show the value of a collaborative case conceptualisation.

EXERCISE



Throughout this chapter, we have used a case scenario to illustrate how assessment information can be used to develop a case conceptualisation with Emily. Using this information and the template included in Appendix 12.1, begin to sketch out information to be included in the case conceptualisation:

1. What do you need to consider before meeting with a service user?
2. How will you explain the purpose of case conceptualisation with a service user?
3. Explain it to a colleague. Does it make sense to them?
4. How will you explain the links between the component parts to Emily?
5. How will the case conceptualisation help Emily set goals?

CONSIDERATIONS FOR PRACTICE

1. What purpose does case conceptualisation serve?
2. How does case conceptualisation help the service user and the practitioner make sense of experiences?
3. How does case formulation inform interventions?

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Appendix 12.1 Case Conceptualisation Template

Note: When using this template, it is important to make links between component parts. There is no order for completion and the intention is to develop understanding.

Presenting problem(s)	Vulnerability factors	Stressors	Helpful coping and protective factors	Unhelpful coping and perpetuating factors
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Impact on health and functioning

Personal:

Social and family:

Environmental:

Physical health:

Mental health:

Risk:

Substance misuse:

13

IDENTIFYING STRENGTHS AND FORMULATING NEEDS STATEMENTS

VICKY NAIDOO



CHAPTER OVERVIEW

This chapter:

- Stresses the importance of gathering assessment information prior to formulating strength and needs statements.
 - Highlights the recovery approach and achieving a collaborative relationship, and how this relates to shared understanding.
 - Discusses the skilled techniques needed to identify strengths and formulate needs statements such as semi-structured interviews.
 - Explains the process of identifying strengths and formulating needs statements in a structured and systematic way.
-

Introduction

This chapter demonstrates how to identify strengths and formulate needs statements, which leads directly on from the case conceptualisation stage (Chapter 12). This, in

turn, will also support the formulation of goal statements (see Chapter 14) and subsequent care plans and psychosocial interventions and treatments.

Identifying strengths and formulating needs statements is a crucial phase in the service user's ongoing recovery (Beckwith and Crichton, 2010). It helps the service user and the practitioner to make sense of the current situation by revisiting information gathered during the various aspects of the assessment and case conceptualisation stages in order to identify a list of needs or 'problems' that are meaningful for the service user and their families.

Key Skills in Identifying Strengths and Formulating Needs Statements

Collaboration

In order to support this process, it is vital that a collaborative, therapeutic relationship is established between the practitioner and service user based on trust. Time needs to be spent to engage with the service user, and this includes: non-sessional-based conversation, humour and a relaxed atmosphere (Kingdon and Turkington, 2008). The term *befriending* is often used to describe the therapeutic relationship between practitioner and service user. Befriending is a professional friendship that includes shared boundaries between the practitioner and service user. It is the responsibility of the practitioner to explain these boundaries to the service user within the early stages of the therapeutic relationship. It is also important for the practitioner not to be overly boundaried within the relationship. The expectation is that the service user will have limited boundaries and will divulge their extremely personal experiences. If this is confronted with a cold practitioner, the therapeutic relationship will not sufficiently develop.

Collaboration is a key skill here. It is important that the service user's own language is used when completing formulations and when listing strengths and needs. This is to allow the service user to have a sense of ownership of their strengths and needs and also to help them with understanding the goal statements, which lead on to the interventions. The practitioner is required to be thoroughly prepared before this session, with the aim in mind to establish what problems currently cause the most difficulty within their day-to-day life.

It is also important to draw on good communication skills to demonstrate this shared understanding, for example, reflecting back or summarising what the service user has said to ensure the understanding is accurate (see Chapter 2). It is also important that the practitioner resists the temptation to list the needs statements that they think the service user should work on. Although the practitioner may believe that they know what the problems are, it needs to be the service user's list.

EXPERT VOICE

An example of this was when I was working with a lady who heard the voice of God. I wanted to work on reducing the amount of times she heard this voice and the volume, and so recommended that we list this as a needs statement. However, this lady was not distressed by this voice and actually found it comforting as she believed this meant she was closer to God.

To ensure the best recovery outcomes and successful collaboration, the service user's family and friends need to be included in the assessment and intervention process wherever possible (Patel et al., 2014). It could be a good opportunity to include them in identifying strengths and formulating needs as they will help to give collateral information as well as support the eventual goal setting stage. It is imperative that the service user is asked if they are happy to include family and/or friends and also the environment and logistics of including them, for example which session, location and boundaries.

Semi-Structured Interviewing

Identifying strengths and formulating needs statements consolidates the information gathered from assessment leading to tangible goals, which, in turn, guide subsequent interventions. One of the best ways to do this is to use a semi-structured interview as the method to analyse and synthesise assessment information. The advantage of a semi-structured interview is that the practitioner can have a set of structured questions already prepared; however, the interview itself can be flexible so as to allow the service user to expand on answers and to discuss in detail the results of the assessment.

EXPERT VOICE

‘What I tend to do is use a case conceptualisation template (see Chapter 12 and Appendix 12.1) and half fill it in, based on the results of the assessments. I then take this into the strengths and needs session and use it as a prompt for the semi-structured interview, and a way to ensure collaboration is achieved.’

All the information gathered at assessment and case conceptualisation stages should be clearly presented at the start of the interview. The suggested format of the interview uses the ‘funnelling technique’ (see Chapter 12), which is often used in semi-structured interviews in the following format:

1. Open Questions

In formulating needs statements, it is also important to start off reviewing the case conceptualisation (which you could also refer to as a *summary* if the term is confusing for the service user). Asking open questions starts the process of making sense of the assessment information and case conceptualisation, and allows discussion and reflection on what the service user feels are their current strengths and needs. It is important that the service user is invited to comment on the case conceptualisation to check that it is accurate from their point of view. It is also important that the practitioner shares their perspective and tentatively offers some suggestions about the way forward. Open questions may include:

- What do you make of this conceptualisation/summary?
- Having heard this summary, what do you feel are your current needs?

- Listening to your story, could I suggest that ... also might be an issue for you at the moment? Would you agree?
- Are there any you feel are more of a priority for you at the moment?
- What are the good things for you at the moment?

2. Clarifying Questions

These questions allow the service user and practitioner to clarify and elaborate on perceived problems or issues to elicit more detail from the open questions. For example:

- Could I suggest that ... seems important for you at the moment? Would you agree?
- Could you describe this problem in a bit more detail:
 - When does this seem to be a problem for you?
 - In what ways is it a problem for you, in particular?
 - Who makes it better/worse?
 - Anything else?
- What are the good things for you at the moment?
 - What do you feel your strengths are?
 - What and who might help us?
 - When might they help us?

The FIND (Frequency, Intensity, Number, Duration) technique can also be used to obtain more specific details about a person's experience (see Figure 13.1).

