

## **Assessment for counselling and the psychiatric services**

by Ian Rory Owen<sup>1</sup>

This article is written with the belief that counselling is better informed if it knows about psychiatry. Psychiatric emergencies occur and if they are handled well, the experience can be positive for clients and counsellors alike. But most of the general population do not understand the complex and contentious issues surrounding psychiatry. The current state of understanding indicates that psychiatric conditions are due to inherited predispositions, which may be triggered by stressful situations or drug use.

The BAC code of ethics states that it is outside the remit of counsellors to work with those who are beyond their ability to provide the care clients need. This situation is compounded by third parties asking for your help, asking you to see their partner, colleague or friend who might be acutely distressed. In my experience, more senior counsellors may see people who have a psychiatric disorder, but most in the profession disagree with the imposition of psychiatric treatment, the improper use of diagnostic terms, misdiagnosis and mistreatment. This paper contains the starting point that if counselling is about forming an alliance with clients in the direction of their positive mental health, then there is a case for sharing this responsibility, when they are acutely distressed. If counsellors are reluctant to notify the GP or emergency psychiatric services for those who can no longer cope, and they have no knowledge of psychiatric diagnostics, then clients are let down.

### **The ethics of diagnosis**

Working with neurotic clients is a high level of responsibility and can be challenging and stressful. Problems can arise for a number of reasons when counsellors come into contact with people whose level of disturbance is high. Psychiatric emergencies can arise after a person

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comes through a deep depression and regains sufficient energy to act on suicidal thoughts. They also occur when someone is troubled by auditory, visual or kinaesthetic hallucinations. If someone has lost their ability to look after themselves, then it behooves counsellors to make appropriate referrals. They may act on them to harm themselves or others. Counsellors may be faced with attempted suicide, persons at risk of suicide, and those who are currently psychotic. Given that a great deal of distress results for counsellors whose clients commit suicide after or during contact with them, it is easiest to proceed when they know where they stand on the boundaries of the relationship they provide. The BAC Code of Ethics, B.4.11, states that counsellors

...hold different views about whether or not a client expressing serious suicidal intentions forms sufficient grounds for breaking confidentiality. Counsellors should consider their own views and practice and communicate them to clients and any significant others...

BAC 1990

But is it within the remit of counsellors to notify the psychiatric services, if agreed with clients beforehand, in the possibility of someone being psychotic or a suicide risk? My answer is yes. I believe that counsellors have the responsibility to recommend a psychiatric assessment as part of their role.

The full spectrum of psychiatric disorders can be split into three broad types. Here I use the term "mental illness" but it is not really suitable. Those who suffer in this way come from all races, cultures, classes and family constellations. The word illness is only partially suitable because it refers to behaviour, personality and abilities, and is not an illness at all. There are those who can make a full recovery through medication, general life changes, counselling or therapy. But some people do not respond, and the changes for them are irreversible, or they deteriorate despite all the help that can be provided.

The amount of people with *psychotic illnesses* is less than one per cent of the population, of whom ten per cent commit suicide as an escape from torment. About one per cent of all people have one of the *depressive illnesses*, and between ten and 15 per cent kill themselves. The third

major psychiatric category is *personality disorder*, and over one per cent of the population are like this. They may kill themselves on impulse, or in an attention-seeking gesture that goes wrong. Good overviews of the psychiatric terms, the role of the psychiatric social worker and psychiatric nursing are found in Fish (1985), Brown (1987) and Townsend (1991).

Thomas Szasz has done much to point out the ethical and legal dilemmas in psychiatry (Szasz 1972). Contrary to him I think there is a good argument for "sectioning": placing people under sections of the Mental Health Act 1983. If a person wishes to receive psychiatric care voluntarily, then there is no need to detain him or her by a section, a legal-medical warrant. Szasz believes that sectioning in psychiatric care is wrong because it is against what he sees an ethical imperative for people to be self responsible and free: But, psychiatry is bound to carry out the law. Szasz's argument implies a request to accept those in acute distress, and asks that they be left alone if they do not ask for help. The other side of this argument acknowledges the needs to provide treatment and social control. I am critical of those who are ignorant of the Mental Health Act 1983 and its sections which have much significance to counselling and psychotherapy. Under the Act those who are a risk to themselves or others may be taken to a safe place, so the public is protected from possible attack. The argument for sectioning aims to reduce suffering on humanitarian grounds, even against someone's will.

