Psychosocial Interventions in Mental Health Nursing

Chapter 1
An introduction to psychosocial interventions

Wendy Turton

NMC Standards for Pre-registration Nursing Education

Domain 1: Professional values

4.1　Mental health nurses must work with people in a way that values, respects and explores the meaning of their individual lived experiences of mental health problems, to provide person-centred and recovery-focused practice.

5.　All nurses must fully understand the nurse's various roles, responsibilities and functions, and adapt their practice to meet the changing needs of people, groups, communities and populations.

Domain 2: Communication and interpersonal skills

Mental health nurses must practise in a way that focuses on the therapeutic use of self. They must draw on a range of methods of engaging with people of all ages experiencing mental health problems, and those important to them, to develop and maintain therapeutic relationships. They must work alongside people, using a range of interpersonal approaches and skills to help them explore and make sense of their experiences in a way that promotes recovery.

5.　All nurses must use therapeutic principles to engage, maintain and, where appropriate, disengage from professional caring relationships, and must always respect professional boundaries.

5.1　Mental health nurses must use their personal qualities, experiences and interpersonal skills to develop and maintain therapeutic, recovery-focused relationships with people and therapeutic groups. They must be aware of their own mental health, and know when to share aspects

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NMC Essential Skills Clusters (ESCs)

Cluster: Care, compassion and communication

6.　People can trust the newly registered graduate nurse to engage therapeutically and actively listen to their needs and concerns, responding using skills that are helpful, providing information that is clear, accurate, meaningful and free from jargon.

By entry to the register:

7. Consistently shows ability to communicate safely and effectively with people providing guidance for others.
8. Communicates effectively and sensitively in different settings, using a range of methods and skills.

Chapter aims

After reading this chapter, you will be able to:

- define what psychosocial interventions (PSIs) are and their role in effective, person-based mental health care;
- provide opportunities to consider mental health care within a psychosocial framework;
- clarify the theoretical underpinnings of PSIs;
- consider the challenges of delivering PSIs in routine mental health care.

Introduction: psychosocial interventions

Case study

Marianne lives with recurrent depression and this time round has been off sick from her job for five months; this latest episode of low mood has caused her to become anxious about returning to work; she has lost confidence in herself and wonders how she will cope with the inevitable questions from her work colleagues. Marianne received a comprehensive psychosocial package of care from her mental health team. Working alongside Marianne, her care team identified that to promote and sustain recovery, she needed appropriate but minimal medication to support her mood. This was as an adjunct to a course of CBT for her depression, to enable Marianne to understand her vulnerability to depression and learn skills to prevent relapsing into a further episode. Marianne's husband received support from the carer's support worker so that he could understand more about depression and so be a pivotal support for Marianne's recovery. Vocational support was given to Marianne and her employer's HR department to support a staggered return to her workplace and Marianne received support with accessing the local leisure centre to begin increasing her level of exercise. Lastly, Marianne was also supported to access bibliotherapy to develop her confidence in managing her mood vulnerability and well-being. Marianne has been discharged for two years now and has not experienced a relapse into depression.

Psychosocial interventions are a group of non-pharmacological therapeutic interventions which address the psychological, social, personal, relational and vocational problems associated with mental health disorders. Psychosocial interventions address both the primary symptoms of the mental health problem and the secondary experiences which arise as a consequence of the mental health problem; as such PSIs are a person-based intervention rather than a solely symptom-based treatment. There

are many different therapeutic models and techniques that fall under the umbrella of PSIs such as cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT), supported employment, and peer support, and we will return to these different techniques and models later in the chapter; some are termed psychological *therapies* but they do come under the PSI umbrella.

The PSIs offered to the person experiencing mental health difficulties will depend on the type of problem they are experiencing and their comprehensive needs, taking into account the impact that the mental health problem has had on their lives. Psychosocial interventions take an overview of the person's unique situation, which is why a comprehensive and collaborative assessment process is necessary. Interagency working is also necessary because the various forms of PSI offered to the individual may come from a number of different sources. For example, someone experiencing psychosis and living with their family may be offered cognitive behavioural family interventions work (CBFI), while someone living with emotionally unstable personality disorder may be offered DBT; both may be offered vocational or educational support and possibly peer support with a view to reducing isolation. The choice is supported through the evidence base for the various therapies and interventions and the findings which support efficacy of the interventions. Following systematic review of available evidence, the National Institute for Health and Care Excellence (NICE) Guidelines for various mental health disorders also recommend specific PSIs.

No matter what model or technique is utilised, the aim of PSIs is to promote, support and maintain recovery by providing:

- a framework for a comprehensive and meaningful assessment ensuring all elements of experience which are pertinent to promoting and maintaining recovery are covered;
- support which is meaningful and psychotherapeutic;
- a framework for developing a bio-psychosocial understanding of the person's experience, developed collaboratively with the person;
- psychological interventions which reduce distress;
- psychological therapy to explore personal psychological vulnerabilities which leave a person open to ongoing mental health problems;
- psychosocial interventions which reduce the interference the mental health difficulties have on the person's life;
- support to reconnect with the social world and so reduce the deleterious impact of social exclusion and isolation;
- support to consider educational and employment opportunities;
- support to regain or develop skills which assist in self-care and activities of daily life;
- cognitive remediation to enhance concentration and cognitive processes.