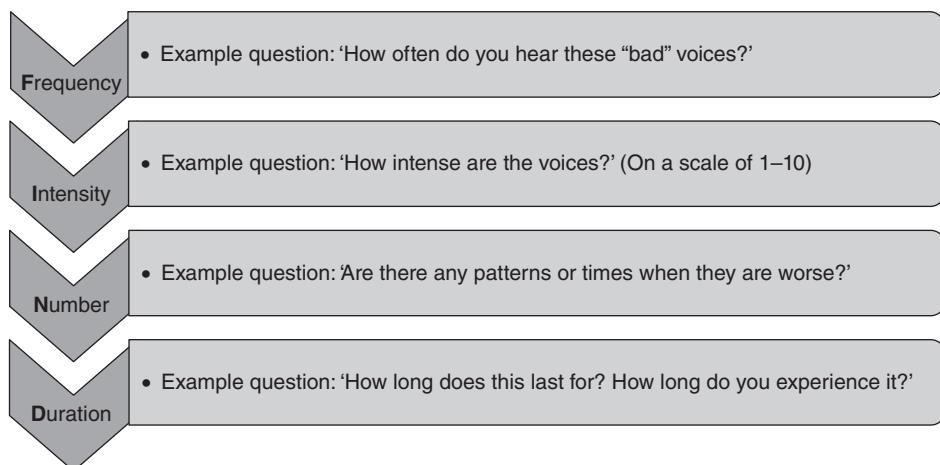


Figure 13.1 FIND technique of questioning

3. Summary

It is helpful to summarise and confirm the responses that were given by the service user to ensure that the practitioner's understanding is a true reflection of the answers. This also gives the service user an opportunity to give further details to their responses (Briddon et al., 2003).

Case Scenario – Emily

Look again at the case conceptualisation of Emily in Chapter 12 (see Table 12.5). From this, a list of needs for Emily may be negotiated and drawn up (see Table 13.1).

Table 13.1 Emily's list of needs

Number	Current Needs
1	Feeling low in mood
2	Struggling to motivate myself
3	Lost focus in my life
4	Frightened to go out
5	Having side effects of medication
6	Don't understand diagnosis or the way that I am
7	Feeling anxious around groups of new people
8	Feeling apathetic

EXPERT VOICE

You may be confronted with a lengthy list of needs following the assessment and case conceptualisation process. If it is not possible to address all of these needs, it is best to be guided by the service user and ask them which needs are the most distressing or the ones which they would like to work on the most, and start with these areas first.

Exploring a Need

The funnelling and FIND techniques described above can be used to explore and clarify needs and begin the process of prioritisation, as illustrated below, using Emily's case conceptualisation:

Practitioner: So, let's look a little more at your social life at the moment. It seems that recently you have lost contact with your friends and rarely leave the house. One of the themes when we look at the various assessments we have done together is that you say that you feel uncomfortable when you go out. Could you tell me a little bit more about that? (Open question)

Emily: I feel people are watching me when I go out.

Practitioner: Is there anything else that worries you when you go out?
(Clarifying question)

- Emily: I can hear people talking about me.
- Practitioner: Can you tell me what they say to you? (Clarifying question)
- Emily: They say I'm evil and they are going to follow me.
- Practitioner: Is this every time you go out? (Frequency)
- Emily: Yes, every time.
- Practitioner: How bad is this for you on a scale of 1–10, where 1 is 'Not bad at all' and 10 is 'Unbearable'? (Intensity)
- Emily: I would say about 8. It's horrible.
- Practitioner: I'm sorry to hear that. Could you tell me if you noted any patterns or times of day when this happens? (Number)
- Emily: No – it's every time.
- Practitioner: When you go out, do you feel that people are watching you and talking about you all the time or some of the time? (Duration)
- Emily: All the time.
- Practitioner: Does anything or anyone help you to cope with this? (Identifying strengths)
- Emily: When I go out with my friend Sue, I feel a bit more confident. She is always there for me. I want to do something about this – I don't want to stay at home forever.
- Practitioner: Okay. So can I check if I understand what you have said? So far, you have said that you stay at home as you are afraid that people are watching you and that every time you have gone out you feel you have heard people telling you that you are evil and you will be followed. You feel you are motivated to cope with this and you feel that Sue may be able to help. Have I got this correct? (Summary)

So, in the first part of formulating needs statements, we have clarified and confirmed that Emily seems to have lost confidence in social situations, and feels frightened about going out and meeting new people. She says she hears voices of people telling her that she is evil, and that they will harm her constantly and consistently every time she goes out. She finds this very distressing. She feels that her friend Sue may be able to help, as she feels safe with her. This seems to be an area that Emily feels is a priority for her, so it would be appropriate to consider formulating a needs statement.

Formulation of Needs Statements

The next step is to formulate a need(s) into a statement that creates the foundation to set the goal for treatment (Beckwith and Crichton, 2010). As mentioned earlier,

it is important to use the service user's own words when formulating the needs statement, as they will then own the needs and are more likely to engage in the intervention process. The needs statements should explore the impact and consequences of the problem, and how it affects the service user on a day-to-day basis.

The needs statement underpins goal statements, which will be explained in more detail in the next chapter (see Chapter 14). When formulating the goals for the service user from the needs statement, it is important not only to focus on the problems but also the strengths. These strengths may make up the service user's protective factors, which have helped them cope in the past, so it is equally important to identify these. Purely focusing on the problems could cause the service user to feel overwhelmed and unable to cope. By encouraging the service user to identify their strengths, they are more likely to feel empowered to tackle their areas of need, be left with feelings of hope and optimism and to become more self-reliant (Saleebey, 2001).

There are two key ways in which a needs statements can be structured:

1. The Antecedent-Behaviour-Consequence (ABC) Approach

In this ABC approach, the needs statement is formulated by identifying:

- *Needs Statement*: A clear summary of the need/problem.
- *Feared Consequence*: What does the service user fear may happen as a result of the need/problem?
- *Antecedent*: What happens before? Or, when is this a problem?
- *Behaviour*: What is done as a consequence of the need/problem?
- *Consequence*: What impact does this need/problem have?

An example of a needs statement using this method for Emily's scenario can be found in Table 13.2.

Table 13.2 Emily's needs statement using the ABC method

Needs statement	I have lost confidence and feel frightened about going out and meeting new people
Feared consequence	I will never be able to leave home
Antecedent	I hear voices of people telling me that I am evil and they will hurt me
Behaviour	I feel frightened all the time, avoid people and can't make friends
Consequence	I don't go out which makes me feel low in mood

2. The Kingdon and Turkington Model

Kingdon and Turkington (2008) provide another example of the way in which needs statements can be structured. This focuses on:

- *Need Definition*: A statement (or statements) in the person's own words which succinctly captures a current need.

- *Impact:* The effect that the need has on the person's day-to-day life and experience.
- *Consequence:* The influence that the need subsequently has on the person's behaviour, thoughts and feelings.

An example can be found in Figure 13.2.