<u>Section</u>	<u>Brief description</u>
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| 2   | Admission for assessment up to 28 days.   |
| 3   | Admission for treatment up to 6 months.   |
| 4   | Admission for emergency treatment up to 72 hours.   |
| 115 | Gives an ASW the power to enter and inspect any premises in which a mentally disordered person is living.               |
| 136 | Gives a police constable the power to remove to a place of safety a person whom he finds in a place to which the public |

have access, and who appears to him to be suffering from mental disorder and be in immediate need of care.

Fig 1 - Some sections of the Mental Health Act 1983.

For myself, if I or a member of my family became mentally ill, then I would want them to have treatment by those who are experienced in it at the earliest opportunity. It can be part of the nature of mental illness that people are not capable of making informed decisions. The sections mentioned above allow those in suffering to be held in a hospital and even medicated against their will. The roles of Approved Social Worker (ASW) and psychiatric staff are to balance the rights of the distressed individual with those of the community at large. As there is no strict dividing line between neurosis and psychosis this is a difficult decision to make. When people are held in a psychiatric hospital it requires the permission of the ASW, general practitioner and psychiatrist to make the application for a section. The ASW must try to contact and inform the nearest relative about the procedure and implications of the section, and they may also give their permission for the section to be carried out. On arriving at the hospital the staff inform clients of their rights. It is possible to appeal against the section, and another psychiatrist would be called in to give a second opinion.

### **On counselling assessment**

Assessment is part of counselling as it formalises the process of selecting who you are going to work with, and whether they are within one's current boundary of competence. Assessment for counselling could be carried out as part of the first six sessions perhaps, and may involve taking a formal history of any previous contacts with the mental health services, any current medication, and record clients' addresses and GP details. The dilemma in assessment is whether to ask direct questions to get the details you need, or whether to let clients unfold their history in their own way. The first step is determining if a client's level of distress is sufficiently high to require an emergency intervention. The second step is knowing how to refer a client in acute distress to the emergency services. Therefore, it is necessary to have a working knowledge of psychiatric diagnostics. An assessment could:

1. Partly be "needs led" and totally from clients' perspectives.
2. Also allow counsellors to identify areas of unmet need and issues clients may need to focus on.
3. Provide clients with choice, flexibility and information so that they can make an informed commitment to counselling.
4. Be orientated around the principles of monitoring the quality of care being provided, and "helping, not harming".
5. Assessment will also include setting the boundaries of the counselling relationship, assessment of the type of intervention required, and psychiatric assessment.
6. Assessment will be on-going, as counsellors monitor their own performance, alone and through supervision, monitor clients' progress, and review the ground covered, while being open about their own limitations.
7. Do you have a strong emotional reaction to meeting them? Do you like them? You do not necessarily have to work with them. It is a sign of maturity to refer on clients who would be best helped by a specialist or more experienced counsellor, or more appropriate form of treatment.

### **Boundary of competence**

There are definitions of the counselling role provided by BAC. Counsellors must know their limitations and capabilities in working, particularly with those clients who may not be helped by a talking cure. The Code of Ethics states that counsellors should "monitor actively the limitations of their own competence ...", (B.2.2.17) and "make appropriate referrals...", (B.2. 2.19). This is done by gaining clients' permission before conferring with others. Also, counsellors shall withdraw their contact if they cannot "work within the limits of that competence ...", (A.4), and when counselling is not helping. Among other qualities counselling provides confidentiality, clear boundaries, safety, permanence and stability. The issue of responsibility also has a boundary which is crossed with peril. The Code of Ethics states:

Exceptional circumstances may arise which give the counsellor good grounds for believing that the client will cause serious physical harm to others or themselves,

or have harm caused to him/her. In such circumstances the client's consent to a change in the agreement about confidentiality should be sought whenever possible unless there are good grounds for believing the client is no longer able to take responsibility for his/her own actions...

#### B.4.4.

These responsibilities are unavoidable. On the one hand, if clients understand a counsellor's statement that they might be best helped by seeing a psychiatrist, then it could be the last straw for someone who has been trying to cope with the help of counselling. Asking depressed clients if they are suicidal, or telling them about the limits of the provision of the care you provide, may cause them to think that they are beyond help: that counselling has not "worked", and as a result they become more desperate. On the other hand, clients may think that they are being taken seriously at last, and this may end any future ruminations on suicide. Another possible understanding is that the same recommendation could be felt as a rejection. It is how your communication is interpreted that counts. So counsellors need to check and ascertain if they have been understood as they wished, and check on the impact of what they have said. Clients reactions are critical at this time and supervision is the place for counsellors to plan and review these interventions.

### **On breaking confidentiality**

Supervision is mandatory for all those who have elected to become members of BAC (B.3.1). Being in supervision is not breaking confidentiality, and neither is asking for the help of another professional, when you know clients require help that you cannot provide. Supervision is an on-going commitment for reasons of safety, stress management, and to provide counsellors with a format for on-going learning and reflection on the effects of their interventions.