Case study

Chelsea is 29 years old. Chelsea dropped out of school when she was 15 and spent three years 'sofa surfing' with friends to avoid sleeping at home. Chelsea was sexually abused by two of her mum's short-term partners when she was 8 and 14, and emotionally abused and neglected by her mum over many

years. Chelsea found employment in various cafés and takeaways and has thrown away her dream of going to university and making something of her life. Chelsea was finally re-housed by the council but ten years on, finds her life can still be chaotic. She has been self-harming by cutting since she was 9, and has had periods when she minimised this and times when she was self-harming frequently. She has moved the body area of cutting so that it is not visible to her customers and her employers. People at work view her as bubbly, if more than a little 'crazy'; she is very impulsive and can fly off the handle sometimes. They also note that Chelsea's mood is very changeable from extremes of happiness to morose-ness and anger, often triggered by the slightest of things. At home Chelsea often becomes distraught and uses alcohol to help her cope with her feelings. She does not cope well with endings or change, and is frequently lost in self-loathing and often feels alone and misunderstood. The friends she makes seem to drift away when they get to know her and Chelsea believes this is because they see her as damaged; the truth is more that they find her inconsistent mood and behaviour difficult to tolerate. Just recently her latest boyfriend has ended their relationship because of her 'moods'. Chelsea finally agrees that she needs some help to change the way she gets through her life and her GP refers her to the Mental Health Assessment Team who accept the referral.

Activity 1.1   *Critical thinking*

What would a comprehensive assessment with Chelsea reveal in terms of her needs and what areas might we need to consider addressing in order to promote sustainable change in Chelsea?

An outline answer to this activity is provided at the end of the chapter.

PSIs have gained momentum over the past two decades because of the growing recognition of psychological processes in the development and maintenance of common and more severe mental health problems. Equally more and more evidence informs us that social isolation, societal stigma and self-stigma are common experiences for people experiencing mental health problems and can impede recovery. We know the havoc mental health problems can wreak on all aspects of a person's life, and that merely reducing symptoms will not create a holistic recovery. The strengthening position of the recovery movement in mental health has also supported the fostering of treatment regimens based on PSI rather than a reliance on medication alone.

The psychosocial dimension

Sometimes in mental health we feel manoeuvred into taking a narrow perspective on people's recovery and find ourselves moving people on from mental health services when biological treatments appear to have stabilised the current health crisis; this situation means that the wider ramifications of a period of mental ill health are not addressed. The psychosocial dimension includes relapse prevention, our sense of ourselves, our aspirations, our relationships, employment, education, social

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inclusion, our ability to live independently and healthily, our sense of security in our world, our physical health and many more.

Activity 1.2   *Reflection*

Dimensions of our lives

Reflect on how many aspects of your life there are, what roles you take in your life, what responsibilities, pleasures, stresses and aspirations you have.

Imagine yourself experiencing high levels of anxiety; reflect on how living with this anxiety would impact and compromise your current life. What difficulties would it create? What might you not be able to continue doing? What might you lose because of the anxiety?

Every health problem has a psychosocial dimension so recovery must be supported within this dimension concurrently with any appropriate pharmacological and physiological treatments. Psychosocial interventions are not in essence anti-pharmacological, but are equally effective as pharmacological treatment in some disorders, e.g. depression (NICE, 2009) and are recommended as concurrent interventions with pharmacological treatments in other disorders, e.g. psychosis (NCCMH, 2014). The best treatment regimens use both in parallel, ensuring that the psychosocial intervention is delivered in a professional and ethical manner and the medication is prescribed at the minimum efficacious dose; such concurrent treatments can arguably increase self-agency in recovery.

Mental health nursing and psychosocial interventions

PSIs are a central element of a mental health nurse's role. Your key skills are comprehensive and collaborative assessment of a person's mental health needs, knowing the recommendations for efficacious intervention in mental health problems, gaining clinical skills in some of the psychosocial therapies used in treatment, and understanding the importance of the psychosocial domain in treatment and recovery. Care co-ordination itself supports a psychosocial approach to intervention because such a holistic approach needs a central person to co-ordinate the range of interventions that are appropriate and to signpost or refer to other agencies.

Case study

Derek is 46 years old. Derek has never married but had a steady long-term job with the local council and a healthy social network mostly with his friends from work. During his life Derek has had a number of short-lived episodes of low mood which he says went away with getting stuck into work, having a short holiday, supported by taking a short course of anti-depressants. He moved to Hampshire five years ago to be nearer to his elderly mother after the death of his father. Since moving

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to Hampshire Derek has been the main carer for his mum, whilst struggling to hold down a job with the local council. Nine months ago Derek hurt his back whilst decorating and has been in constant pain since then. He is on long-term sick leave from work but is now on Statutory Sick Benefit and struggling financially. Derek reported to his GP that his mood has lowered again, but that there is nothing that can bring it back up. Derek feels as if his life is a failure, he cannot work, cannot look after his mum, and has no respite from his worries and racing thoughts. He feels despairing and pessimistic. He feels trapped, lonely and hopeless.