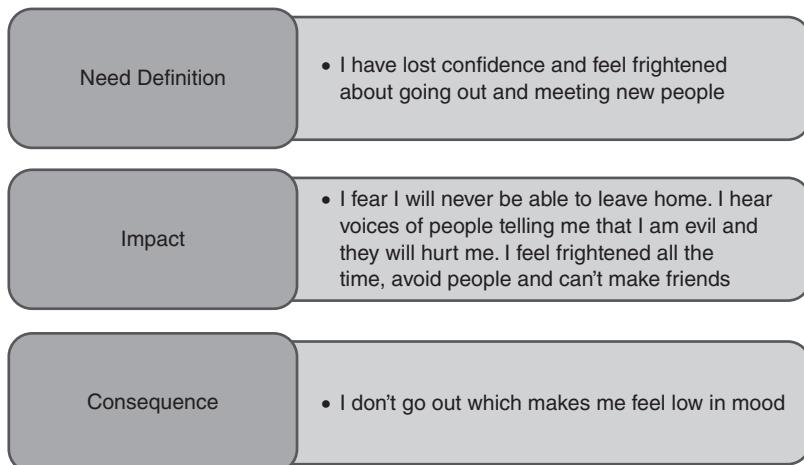


Figure 13.2 Emily's Needs Statements, using the Kingdon and Turkington (2008) Model

Errors in Need Formulation

Collaboration

The most important element to remember when identifying strengths and formulating needs statements is that it is a collaborative process. Try not to second-guess the needs or strengths of the service user and ensure that the service user's own language is used throughout the process.

Importance of Engagement

It is important to consider the literacy and understanding of the service user. Complicated language and words such as 'antecedent', 'conceptualisation' and so on could appear intimidating. Equally, presenting information in an overly simplistic way could also appear patronising to another service user. Ensure that time is taken during the engagement and assessment period to understand the context which the service user is coming from.

Chapter Summary

This chapter has aimed to give the reader an overview of identifying strengths and formulating needs statements as well as practical hints and tips on how to formulate them when working with service users. The chapter began with an overview of the approach within mental health care as this underpins all the assessment and intervention work that is carried out with our service users. It demonstrated some common techniques and the semi-structured interview style as the preferred model to collect the more detailed information required when formulating needs statements. The chapter then went on to discuss the importance of not just focusing on the service user's needs but also their strengths as this will ensure better recovery outcomes.

EXERCISE



1. With a colleague (and perhaps role playing, using the information supplied in Emily's case scenario), practice using the format techniques described in this chapter to identify strengths and formulate needs statements. Concentrate on developing the skills described in the funnelling and FIND techniques.

CONSIDERATIONS FOR PRACTICE

1. How might you involve family and friends in identifying strengths and formulating needs statements?
2. A good rapport and a supportive trusting relationship needs to be established before identifying strengths and formulating needs statements. Sensitivity is needed when discussing a person's needs. Given that mental health services can be very busy environments, how might you ensure that you spend sufficient time in developing a therapeutic alliance with a mental health service user?

Further Reading

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14

FORMULATING GOAL STATEMENTS

ALISON ELLIOTT, JOHN BUTLER AND
TRACEY KEARNS



CHAPTER OVERVIEW

This chapter:

- Provides an understanding of goal formulation.
 - Considers practical methods for engaging the individual/family member(s) in identifying and prioritising meaningful personal goals as a key component of the psychosocial approach.
 - Considers helpful ways of reviewing and monitoring the achievement of goals.
 - Promotes an awareness of strategies and resources that are helpful in overcoming difficulties/obstacles to goal formulation, thus supporting goal attainment.
 - Offers some resources to support the practice of goal formulation and review.
-

Introduction

This chapter introduces the concept of goals and collaborative goal formulation as a key feature of psychosocial assessment and intervention, which follows directly on from identifying strengths and formulating needs statements (Chapter 13). It offers

practitioners a practical approach to working alongside individuals to formulate meaningful short- and long-term goals, exploring how this can be achieved, and highlighting useful tips in the event of difficulties and obstacles.

The Importance of Goal Setting

Clear goal setting is an essential component of a psychosocial approach. This process not only allows the negotiation and agreement of subsequent therapies, care or treatments to address identified needs, but also allows the review of whether such interventions have had any impact on the distress/problems experienced by the individual (Laidlaw, 2015).

A ‘goal’ may be regarded as a desired outcome, as something that a person wishes to achieve, such as living independently, getting a job or getting married (Wright et al., 2014). Setting and working towards personal and meaningful goals is an effective way of focusing on issues that affect an individual, achieving a sense of value and managing stress, which enhances morale, motivation, sense of achievement and self-confidence, reduces distress and the sense of demoralisation and hopelessness, and thus promotes hope and recovery (Meyer et al., 2010; Powell, 2009; Westbrook et al., 2007; Wright et al., 2014).

Importantly, practitioners and teams who are trained in goal setting are more likely to set goals that service users/family members will be able and wish to meet, which is likely to have a positive impact upon recovery. As a notable example, Clarke et al. (2009) demonstrated improvements in the practice of goal setting following training, in areas such as: recovery focus; levels of goal attainment; and problem-solving the barriers to goal attainment.

Working Towards a Shared Understanding

Setting goals can be difficult, as many people lack a goal orientation in their lives. People may also be unsure about how best to set goals or they may fear, or have experienced, failure or disappointment. They may also have felt pressured to pursue the goals of others (Meyer et al., 2010; Powell, 2009). Furthermore, negotiating and agreeing goals with a couple or a family can prove challenging, as different and perhaps conflicting priorities may arise prior to reaching agreement. Establishing a good rapport and working relationship with the individual/family is a prerequisite to collaborative and meaningful goal setting, strengthening and facilitating decision-making.

As with case conceptualisation and the identification of strengths and the formulation of needs statements (see Chapters 12 and 13), the role of the practitioner takes the lead in facilitating and guiding this process. For goal setting to be meaningful, the practitioner clearly needs to adopt a style and approach consistent with some important principles for practice, including:

- *Collaborating* or working together with the person, assisting them to agree goals which are *personal* and *highly relevant* to their priority issues.
- *Helping* to focus the individual on a desired outcome that is achievable.
- *Enabling* the person to establish goals that are *clear* and *specific*.

This can be a difficult process. Consider, for example, the person who simply states: 'I want to feel better.' While this is, of course, a reasonable position for anyone to take, it is not clear what this actually means. If goals take the form of such vague, general and unfocused statements, they may never be achieved and may contribute to feelings of failure and hopelessness. It is therefore more helpful to set *specific* and *clear* goals. It is also essential that the person is encouraged and assisted to develop their own, personal and individualised goals. This expresses a commitment to act/do something, and promotes ownership and personal responsibility (Powell 2009).

Adequate time needs to be allocated for setting goals, being mindful of the potential difficulties that may arise. Negotiation is key during this process, ensuring the agreement of specific attainable goals, and providing the individual and practitioner with the opportunity to explore potential barriers and challenges to achieving the goals. Furthermore, when facilitating goal setting, it can be really helpful to use strategies such as open questions, positive reframing/rephrasing, reflecting upon previous positive experiences, considering the person's strengths, abilities and availability of support, and maintaining a focus on small steps. These strategies will enhance the chances of achievement/success and reduce the risk of failure, demoralisation and blame. For example, consider the individual who struggles to believe in their ability to achieve their goal, perhaps saying, 'I want to go to the shop, but I can't.' S/he could be encouraged to consider:

- What has helped in the past?
- Who has helped in the past?
- What/who would help me in achieving this goal of going to the shops?

Identifying and Prioritising Personal Goals

Goal setting is a meaningful intervention that may be structured as a series of steps (Meyer et al., 2010; Powell, 2009; Wright et al., 2014), as shown in Table 14.1.

It is therefore important to help the individual to consider both long- and short-term goals, which may be described as follows:

- *Short-term goals:* Tend to relate to the stages or steps that are necessary in achieving long-term goals, often being the first steps towards recovery, which are possible to achieve in the short term (e.g. a few weeks) – they may thus be viewed as process orientated.
- *Long-term goals:* Focus on what the individual would like to achieve in the longer term (e.g. 3–6 months), providing overall direction and hope, and usually focus on developing meaningful activities, e.g. a job, independent living, confiding/intimate relationships (Wright et al., 2009) – they may thus be viewed as desired outcomes (being outcome orientated), and are ideally recovery focused.

Although it is helpful to develop both short and long-term goals, it is important to realise that short-term goals are likely to be more helpful in the first instance, as these will have a greater chance of early success, and will therefore assist in further enhancing the individual's hope, morale and commitment to change (Morrison et al., 2004). A long-term goal, however, is aspirational and provides drive and motivation.

Table 14.1 The steps of goal setting

Step 1	Explore your interests and goals before you became unwell, thinking creatively about different areas of your life (e.g. family, home, work, study, leisure) in beginning to identify valued goals, or what you'd like to achieve/improve over the next few years
	<i>As a critical first step in enhancing motivation to change, clarify what is important</i>
Step 2	Review your emerging list, modifying or dropping those potential goals that are incompatible or unattainable (Powell, 2009)
Step 3	Identify a long-term recovery-focused personal goal, focusing on the desired outcome, and consider the benefits of change, e.g.: <i>How would things be better if you achieved this goal?</i> (Meyer et al., 2010; Treasure, 2004; Wright et al., 2014)
Step 4	Identify two or three related short-term or smaller manageable goals, and select one as your initial focus (Meyer et al., 2010; Wright et al., 2014)
Step 5	Create specific steps or committed actions for making changes and achieving each short-term goal (Meyer et al., 2010; Wright et al., 2014)
Step 6	Identify and plan for the obstacles or challenges that may need to be overcome (Powell, 2009)
Step 7	Steadily take steps towards the goal, gaining support and assistance as needed (Meyer et al., 2010)
Step 8	Recognise and celebrate effort and success, and overcoming obstacles (Meyer et al., 2010; Powell, 2009)

When negotiating goals, it is essential to clearly define and prioritise goals with the person. Negotiation and collaboration are key to reducing any potential conflict, clarifying the rationale and meaning of the goals that are agreed, and in agreeing priorities.

When prioritising, it is important to consider risk/urgency, the importance of the various goals, the individual's level of distress, or whether one goal needs to take precedence (Westbrook et al., 2007). To enhance a sense of ownership, hope and recovery, it is pivotal that the identified goals are generated by the individual and, wherever possible, written in their own words and a language that they can understand.

Forming Meaningful Goal Statements

Meaningful goals must be personalised, clear and specific. There are a number of methods that may be used to start to have meaningful conversations with people about their goals. Westbrook et al. (2007) and Wright et al. (2014), for example, recommend facilitating this process of identifying a meaningful goal by asking a few open questions, for example:

- What would be a meaningful change for you?
- What would you like things to be like?
- What would give you a sense of purpose?
- What would you like to be different?

In considering the formulation of meaningful goal statements focusing on addressing risk issues, Hart (2014) describes a helpful structure which involves considering:

- The concerned person – or, who will take responsibility for the action/solution.
- The objective – what will be achieved.
- The context/setting – the circumstances.
- The time frame.

Fox and Gamble (2006) suggest that forming a meaningful goal statement could be best facilitated by asking the individual to describe what they would like to achieve, encouraging them to describe something they would be doing (a positive change or alternative behaviour) that would indicate that the problem/issue is less severe or has been resolved. They also propose the use of a very helpful structure in formulating a clear and meaningful goal statement:

- Behaviour: What would the person like to do?
- Conditions: With whom? under what circumstances?
- Frequency: How often?
- Duration: For how long?

Expressing Goal Statements

The next stage would involve enabling the individual to phrase a goal statement, using the person's own words. Facilitating this process would involve reflecting back what s/he wishes to achieve, in clarifying, refining and fine-tuning the goal statement.

In developing meaningful goals, it is highly recommended that each goal is clearly expressed, to facilitate a meaningful review at key points. It is therefore important to ensure that each goal is consistent with a series of key criteria or principles, which have been summarised by several authors in the form of 'aide memoire' style acronyms, as shown in Figure 14.1 and described below.

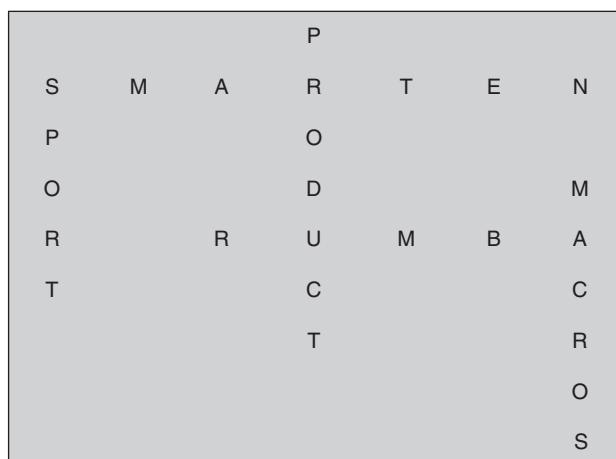


Figure 14.1 Aide-memoires for expressing goals

These acronyms refer to:

- SMART = Specific, Measurable, Achievable, Relevant/Realistic and Time-limited (Wright et al., 2014)
- SMARTEN = Specific, Measurable, Achievable, Realistic, Time-orientated, Explicit and Negotiated (Padmore and Roberts, 2013)
- RUMBA = Relevant, Understandable, Measurable, Behavioural and Achievable
- SPORT = Specific, Person-centred, Observable, Realistic and Time-bound
- MACROS = Measurable, Achievable, Client-centred, Realistic, Outcome-written and Short (Barrett et al., 2012)
- PRODUCT = Person-centred, Recordable, Observable and measurable, Directive, Understandable and clear, Credible, Time-related (*ibid.*)

These variations of well-known acronyms clearly share and reinforce the importance of some common principles:

- *Realistic*: It is important to ensure that each goal is realistic, not too limited or over-ambitious, which may require some delicate negotiation with the individual (Westbrook et al., 2007), thus increasing the likelihood of completion – so, can you make it happen?
- *Understandable*: Each goal needs to be written in a simple way, such that the meaning is clear – so, does this make sense to you?
- *Measurable*: Clarifying how the goal will be measured allows for frequent and specific reviews of progress – so, how would you know that you've completed your goal?
- *Behavioural*: Describing something that the person would be doing – so, does it clarify the action that will be taken?
- *Achievable*: Negotiating what will be achievable, given the individual's own resources and abilities (e.g. skills, time, support from others, money, transport), focusing on what is within the person's control, rather than relying on the actions of others – so, is it possible for you to do?
- *Specific*: Ensuring that the goal is very clear to the individual and is tailored to need, clearly identifying what will be done – so, is your goal specific enough?
- *Time-bound*: Agreeing the time frame for completion allows for a focus on progression, although some flexibility is helpful – so, when will you have achieved your goal?

It is helpful to select and apply one of these aide memoires in ensuring that you have negotiated a meaningful goal, thus promoting the individual's success in actually achieving the goal. This may lead to modifying and strengthening the goal statement and/or further breaking down a goal into a series of sub-goals. In practice, as you collaboratively formulate a goal statement, explain the preferred aide memoire to the individual as a guide to testing and agreeing a meaningful goal.