Activity 1.3   *Team working*

As a care co-ordinator, identify the psychosocial needs that Derek has. What other agencies and professional disciplines might you need to involve in this care? How would you co-ordinate the range of PSIs indicated as appropriate in Derek's holistic recovery-led care?

An outline answer to this activity is provided at the end of the chapter.

Training and expert clinical supervision are a must to support PSI delivery. When we as nurses identify that a PSI is appropriate for someone's treatment we must ensure that it is delivered at an appropriately high standard and that the quality of the intervention is rigorously monitored. Some forms of PSI require more training than others; CBT and DBT (two of the psychological therapies under the PSI umbrella) for example require professionally led clinical training followed by structured clinical supervision, whereas PSIs that focus on employment or educational needs will have a different training and supervision structure, and some PSIs such as using a cognitive behavioural approach to intervention can be supported through less intense training and good supervision – but using this approach for example is not the same as delivering CBT, and it is important that we know what we are delivering and are aware of the limitations of our knowledge and skills. It is equally important that we do not undertake to deliver PSIs that we do not thoroughly understand or have not received appropriate training for, particularly so when we are considering the psychological therapies.

Theoretical underpinnings of psychosocial interventions: the stress-vulnerability model

Psychosocial interventions are underpinned by the stress-vulnerability model of health; it is important that we spend some time in this introductory chapter familiarising ourselves with this key concept.

Whilst there were earlier writers developing the stress-vulnerability model, Zubin and Spring offered a seminal paper on this model in 1977 focusing particularly on psychosis, and other

writers have continued the development of the model since and considered it as a framework for wider psychopathology (e.g. Nuechterlein and Dawson, 1984; Ingram and Luxton, 2005). Within this model both the impact of stress on the individual and their predisposing vulnerabilities are recognised determinants of health. In mental health, this model supports the understanding that all of us have particular biological and psychological vulnerabilities to developing mental health problems or illnesses when combined with a 'critical' amount of stress in our lives. Indeed, the understanding of the interaction of stress and vulnerability is arguably essential for understanding the development of mental health problems (Ingram and Luxton, 2005).

Nuechterlein and Dawson (1984) proposed that enduring vulnerability plus stress leads to a transient intermediate state of a cognitive, interpersonal and intrapersonal processing overload which leads to 'outcome behaviour'. They specifically looked at psychosis and so deemed the outcome behaviour to be the symptoms of psychosis, but we can extrapolate from their modelling to other mental health disorders, whereby personal vulnerability plus stress lead to a similar overload which results in anxiety disorders or depression, self-harming behaviour, 'behaviour that challenges', or another expression of mental distress. 'Behaviours that challenge' is a term in the mental health field which describes 'actions and incidents that may, or have potential to, physically or psychologically harm another person or self, or property' (SA Health, 2012)

How do we define stress?

Stress is an accessible lay concept; we can each quite readily recognise stress by reflecting on our own lives. Stressors, those elements of our life which cause us to experience stress, can be significant life events; for example one highly significant event, a traumatic experience, a major life change, a personal loss. But stress can also be a culmination of minor life stressors which add up to a major stressful impact on our life and so on our health, both mental and physical.

It is important to note that stressors can be external or internal. External stressors are, as noted, easily identified. But how do we account for individual differences in response to common stressors? The answer is that the very manner in which we perceive and then appraise the stressor is dependent on our own cognitive and psychological make-up. Some of us may find particular life events easier to cope with because we do not view them as a significant threat to our psychological or physiological integrity; we do not see them as insurmountable, life changing, challenging, or bringing with them serious personal consequences. We have a sense that we are capable of managing the particular stressors; we either are confident in our personal resources or have a supportive network to help us cope. But others of us will see the same stressor as being more threatening or consequential, and more perhaps we do not have the same 'coping' styles, so that we make a different appraisal of the stressor and that determines our response to it.

Experiencing stress impacts on our wellbeing because it disrupts our usual ways of coping with our lives. Stress upsets both our physiological and psychological processes, changing our thought processes, our emotions, and the way our body responds. Our immune system can become compromised because of this impact causing us to be more physically vulnerable to ill health, and stress hormones such as adrenaline and cortisol can impact on other physiological systems such as our blood pressure and our digestive system, causing further problems.

Ways that we would normally manage our lives become compromised, and those strategies familiar to us for coping become inaccessible or useless. We probably find ourselves not coping as well as we usually would, behaving in unfamiliar ways, and instead of managing the difficulties that have arisen we find that we are overwhelmed and disabled by the stress, often stuck in attempts to manage the stress which inadvertently maintain our stressful experience rather than alleviate it. Over time stress becomes distress, and our lives and our mental health become more seriously impacted.

How do we define vulnerability?

Vulnerability is defined as a predispositional factor that makes us more likely to respond to stress in particular ways and so more likely to develop problematic mental health states. Vulnerabilities are biological, genetic and psychological. Biological and genetic factors are stable and usually latent factors within a person's make-up, which become known when a critical mass of stress is experienced. Vulnerability to psychosis is often the case that is given as an example. Whilst the aetiology (cause) of psychosis is not certain, there is evidence that suggests a biological or genetic vulnerability for the development of this disorder, which is latently but enduringly present within the individual, only developing as a mental health illness following the experience of personally significant levels of stress (Zubin and Spring, 1977; Nuechterlein and Dawson, 1984). Psychological vulnerabilities can stem from faulty learning (Ingram and Luxton, 2005) or exposure to traumatic or abusive events during earlier years (Lanktree and Briere, 2008), including from dysfunctional attachment to primary care givers (Gumley et al., 2014). Vulnerabilities are now robustly argued to include reduced cognitive processing capacity, autonomic hypersensitivity, and interpersonal and personal skill deficits including poor emotional literacy, and equally robustly shown to be linked to mental health problems (Ingram and Price, 2010).

The important factor about biological and psychological vulnerability factors is that they are accessible to treatment and so to change. For example, autonomic hypersensitivity, a biological vulnerability which is linked to anxiety disorders, is responsive to medication and to psychological interventions (Anxiety Care UK, 2014). Psychological vulnerabilities are highly responsive to PSIs.

Vulnerabilities can be defined as proximal or distal factors. Distal vulnerability factors, meaning further away from the onset of the mental health problem, might include developmental experiences which were aversive to normal development, and perhaps developed in us low self-esteem, or a view of the world of being threatening and untrustworthy. Proximal vulnerability factors, meaning closer to the development of the mental health problem, might be the thinking styles or coping strategies which we have developed for managing stress, but which are influenced by our distal vulnerabilities and so not necessarily helpful strategies for resilience and stable mental health. Both types of vulnerability play a role in the development and maintenance of mental health disorders and both are amenable to change through PSIs (Ingram et al., 2011; Beck, 1976; Beck et al., 1979).

The convergence of stress and vulnerability

The stress-vulnerability model perceives mental health problems emerging as vulnerabilities and stresses converge and become too great a task for the individual to manage.

We all have a particular vulnerability to developing some form of mental distress given our 'critical' amount of stress. We probably do not know in advance what form that distress might take, nor will we be aware what our maximum capacity for stress will be. However, we will all be somewhere on the vulnerability axis depending on our early experiences and our biological and psychological make-up. Then, as our lives go along we will inevitably experience stress; the more stress, the higher up the stress axis we move. At a critical convergence of stress levels and vulnerability we will reach and go beyond the 'distress' line. Beyond this line, our vulnerabilities cause us to not have sufficient capacity to cope with the stresses, and our strengths and natural coping mechanisms are insufficient to manage the distress caused by our life stressors. It is at this point we begin to experience disordered emotional states which drive responsive behaviours; for some this will be an anxiety disorder, for others psychosis, for others depression. For some it will be expressed as self-harming behaviour or 'behaviours that challenge'. Figure 1.1 is a common and simplified depiction of this model.
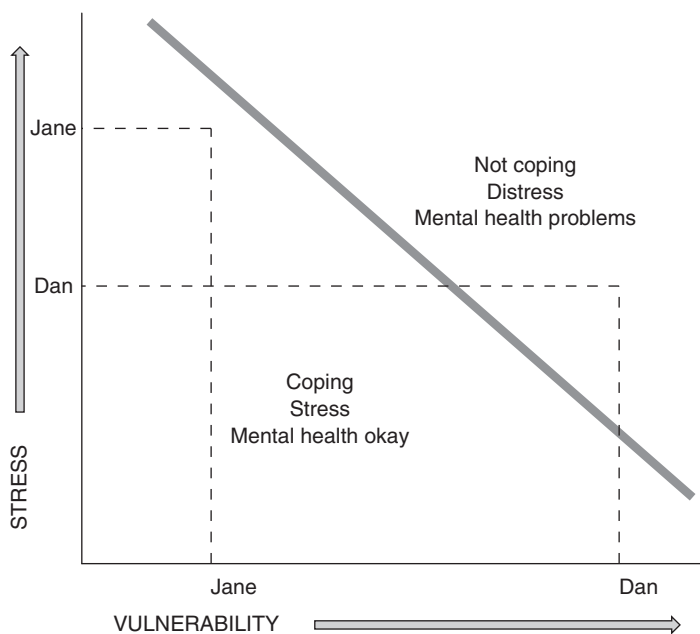

Figure 1.1: The stress-vulnerability model

We can see from Figure 1.1 above that when we use this model to understand the development of mental health distress we can visualise the convergence of stress and vulnerability and the development of psychological and emotional states which are beyond our capacity to manage.