So, looking back at Emily's story (which can be found in Case Scenario 12.1), and her needs statement (see Table 13.1 and Figure 13.2), a meaningful short-term and related long-term goal statement for Emily may look like the one in Table 14.2.

Table 14.2 Goal statement example (Emily) (using the ‘behaviour, conditions, frequency and duration’ method)

Short-term goal (6 weeks)			
Behaviour	Conditions	Frequency	Duration
I would like to be able to go into town to do some shopping	with my friend Sue	twice a week	for at least 90 minutes each time
Long-term goal (6 months)			
Behaviour	Conditions	Frequency	Duration
I would like to be able to go to college to attend childcare classes	on my own	three times each week	for each timetabled class (2 hours)

Reviewing and Monitoring Achievement

The risk of failure to achieve the agreed goals will increase if you are not clear, specific, realistic and time-orientated (Meyer et al., 2010). It is also very important to ensure opportunities for the frequent review and monitoring of progress in achieving agreed goals, for which several options may be considered.

Meyer et al. (*ibid.*), Powell (2009) and Wright et al. (2014) offer goal-monitoring record forms, which may be useful in explicitly recording and reviewing the setting and completion of goals. In addition to writing out a SMART goal, these goal-monitoring proformas also involve specifying a series of related action steps. A blank copy of a proforma is provided for your own use in Appendix 14.1, and see Table 14.3 as an example of how this might be used for Emily’s case study. As shown in the example, the individual is involved in monitoring and rating how close they are to achieving their goal, using a simple goal-attainment scaling method.

Table 14.3 Example goal-monitoring record

Long-term goal

Instructions: Write down the goal you’d like to achieve over the next 3–6 months, considering how you’d like things to be different in terms of your feelings and behaviour

I would like to be able to go to college to attend childcare classes on my own, three times a week for each timetabled class (which last 2 hours)

Short-term goals

Instructions: Now break down your long-term goal into two or three smaller, manageable, short-term goals that you’d like to achieve over the next few weeks; then highlight the short-term goal that you’d first like to work on, by circling it

Goal 1 *I want to better structure my day, getting up by 9 a.m. each morning – within 2 weeks*

Goal 2 *I would like to apply for a childcare course at my local college – within 4 weeks*

(Continued)

Table 14.3 (Continued)

Goal 3 *I would like to be able to go into town to do some shopping with my friend Sue twice a week, for at least 90 minutes each time – within 6 weeks*

Steps: You may also find it helpful to write down a series of steps/actions that you need to take in achieving your chosen short-term goal

Step 1 *To review my medication with my psychiatrist*

Step 2 *To make a list of potentially helpful ways of coping and managing my anxiety about being around people*

Step 3 *To select two ways of coping with my anxiety and to try these out*

Step 4 *To monitor how well these coping strategies work through my diary*

Monitoring your progress

Write in the dates for review	<i>Instructions:</i> Using a 0–10 scale, rate how close you are to achieving your goal, by placing a mark on the scale below (0 = no progress; 5 = partially achieved; 10 = fully achieved)										
2 July	0	1	2	3	4	5	6	7	8	9	10
12 July	0	1	2	3	4	5	6	7	8	9	10
22 July	0	1	2	3	4	5	6	7	8	9	10

Monitoring performance and providing feedback has the potential to further enhance motivation and progress, allowing the person to consider what they hoped to achieve versus what they actually achieved (Clarke et al., 2006).

Supporting Goal Attainment: Identifying Strengths and Resources

Psychological well-being and goal attainment are closely associated and, according to Schindler and Sauerwald (2013), the support of friends and family is an influential factor in relation to goal attainment. It is important, therefore, to consider how goal attainment may be effectively supported by family/friends.

Here, it is necessary to explore the helpful and unhelpful relationships in relation to the desired goal, and potential difficulties with regard to achieving it. Ask the service user to consider those people who may be supportive of their goal attainment and those who may not be supportive or may sabotage goal attainment, with the aim of increasing contacts with more supportive people, thus making attainment more likely.

For Emily, it would appear that Sue is very helpful to her, therefore in terms of supporting goal attainment, it would be important to enlist Sue's help (with Emily's consent and assuming that Sue would be comfortable with this).

In addition to enlisting the support of family and friends, it is also helpful to record success and challenges (aided by the use of keeping a diary or journal, for example) and to ensure that progress towards the desired goal is monitored regularly. However, building in an awareness of times and situations when attainment may be more difficult or less likely (such as how stress can adversely affect

motivation and impact upon symptoms) can be helpful to develop realistic contingency plans in supporting goal attainment. Other strategies can include the provision of information about local and online resources where service users and families may be able to access support (for examples, see the end of this chapter).

Identifying and Overcoming Difficulties and Obstacles

There may be occasions when the practitioner and individual do not agree on goals (for example, when an individual has been detained under the Mental Health Act who may want to be immediately discharged), which reinforces the need for sound therapeutic engagement and negotiation skills for practitioners, but also that goals should be achievable and relate to things over which the person has some control. It is also important to consider whether the service user has the resources they need in order to achieve their goals.

There are a number of methods to support the person to identify and overcome difficulties in achieving their goals.

Supporting Motivation

Motivation arises when there is a discrepancy between how people currently see themselves/their situation, and how they want things to be, e.g. wanting/achieving personal goals (Boudreax and Ozer 2013; Westbrook et al., 2007; Wright et al., 2009). Motivation, however, diminishes if:

- A person finds it too difficult to identify specific goals due to feeling distressed.
- Agreed goals are set too low or too high, e.g. short-term goals seeming too simple or being inconsequential for the person, or being unable to progress long-term goals.
- There is too much pressure on the person to achieve the set goals.
- The person works on multiple or conflicting goals at the same time.
- Goals are poorly defined.

McKeown et al. (2002) suggest that practitioners should ensure that when working collaboratively with service users, goal statements are kept as simple as possible, using behavioural (measurable), clear and unambiguous wording. However, sometimes, activities and goals can be overwhelming, and so it can be useful to break down goals into specific and smaller steps, working at the person's own individual pace. Being specific, clear and concrete when setting goals also assists in identifying barriers or difficulties the individual may have in achieving them. However, it is also important to avoid framing goals in terms of how the service user would prefer *not* to be, e.g. *not* drinking, *not* feeling afraid or staying in all the time. Instead, service users should be asked to consider how they would like things to be or what they do want to do.

The Miracle Question

Using the **Miracle Question** (see Westbrook et al., 2007) can help this process, as described below:

I'm going to ask you a question that sounds really strange, but it'd be really helpful if you could try and answer it as honestly as possible, is that OK?

Imagine that you go to bed tonight and, while you are asleep, a miracle happens, which means that the problem you've come here with completely disappears. When you get up in the morning, how would you know that the problem had been solved? What sorts of things would be happening? What would you see? What would you be doing?

When following this up, it's important to ask for positive behavioural (measurable) descriptions – e.g. 'If you felt happier, what would you be doing?' – and to reinforce this by asking further questions such as 'What else?' questions and 'relationship questions' such as:

- What else would be happening?
- What would other people say or do?
- What would they think?
- How would other people notice that this miracle had happened and that you were different?
- What would they say?