We all have a level of vulnerability to developing mental health difficulties, we all have a limit to the amount of stress we can manage, we all have a 'critical point' when stress and vulnerability meet, and we can all cross the line into not coping, distress and mental health difficulties. None of us is absolutely aware of our vulnerabilities, and neither our ability to cope with life stresses. We do not know where our 'critical point' is, where we will cross the line in non-coping and distress (see Figure 1.1), nor do we know how our distress will be expressed; it may be anxiety, depression, psychosis or behaviours driven by an underlying personality disorder.

If we consider Jane from Figure 1.1, we can see that she has a fairly low vulnerability to developing mental health problems and so can manage a high amount of stress with lower consequences on her mental health. Dan, however, has a higher vulnerability to developing mental health problems and so it takes less life stress to move him across the line to distress and mental health difficulties.

Take some time to practise explaining this model of understanding mental health. The more familiar you are with this model the more confident you will feel when explaining it to service users.

Using psychosocial interventions informed by the stress–vulnerability model

We develop an understanding of a person's episode of mental health difficulties by assessing for present stressors, vulnerability factors and psychological make-up. We need to know what problems they are experiencing in their lives at this time (stressors), how they are appraising these difficulties (psychological make-up) and whether there are significant past events which have contributed to their current appraisal (vulnerabilities). That is, are there significant past events which influence the way they are reacting to their current stresses? We also need to know about strengths, both internal, e.g. cognitive styles, and external, e.g. social support. Psychosocial interventions aim to address the distress experienced by the person and the consequent disruption to life, so it is important that we gather information both about the level of subjective distress and about how people's lives have changed since the onset of their mental distress. This gives us a baseline for recovery and identifies therapeutic goals. When we have this information we are in a position to decide which PSIs will be most appropriate to promote and support recovery in that person.

Case study

Nicki is just 17 years old; her early life was troubled due to the tempestuous relationship between her parents. The father was gaoled for serious domestic violence when Nicki was 7 and she has not had any contact with him since. She has few friends at college as her experience of school has not been a happy one and she finds it difficult to trust her peers. Nicki has experienced ongoing bullying from a group of girls at her secondary school, including two incidents of physical harm from the group, one of which was filmed and posted online which caused Nicki to feel publicly humiliated. For a long time Nicki felt low and scared but recently has found a group of friends outside of the college who appear to accept her for who she is. Nicki has begun to spend most evenings and weekends with her new friends. They mostly hang around in the park, not causing trouble, but do smoke a lot of cannabis and dabble in other drugs. Nicki was beginning to feel happier, but suddenly finds herself feeling anxious again

(continued)

and a little paranoid, and now is aware that she is hearing a voice that no one else can hear. Nicki is worried because her Uncle David has had quite severe mental health problems all his life, so finally she confides in her mum. Nicki reluctantly attends a GP appointment with her mum and is referred to the Adult Mental Health Services.

Activity 1.4   *Critical thinking*

If Nicki was offered only anti-psychotic medication, what would be missed in promoting a holistic and sustainable recovery?

An outline answer to this activity is provided at the end of the chapter.

The importance of a stress-vulnerability approach to mental health

This understanding of psychopathology affords us as nurses a valuable opportunity to intervene therapeutically and meaningfully. It defines mental health disorders as consisting of domains (stress and vulnerability) which are understandable and accessible to biological, psychological and social interventions. Let us consider depression: we know that certain early events and life experiences make us more vulnerable to developing depression given our critical stress capacity, and we have evidence that biological (medication and exercise), psychological and social interventions are effective in promoting and maintaining recovery (NCCMH, 2010). Our practice is therefore guided by using this stress vulnerability framework to help develop a collaborative understanding of the development and maintenance of the depression, the identification of strengths and of underdeveloped skills, and the use of PSIs to address recovery through addressing psychological vulnerabilities and both internal and external stressors.

Case study

If we think back to Derek, we are not sure from the information we begin with about what has caused Derek to be vulnerable to developing depression when life stresses become unmanageable, so our journey would begin with exploring his life experiences and his psychological make-up to better determine what his vulnerabilities are. We also need to know what stresses he is able to cope with without experiencing low mood, and those which trigger low mood. We are aware that he has had a previous strategy for coping with his mood change, which seemed to work for him. We need to assess what is different for him now that is causing his previous coping strategies to be less effective. For Derek,

triggers for this episode of low mood are likely to be internal as well as external. We know that he is managing a great deal of stress from his current life circumstances and that there are many depressogenic factors around for Derek such as many losses in recent times (father, old work mates, old role in life, physical ability, financial security). We also know that people with recurrent depression can experience relapse because there is an overreaction to negative thoughts and short-term low mood, fuelling a relapse into depression. Thus, we need to engage Derek in an exploration of vulnerabilities, current stresses, previous strengths and what is causing these previous strategies not to work now. We can develop an understanding of those strategies and explanations we need to develop in Derek to help promote and sustain his recovery this time.

We might for example offer CBT to address the psychological depressogenic vulnerabilities and the internal stressors of negative thinking and we might offer psychosocial support through behavioural activation and increasing social contacts to address isolation and the withdrawal from opportunities offering positive feedback. There may too be issues of employment support and support increase in physical exercise, as well as monitoring medication regimens.

What kinds of psychosocial interventions are there?

Many PSIs exist and their point of focus varies. Difficulties in life are never isolated to one issue, or exist only in one area; difficulties in one area impact on other areas of life. Being anxious will influence your relationships, how you are able to be with your friends, how you are able to remain in employment or not. A useful element of PSIs is that when we choose a target for treatment, benefits from that specific focus will ripple out into other areas of our lives that had become problematic. So we might focus on anxiety management, but through that focus you may be able to sustain a return to work or develop confidence in friendships again. Indeed the most effective PSIs encourage the recipient to extrapolate the learning from a specific focus of therapy to other areas of their life, thus allowing for the generalising of successful experiences, new learning and change. Psychosocial interventions are collaborative in nature and as such do require the use of good engagement skills to develop and support a commitment by the person to engaging with the intervention. The recipient is an active participant in any PSI, ultimately being left at the end of the PSI input with the skills to maintain and further promote their own recovery thereby increasing well-being and reducing the likelihood of relapse.

Table 1.1 indicates the types of interventions that can fall under the umbrella of PSI. Their range is wide because the psychosocial domain of our lives is diverse. Psychosocial life elements are also inter-related so that addressing one area will influence another. This can be illustrated for example when focusing on increasing social contacts for people living with psychosis in that this enhanced relational aspect of their lives can impact positively on self-esteem and improved mood.

Cognitive behaviour therapy	Group interventions	Physical health monitoring
Mindfulness-based cognitive therapy	Independent living skills	
	Coping strategy enhancement	Lifestyle education
Dialectical behavioural therapy		Vocational support
Acceptance and commitment therapy	Health education	Peer support
	Cognitive remediation	Spiritual support
Compassion-focused therapy	Computer-assisted therapy	Social support
Schema-focused therapy	Self-help	Social skills training
Psychodynamic counselling	Bibliotherapy	Social inclusion
Family interventions		

Table 1.1: Interventions under the PSI umbrella

Descriptions of some psychosocial interventions

Here are some brief explanations of a few PSIs to begin to develop your understanding and knowledge; the book will of course cover some in depth.

Cognitive behavioural therapy

Cognitive behavioural therapy is a psychological therapy developed by Aaron Beck in the 1960s. This model explores the sense we make of events (our thoughts), how unhelpful thoughts and thinking styles are associated with troublesome emotional and physiological states, and drive behaviours which maintain our problems rather than resolve them. CBT has a robust evidence base across many mental health disorders. To deliver the therapy, specialist training is required. Traditional CBT is termed 'second wave' CBT.

Third wave cognitive therapies are those CBT-based therapies which do not work to challenge thoughts but focus on acceptance of the troublesome or distressing thought and a non-reactive acknowledgement of them.

Cognitive behavioural family interventions

Cognitive behavioural family interventions are supported in the NICE Guideline for the treatment of psychosis (NCCMH, 2014) for all individuals experiencing psychosis who remain in contact with their families. This therapy works with the whole family unit to explore the problems associated with the presence of psychosis within the family unit. It uses collaborative approaches to distress and problem minimisation through enhancing understanding and communication within the family.

Mindfulness-based cognitive therapy

A third wave cognitive therapy using mindfulness-based cognitive therapy (MBCT) as a therapeutic technique (Segal et al., 2002). Mindfulness is a form of meditation which allows for an awareness

of distressing emotional arousal or problematic cognitive processes to be gained by the person and then to apply a meditative approach to managing and changing that response or process. This therapy is developing an evidence base of effectiveness for both depression and psychosis.

Acceptance and commitment therapy

Acceptance and commitment therapy (ACT) is a 'third wave' cognitive therapy (Hayes and Strosahl, 2004) which focuses more on the behavioural component of a person's problematic experience, exploring the function of the behaviour rather than the content. ACT can be used transdiagnostically – that is that this is a PSI which is not linked specifically to the treatment of a particular diagnosable mental health condition but can be used for a variety of psychologically distressing experiences whatever the underlying cause.

Person-based cognitive therapy

Person-based cognitive therapy (PBCT; Chadwick, 2006) is another third wave cognitive therapy, used specifically for people who hear distressing voices.

Dialectical behaviour therapy

Dialectical behaviour therapy (Linehan, 1993a) is a further third wave therapy which is designed for working with people who have specific personality disorders.

Psychodynamic counselling

Psychodynamic counselling works through the present to access the past which is believed to influence us in the present but perhaps outside our consciousness. This allows for exploration of subconscious conflicts within ourselves that are keeping us stuck in our present problematic and distressing circumstances. Psychodynamic counselling can be used for a broad range of issues including relationships, anxiety, depression, trauma and abuse.