It is important to appreciate that this process may be difficult for service users, and envisaging a future without problems might be challenging. However, the process can allow practitioners to raise service users' awareness of exceptions in their lives, as follows:

- I know that this miracle hasn't happened, but are there any, even really small, things that have already happened/are happening already?
- Tell me about a time when this problem wasn't so bad, what things were happening then?
- What was happening when you dealt with this more/most successfully?
- Are there times when this problem is not as apparent? What did you do to influence this?

Chaining

Another potentially useful strategy is that of **chaining**, which, according to Grist, 'allows for the motivation muscle to be stretched' by linking smaller activities to an ultimate goal (2015: 119). This allows the person to see the impact of their behaviours, thoughts and feelings on their goals. Consider the example of Emily in relation to going to the supermarket (see Figure 14.2).

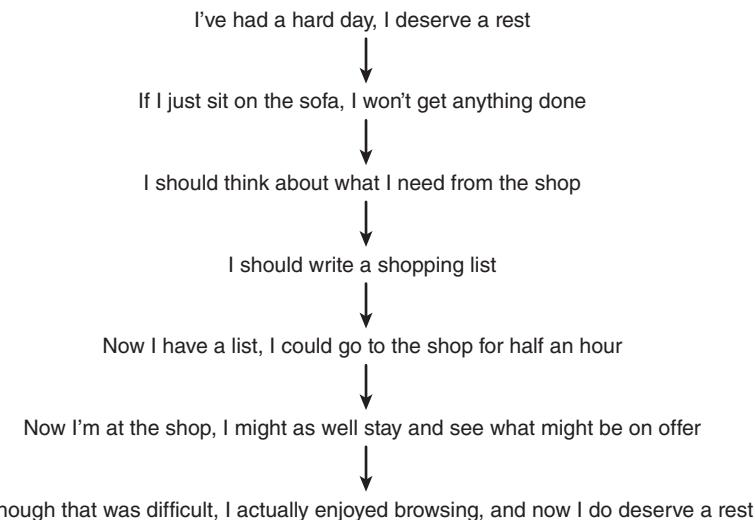


Figure 14.2 An example of chaining

Remember: one of the key barriers to service users achieving their goals, and therefore making disengagement more likely, is that goals have been poorly articulated and written.

Formulating Goals: 10 Key Points

- A goal may be regarded as a desired outcome, as something that you wish to achieve.
- Goal setting involves a series of structured steps.
- Establishing a good rapport and working relationship with the individual/family is a prerequisite to collaborative and meaningful goal setting.
- Short- and long-term goals should be specific, highly relevant and personalised.
- Working towards short-term goals is likely to be more helpful, offering a greater chance of early success, and further enhancing motivation and commitment to change.
- When formulating goal statements, succinctly define the behaviour in positive terms (i.e. what the person will aim to do, rather than what they will aim *not* to do) and, as relevant, capture any required conditions, the frequency and the duration.
- Test and fine-tune goal statements by using an aide memoire, such as SMART.
- Ensure opportunities for the frequent review of progress in achieving agreed goals.
- Consider accessing the support of friends, family and other resources in progressing agreed goals.
- Consider the use of helpful practical strategies in overcoming difficulties, challenges and obstacles – e.g. breaking goals down into smaller manageable goals, use of the Miracle Question and chaining techniques.

Chapter Summary

We have considered the place of goal setting within the contemporary practice of psychosocial and mental health assessment. We have presented a series of practical methods for the negotiation of personalised, recovery-focused meaningful goals, and considered the importance of frequent monitoring and review. In discussing a series of potential difficulties and challenges, we have highlighted a number of helpful practical strategies and signposted some potentially helpful resources.

In ensuring a positive experience for the individual, we recommend that practitioners adopt a highly collaborative, flexible and creative approach in actively engaging the individual and their family members in identifying and achieving their personal goals.

EXERCISES



1. Review Emily's case conceptualisation (see Table 12.6) and try to identify more examples of short- and long-term goals.
2. Try proposing some steps that Emily could take to achieve short-term goals, as described in Table 14.1 How would you ensure that you collaborate with Emily on this and also ensure that short-term goals are clearly negotiated?
3. Taking time to review this chapter, critically review the following goal statements, considering the extent to which each goal is SMART and, if appropriate, propose an example of a better phrased and SMARTer goal statement:
 - For Gillian to sleep better at night.
 - For Julie to remain stable in mood.
 - Julie will be symptom free.
 - Jim would like to have quality time with his wife.
 - For Melanie to comply with her medication.

You may find it helpful to relate these goal statements to particular individuals drawn from your own clinical experience. Once you have proposed your own alternative goals, consider the examples provided in Appendix 14.2.

4. Case Study: Luke

Reviewing the practice recommendations that have been made in this chapter, consider the following short case study and identify some precipitating factors and presenting problems (see Chapter 4) for Luke and his wife. Then, propose one or two meaningful goals both for Luke and for his wife:

Luke is a 29-year-old man who is married with a young daughter. He is unemployed after being made redundant, is experiencing financial difficulties and

smokes cannabis on a regular basis. Prior to Luke's relapse, his father died suddenly. Luke spends the majority of his time in his house. He finds it difficult to trust others because he believes that someone is going to harm him or his family. As a result of this, Luke has stopped socialising with his friends, although he does communicate with them via social media as he believes no harm can come to him this way. Luke occasionally goes out with his wife and daughter shopping, but he finds this very difficult and has had to leave due to severe anxiety and paranoia. As a consequence of Luke's withdrawal, his wife's social activity has also reduced. They often used to have meals with friends in the house and have regular gatherings with the family.

Appendix 14.1 Goal-Monitoring Record

Long-term goal

Instructions: Write down the goal you'd like to achieve over the next 3–6 months, considering how you'd like things to be different in terms of your feelings and behaviour

Short-term goals

Instructions: Now break down your long-term goal into two or three smaller, manageable, short-term goals that you'd like to achieve over the next few weeks; then highlight the short-term goal that you'd first like to work on, by circling it

Goal 1

Goal 2

Goal 3

Steps: You may also find it helpful to write down a series of steps/actions that you need to take in achieving your chosen short-term goals

Step 1

Step 2

Step 3

Step 4

Monitoring your progress

Write in dates for review *Instructions:* Using a 0–10 scale, rate how close you are to achieving your goal, by placing a mark on the scale below (0 = No Progress; 5 = Partially Achieved; 10 = Fully Achieved)

0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10

Appendix 14.2 Some Alternative Goal Statements

As more meaningful alternatives to the stated goals in Exercise 3 (see Exercises section above), consider the following examples:

1. Gillian would like to have seven hours of sleep each night, during the majority of nights – over the next two weeks.
2. Julie would like to be able to recognise and manage the changes in her mood – within three weeks.
3. Julie would like to learn ways of coping with the voices – within four weeks. Julie would like the voices to be less frequent, less intense and less distressing – within four weeks.
4. Jim would like to go out with Gillian for a meal in a restaurant – within the next two weeks. Jim would like to go to the cinema with Gillian – within the next seven days.
5. Melanie would like to understand more about her prescribed medication – within two weeks. Melanie would like any side effects of her medication to be resolved or managed – within six weeks.