Bibliotherapy

Bibliotherapy uses books to treat mild mental health problems. People can be helped by reading appropriate 'self-help' material. Books are now available covering a wide range of subjects including anxiety, bereavement, depression, self-esteem and stress. Such books are usually written by field experts and offer explanations, first person accounts and practical tips. Bibliotherapy can be either supported or unsupported by a nurse or clinician. This style of intervention can be offered at any step in the care pathway from pre-primary care to secondary care.

Support groups

Support groups are therapeutic forums in which people who share similar experiences, problems or aims meet together to support each other in staying well. They can be facilitated by nurses and other professionals, or can be self-facilitated. Support groups can be created to support many problematic experiences and have an additional social context compared to individual support or therapy.

Computer-assisted therapy

Computer-assisted therapies have grown in number over the last few years due to the accessibility and increasing reliance on computer technology. They are special online learning packages similar but going beyond bibliotherapy. Like bibliotherapy, computer-assisted therapies can be facilitated by professionals or done alone. This type of therapy most often addresses depression but its range is widening particularly due to the increase in therapy 'apps' for smart phones.

Vocational support

Vocational services provide support and practical help for people with mental health problems who want to return to work. Support can be through individual support outside of the workplace or can be supporting someone during their return to work within the workplace and through negotiating with employers.

Creating an environment for psychosocial interventions in mental health care

Mental health service provision has been through radical changes over the past 40 years in the UK since the movement to close off large asylum-oriented care and embrace community-based care. There have been several reorganisations of NHS and social care services over these years, and variations in funding, but provision of mental health treatment continues to be under-resourced (LSE, 2012).

Back in 2007 there was an increased sense of optimism about NHS mental health service provision. The 2007 Appleby Report *Mental Health Ten Years On: Progress on Mental Health Care Reform* on the then Labour Government's ten year plan of mental health reform launched in 1999 noted an increase in mental health funding, major developments in community mental health teams with 100,000 people being treated at home rather than admitted to hospital and large increases in all the main staff groups, including a rise of 1300 consultant psychiatrists, 2700 clinical psychologists and almost 10,000 mental health nurses. The national patient survey at that time showed that 77 per cent of community patients rated their care as good, very good or excellent. The suicide rate had fallen to the lowest figure on record – and records began in 1861 – and the WHO said that England has the best mental health services in Europe.

This ten-year programme included the establishment of NICE to provide national guidance and advice to improve health and social care. These NICE Guidelines for best clinical practice provided recommendations for treatments based on a systematic review of research evidence, and such recommendations support the use of PSIs in mental health care.

The development of IAPT and the Stepped Model of Care

In 2008 the National IAPT (Increasing Access to Psychological Therapies) services were developed, providing evidence-based psychological and psychosocial treatments for people experiencing depression or anxiety disorders in primary care. IAPT services were developed around the Stepped

Model of Care (NICE, 2011) whereby care provided is initially the least intensive intervention that is appropriate for that person, and people can step up or down the care pathway as according to changed needs and in response to treatment. At present, Steps 1 to 3 are primary care and IAPT, Step 4 is community mental health care, and Step 5 is inpatient or equivalent intensive home treatment and specialist mental health services. What this does mean is that there is a provision of different PSIs depending in which Step people are accessing their mental health care.

IAPT is in an initial six-year expansion programme, fully-funded in the Governmental Spending Reviews and designed by 2014 to provide NICE-recommended psychosocial and psychological therapy in Steps 2 and 3 care services each year to 15 per cent of those in the general population suffering from depression or anxiety disorders with a target recovery rate of 50 per cent. IAPT services are developing further, 2013 onwards, to consider how to increase access to psychosocial and psychological therapy for people experiencing severe mental health problems such as psychosis, bipolar disorder and personality disorder. These are likely to include workforce development in Steps 4 and 5 so that this provision can be provided by mental health practitioners, including mental health nurses, in these services.

A continuing struggle

A change of UK Government in 2010 brought in superseding mental health policy documents beginning with the 2010 *Equity and Excellence: Liberating the NHS*, developing the role of NICE through their provision of quality standards for care. This was followed in 2011 by the *No Health without Mental Health* strategy with six shared objectives:

1. more people will have good mental health;
2. more people with mental health problems will recover;
3. more people with mental health problems will have good physical health;
4. more people will have a positive experience of care and support;
5. fewer people will suffer avoidable harm;
6. fewer people will experience stigma and discrimination.

However, in 2012 a report by the Mental Health Policy Group at the London School of Economics (LSE) *How Mental Illness Loses Out in the NHS* (LSE, 2012) noted that among people under 65, nearly half of all ill health is mental health illness, yet only a quarter of those are in treatment. They state:

> *The under-treatment of people with crippling mental illnesses is the most glaring case of health inequality in our country.*
> (p2)

In 2013 the UK Government published *Making Mental Health Services More Effective and Accessible* applicable to England NHS and social care services. The policy notes that the largest cause of disability in the UK remains poor mental health, and notes the link between poor mental health and a range of psychosocial problems such as employment, parenting, relationships, poor physical health and educational prospects. The aim of this latest policy is to force equality between mental and physical health services, make reducing mental health problems a priority for Public Health England, and include in these changes a further increase in the provision of psychological therapies.