How do these examples compare with your own suggestions?

Further Reading

Gamble, C. and Brennan, G. (2006) *Working with Serious Mental Illness: A Manual for Clinical Practice*, 2nd edn. Edinburgh: Elsevier.

A popular text among mental health practitioners who are working with those who experience a serious mental illness. Jayne Fox and Catherine Gamble explain their method of formulating problem and goal statements in chapter 9.

Powell, T. (2009) *The Mental Health Handbook: A Cognitive-Behavioural Approach*, 3rd edn. Milton Keynes: Speechmark.

A really helpful text, this provides a set of practical resources and handouts to support therapeutic assessment and intervention, primarily based on the cognitive behavioural approach. A CD-ROM resource is provided with the handbook, which includes materials on goal planning.

Westbrook, D., Kennerley, H. and Kirk, J. (2007) *An Introduction to Cognitive Behaviour Therapy: Skills and Applications*. London: Sage.

A popular text among mental health practitioners interested in the application of cognitive behavioural intervention. A helpful section is included on the use of the Miracle Question as a strategy to facilitating goal setting in chapter 11.

Wright, N.P., Turkington, D., Kelly, O.P., Davies, D., Jacobs, A.M. and Hopton, J. (2014) *Treating Psychosis: A Clinician's Guide to Integrating Acceptance and Commitment Therapy, Compassion Focused Therapy and Mindfulness Approaches within the Cognitive Behaviour Therapy Tradition*. Oaklands, CA: New Harbinger.

Focusing on the use of an integrative approach for working with service users with psychosis, this clinical guide sets out practical interventions and exercises, supported by sample resources and downloadable tools, which include goal setting.

For Service Users and Families

healthtalk: www.healthtalk.org/people-experiences/mental-health/experiences-psychosis-topics

This has useful information about psychosis, causes, treatments and coping strategies.

Mental Health Foundation: www.mentalhealth.org.uk

The Mental Health Foundation provides information about a range of mental health problems, as well as being involved in research and policy development.

Mind: www.mind.org.uk

The organisation Mind provides information about a range of mental health problems and rights and where support can be accessed.

MoodJuice: www.moodjuice.scot.nhs.uk

A Scotland-based website designed to help people think about emotional problems and work towards solving them. It provides information and links to local resources for a range of issues, e.g. benefit and debt advice, health-related information, organisations and services and self-help guides.

NHS choices Moodzone: www.nhs.uk/Conditions/stress-anxiety-depression/Pages/low-mood-stress-anxiety.aspx

The ‘Moodzone’ has information about common mental health problems and tips on improving mental well-being, as well as links to other potentially useful information.

Psychology Tools: <http://self-help.tools>

Provides free downloadable self-help tools, information about CBT and advice about how to find an appropriate therapist.

Rethink Mental Illness: www.rethink.org

Rethink provides information and advice in relation to living with mental illness, has a range of services and support groups nationally, and campaigns to improve policy in relation to mental health.

Self Help UK: www.self-help.org.uk

A free searchable database of over 1000 self-help organisations, support groups and charities across the UK that provide support, guidance and advice to service users, families/carers and their relatives. The groups and organisations cover a range of medical conditions, diseases and treatments.

SelfHelp: www.selfhelpservices.org.uk

A North England-based user-led mental health charity, which provides a range of support, services and opportunities for people living with common mental health problems such as anxiety, depression, phobias and panic attacks. At least 60 per cent of the staff have had personal or lived experience of a common mental health problem.

Turning Point: www.turning-point.co.uk

This is a social enterprise, providing services which focus on improving lives for people, especially those with complex needs, across mental health, learning disability, substance misuse, primary care, the criminal justice system and employment.

For Practitioners

Centre for Clinical Interventions: www.cci.health.wa.gov.au/resources/index.cfm

Free downloadable resources to assist in providing interventions for mental health problems. The resources aim to provide general information about various mental health problems, as well as techniques that focus on a cognitive behavioural approach to managing difficulties.

getselfhelp: www.getselfhelp.co.uk

Has free downloadable information leaflets, handouts and tools.

healthpsych: <http://healthpsych.com/psychology-tools-series>

This has 20 free downloadable practical psychology tools based on cognitive behavioural science and mindfulness-based theory.

Psychology Tools: <http://psychology.tools/>

Has free downloadable information about a range of therapeutic approaches and techniques to a range of problems, in a range of different languages.

Therapist Aid: www.therapistaid.com

Has free downloadable resources such as worksheets, videos and guides.

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GLOSSARY

active listening conscious responsive listening which acknowledges and demonstrates to a speaker – via verbal and non-verbal behaviour – that their communication has been heard

ascites free fluid, often yellowish in colour, that is in the peritoneal cavity

atopic eczema eczema with an unidentified cause

Beliefs About Voices Questionnaire (BAVQ) self-report measure of a service user's beliefs, emotions and behaviour towards their auditory hallucinations

Body Mass Index (BMI) the weight of the person (kg) is divided by the square of their height (m)

Brief Psychiatric Rating Scale (BPRS) an assessment scale which practitioners can use to measure psychiatric symptoms

case conceptualisation a framework which encompasses all the information gathered through the engagement and assessment stages. It forms the basis for the service user to understand the reasons for: their illness; a hypothesis or theory about a client's current problems; a way of integrating information gathered through the assessment phase, in reaching a shared understanding of the themes and issues concerning the individual's and/or family's presenting issues, needs and strengths, which become the focus and guide for intervention

case formulation a framework which encompasses all the information gathered through the engagement and assessment stages that form the basis of therapy and treatment

CAT (computerised axial tomography) a computerised technique that can examine a cross-section of the body. Also known as a CT scan

chaining a method of linking smaller activities to an ultimate goal

chest X-ray electromagnetic waves are utilised to view the image of the internal chest cavity

clarifying assessment assessments that seek a deeper understanding of a person's experience through more detailed questioning or the use of specific rating scales

clinician-administered psychometric tools and rating scales which are administered by practitioners

cognitive behavioural therapy (CBT) a type of therapy that aims to solve unhelpful thinking patterns, by using a combination of behavioural and cognitive interventions

concurrent validity a type of validity where a measurement instrument produces the same findings as the 'gold standard' instrument

congruence genuineness and authenticity

construct validity relates to the ability of the measurement instrument to measure the theoretical underpinning constructs from which the instrument was designed

content validity a type of validity that is more rigorous than face validity and relates to the extent and breadth to which the content of a measurement instrument measures the aspects of the construct it alleges to measure

criterion validity relates to the extent to which a measurement instrument produces the same findings as an established and already validated instrument