Embracing an evidence-based treatment approach within mental health services should be the role of all mental health nurses, independently of the vagaries of Government. The potential annual savings to the NHS from the provision of interventions to treat depression for those currently untreated could be as high as £16 million by 2026 (King's Fund, 2008).

Psychosocial treatments are shown to be effective in promoting and maintaining recovery, and the ethos of mental health nurses is to promote and support recovery. More, there is a professional empowerment in being directly involved in the recovery process of service users and delivering PSIs as an adjunct to medication, and providing a comprehensive treatment package offering a different quality of recovery than a medication-only approach. Indeed the 2006 *From Values to Action: The Chief Nursing Officer's Review of Mental Health Nursing* made a series of recommendations as to how mental health nurses could best improve the care provided to people with mental health problems. It noted that mental health nurses should incorporate the broad principles of the Recovery Approach into every aspect of their practice, being positive about change and promoting social inclusion for mental health users and carers. There was also a focus on improving outcomes for service users underpinned by the principles of PSIs: positive therapeutic relationships, taking a holistic approach and providing more evidence-based psychological therapies. Embracing a psychosocial approach to mental health nursing care and availing ourselves of the range of PSIs is a good step forward for all, our service users and our profession.

Chapter summary

- Psychosocial interventions should be used in mental health care to support a comprehensive and person-based effective approach that promotes and sustains recovery.
- Psychosocial interventions are underpinned by a parsimonious theoretical understanding of the development and maintenance of mental health problems – that is, a theory which is able to be simple and accessible and acceptably or robustly explanatory.
- There are many interventions which fall under the psychosocial umbrella; comprehensive and collaborative assessment guides the choice.
- It is an intrinsic part of every mental health nurse's role to incorporate a psychosocial approach within their mental health nurse practice.

Activities: brief outline answers

Activity 1.1 Critical thinking

A comprehensive assessment might reveal the need for emotional coping skills or DBT.

Other areas to address might include: independent living skills, a return to education, psychological therapy to resolve trauma and vulnerability from her experience of recurrent abuse, relationship skill development, substance misuse education, assertive engagement to support Chelsea in committing to her care package.

Activity 1.3 Team working

Your answer might include: noting the major life change that Derek undertook five years ago, the reduction and loss of his social network, the increased burden of looking after his ailing mother, the loss of his father, his previous vulnerability to depression, current loneliness, financial pressures, employment insecurity, insecurity

and possible pessimism about his future, ongoing physical ill-health, constant pain, depression. Agencies which could be part of a comprehensive psychosocial care package would include the mental health team, carer's support services, Derek's GP, physical health community teams, pain-management teams, physiotherapy, befriending services, peer support, social services to support the care for his mum. Co-ordination of such a complex inter-agency care package could be undertaken by the mental health care co-ordinator whilst Derek is under their care. This role would require good communication with Derek and all the agencies with an agreed format for sharing appropriate information. Aims and goals for this package of care, with agreed time scales for interventions, and agreed relationships with other agencies once Derek is discharged from mental health care are vital to prevent relapse and to support his sustained recovery from depression.

Activity 1.4 Critical thinking

Your answer might have included: psychological therapy to resolve the life traumas she has experienced which will act as a vulnerability to her future mental health, PSI to understand her potential increased vulnerability to developing psychosis and to strengthen her skills to minimise this potential outcome, relational and social literacy, substance misuse and its links to mental health problems and personal vulnerability to harm or exploitation from others, even for example the need for assertiveness training.

Further reading

Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care (Update) [Internet]. Chapter 8. NICE Clinical Guidelines, No. 82. National Collaborating Centre for Mental Health (NCCMH), UK.

This chapter looks at psychological therapy and PSIs in the treatment and management of schizophrenia. It is available as an electronic book.

Mullen, A (2009) Mental health nurses establishing psychosocial interventions within acute inpatient settings. *International Journal of Mental Health Nursing*, 18(2): 83–9.

This article looks at the problems with mental health nursing practice in acute inpatient units, putting forward an argument for routine use of PSIs as a way of addressing some of these issues.

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

This book provides further foundations in common psychological interventions used in mental health nursing.

Useful websites

www.bps.org.uk

The website of the British Psychological Society provides information and links to information about the use of psychology for the public good.

www.mind.org.uk/information-support/drugs-and-treatments/?gclid=COaq8cj7kb8CFUTItAoda WYAjA

MIND have a wealth of resources for mental health including information on PSIs which is written in clear language and especially useful for sharing with service users.

www.nice.org.uk/CG51

The National Institute for Health and Care Excellence website hosts a whole array of guidance designed to help us provide high quality care. This Clinical Guideline (51) outlines PSIs recommended for drug misuse.