Cushing's syndrome a condition where there is over-secretion by the adrenal cortex

cyanosis individuals present with a bluish tinge to their skin and mucous membranes which is due to inadequate oxygenation of the blood

deep vein thrombosis (DVT) a blood clot that has formed in the deep veins of the lower leg

delirium tremens (so-called DTs) severe symptoms experienced during withdrawal from chronic alcohol use, involving tremors, hallucinations, anxiety and disorientation

dependence occurs when the body adapts to prolonged use of a drug and where the person experiences withdrawal in its absence

depot an injection which is given deep within the muscle to allow for longer absorption and is therefore longer-acting

diabetes mellitus a metabolic disease where the body is not able to regulate blood sugar levels due to an inability to produce insulin

dopaminergic related to the action of dopamine, a neurotransmitter

Doppler a device that measures the frequency of blood flow, e.g. in the leg

dual diagnosis co-morbidity of two illnesses or conditions, commonly a mental condition with substance misuse

dyspnoea laboured breathing

effusion water on the knee (or other joints)

empathy the ability to share another person's point of view

epilepsy convulsive attacks caused by a number of conditions which are due to disordered electrical activity in the brain

exogenous stressors stress which derives from outside the body such as life-event stress

external reliability consistency over time and between different raters using the same measurement instrument

face validity a basic form of validity and an intuitive and subjective evaluation

femoral the artery that runs from the groin to the knee

flexures a bend or curve such as the back of the knee

flourishing thriving

funnelling approach an interviewing approach which starts off with broad questions before seeking clarification through asking more specific and detailed questions

global assessments broad assessments of a person's overall holistic needs

glomerular disease refers to the kidney's inability to maintain a balance of specific substances in the blood stream

glycosuria glucose is present in the urine, one indicator of diabetes

goal a desired outcome, or something that you wish to achieve

goal attainment scaling a method for evaluating progress towards goals, which involves the use of a personal rating tool/scaling technique

goal statement a personally meaningful, structured statement outlining the short- and long-term goals of a person based on identified needs or problems

head-to-toe systems approach a structured, systems-based approach to physical health assessment

hyperlipidaemia high blood lipid levels

hyperparathyroidism excessive activity of the parathyroids

hypertension elevated blood pressure

hyperthyroidism excessive activity of the thyroid gland

hypothetical questions questions regarding situations, statements or about something imaginary, rather than something real

hypothyroidism insufficiency of thyroid secretion

initial conceptualisation an initial outline of a case conceptualisation usually made on first contact with a person presenting for assessment

internal reliability the consistency within the measurement instrument itself

jaundice bile pigment in the blood that causes a yellow discolouration of the skin and conjunctivae

Johari window a tool for improving self-awareness and understanding between individuals

life-course approach an approach which looks back over an individual's life and experiences (including social, economic and cultural contexts) for an understanding of current patterns of health and illness

long-term goal a recovery-focused desired outcome that can be achieved in the longer term, within 3–6 months or sometimes longer, such as gaining employment or independent living

Magnetic Resonance Imaging (MRI) an imaging technique used to obtain cross-section images of the body in any plane

Miracle Question a specific goal-orientated strategy from Brief Solution Focused Therapy, which involves considering indicators of positive change following the imagined experience of a 'miracle' that resulted in the presenting problem disappearing

motivational interviewing a person-centred counselling technique supporting health behaviour change

multiple sclerosis a chronic and progressive disease which is characterised by patches of demyelination throughout the spinal cord and brain

myocardial infarction (MI) cardiac arrest which requires urgent intervention, including ABC (Airway, Breathing, Circulation) assessment and urgent assistance

needs statement a structured statement which clearly articulates a person's need or problem

nerve conduction studies utilised to assess a number of facets, including nerve impulses

nocturia the production of large quantities of urine at night

nocturnal dyspnoea laboured breathing at night

normalising rationale an affirming statement which aims to identify the commonality of a person's experiences

oedema an excessive amount of fluid in the body tissues

ordinal rank ordering

orthopnoea breathing is laboured unless in an upright position such as sitting

oxygen saturation the level of oxygen in the blood

paroxysmal nocturnal dyspnoea reoccurring laboured breathing at night

perpetuating factors factors which maintain a problem

personal recovery outcomes health care outcomes which are defined by the individual as opposed to mental health practitioners or services

polycystic ovary syndrome (PCOS) numerous cysts in the ovaries

polyuria abnormally large outputs of urine

popliteal dorsis pedi a blood vessel of the lower limb that carries oxygenated blood to the dorsal surface of the foot

posterior tibial artery carries blood to the posterior compartment of the leg

precipitating factors factors which have preceded a person's current problem

predictive validity measurement instrument that accurately predicts an event or phenomena such as changes in, for example, psychotic symptoms, relapse, recovery, self-harm or the development of a specific condition

predisposing factors factors in a person's previous history and experience which have increased their vulnerability to mental health or other health care problems

presenting problem the person's current problem

prosocial activities voluntary activities to promote social activities to benefit an individual or group

protective factors mitigating factors which support the person

proteinuria an excess of serum proteins in the urine

psoriasis a chronic skin condition characterised by large plaques

psychoactive substance any substance which alters brain functioning

psychoeducation learning which is offered to service users and their families who suffer from mental illness. This education can come in many forms, including written and oral information, techniques and behavioural interventions

psychometric tools tests which measure properties of mental capacities

psychosocial interventions (PSI) evidence-based interventions which are underpinned by psychological tools to support individuals in their recovery

recovery approach an approach to mental health care that stresses the holistic and biopsychosocial approaches whilst emphasising individual and personal pathways of recovery

Recovery StarTM an assessment and outcome measure which highlights 10 areas of need and asks the service user to rate themselves in each area. It can be repeated to show progress

reflexive a bidirectional influence in which the cause and effect influence each other

reliability in statistics, an overall consistency of a measure

remote patient monitoring (RPM) the monitoring of a patient's symptoms at a distance, using medical sensing devices, often in the patient's own home

rheumatoid arthritis a chronic, progressive inflammation of one or more joints

schizophrenia a severe mental disorder which is characterised by a loss of reality. This includes symptoms of hallucinations and delusions as well as a deterioration in function and activities of daily living

self-efficacy the perception of the person's own abilities to achieve

self-report assessment information of an individual which is collected by the individual themselves

sensitivity the ability of a tool to reveal a true positive rate

short-term goal a process-orientated stage or step towards a longer-term goal that can typically be achieved within a few weeks and is often the first step towards recovery

SMART goal referring to the use of the well known SMART (Specific, Measurable, Achievable/Attainable, Relevant/Realistic and Time-bound) acronym for testing the quality and value of a personal goal statement. Alternative acronyms include RUMBA and SPORT

social capital the totality of an individual's social, community and interpersonal resources

Social Functioning Scale (SFS) assesses the daily functioning of an individual with a mental illness. This includes social relationships, interpersonal skills and activities of daily living

sociogram a diagram of a person's social contacts and networks

specificity the ability of a tool to reveal a true negative rate

subarachnoid/intracranial haemorrhage bleeding into the subarachnoid space

synovitis inflammation of the membrane which lines joints

tachycardia abnormally rapid action of the heart which results in an increased pulse rate

telemental health (TMH) the provision of mental health care from a distance, including mental health assessment, treatment, education, monitoring and collaboration

telephone triage assessment undertaken over a telephone, often in a crisis and accompanied by health care advice, guidance, treatment and/or support

thyrotoxicosis *see* hyperthyroidism

timeline representation of chronological events in a person's life

tolerance the body's diminished responsiveness to a drug

torticollis also known as 'wry neck', when the cervical muscles contract causing torsion

ultrasonography the deep structures of the body are visualised by a radiological technique

ultrasound interior organs of the body are examined by ultrasonic waves

unconditional positive regard a non-judgemental, positive attitude to another

validity the extent to which a study measures what it is supposed to measure

white cell count can be raised due to certain infections (leukocytosis)

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