A helpful perspective is gained by comparing counselling practice to that of psychologists. Confidentiality is discussed by Bromley who suggests that there are several levels of confidentiality appropriate to different situations (Bromley 1981). Bromley offers one aspect of confidentiality which concurs with the BAC Code, B.4.6: "Counsellors should take all reasonable steps to communicate clearly the extent of the confidentiality they are offering to

clients". Bromley concludes that at first confidentiality should be all embracing, but this may be changed if necessary, and in consultation with clients. At no time do psychologists disclose they are in supervision. As the meetings continue, it is left to the discretion of psychologists to disclose information to others as needed, and this is done in a professional manner.

### **In case of emergency**

An aspect of the counsellors' role is to play their duty as citizens who acknowledge the law and who know how to gain access to the emergency services on clients' behalf. If the route to making a referral to the psychiatric services is made, the procedure is first of all discuss your reasons for involving other professionals with your supervisor. Then give your reasons to clients so you may both discuss how to proceed. If clients give permission then contact their GP who will check that you already have permission to make that notification. The responsibility has now been shared, and it is up to the GP to make a home visit, or call in other help, if the GP feels it necessary. If the GP decides that the situation requires a psychiatrist to make an assessment, then this will be arranged. If an ASW is called to make an assessment, then they have to talk to people in a manner appropriate to them. ASWs are not out to admit all whom they assess.

If clients do not give permission for you to make this contact, then you should request them to seek help themselves. Put your opinion forward and state your concerns. Explain that you feel they need to see a doctor who could help them. Counsellors would gain from establishing a link with their local mental health unit so that a first contact is made prior to any emergency referral.

There are other issues which counsellors also need to consider. These include asking clients if they have previously seen a psychiatrist or GP for help, and asking permission to make contact. If agreed counsellors could make a referral to the GP in writing, or by telephone, and request a psychiatric assessment for clients. This is an appropriate way of sharing responsibility for clients in crisis. For those who are no longer self-responsible, counsellors can notify the GP, or duty psychiatrist at the client's local hospital. If you feel harm is about to occur you could contact the duty ASW in an extreme so that the services receive a referral. You also need to work out where you stand on the possibility of giving clients your home phone number and asking them to ring you if they cannot cope. This option has repercussions as it distorts the usual

counselling relationship. In the event of taking a holiday when clients are acutely distressed, you could ask a colleague to cover for you. It may be possible to have the phone number of the local emergency out of hours social work team to hand and to give this to clients if they are experiencing severe difficulties. Also, perhaps the Samaritans could help in an emergency, and again it would be most suitable to familiarise yourself with their procedures in advance of making any referral to them.

## **Community care**

The Community Care Act 1990 continues 30 years of liberalization of the psychiatric services in Britain and allows many previously institutionalized people to be released and the number of acute in-patient beds to fall. Community Care aims to provide higher quality, more flexible care, geared to individual needs. But the Act is being implemented with methods of budgetary restriction. Also, the Patient's Charter is effectively an act of double speak as it gives the impression that the services are not working at peak capacity, and implies clients should be more assertive and knowledgeable about what resources they can access. Frequently, waiting lists for counselling, clinical psychology and psychotherapy on the NHS vary from two months to two years.

Working life in the psychiatric services is difficult for many reasons. Most staff are highly stressed, poorly paid and are struggling as their job cultures change in unprecedented ways. Psychiatric care is not perfect, but the alternatives are few. I also believe that psychiatric hospitals are required for a low-cost alternative to what clients might really need. As it is usually impossible to provide 24 hour intensive psychiatric nursing in the home of the acutely disturbed, the only places which can provide that care are psychiatric units, mini-hospitals, housing associations and hostels where staff can help with daily living and rehabilitation. If clients are given anti-psychotic medication most gain some reduction in symptoms. But there are drawbacks to drug treatments which include possible brain damage, muscle tremor and stiffness, and these side effects need to be treated with another drug.

Community Mental Health Teams were meant to be in force throughout the country by 1 April 1993. These are integrated teams of psychologists, psychiatrists, community psychiatric nurses, occupational therapists and psychiatric social workers which focus on the specific



objectives for providing acute and long-term care for the mentally ill (Patmore & Weaver 1992). They may also offer counselling, psychotherapy and clinical psychology. In some parts of the country these teams are not in place.

Making a referral by BAC ethics requires you to have some knowledge about the approach of the psychiatric units' in your area. Some people are unamenable to counselling and psychotherapy, and some deteriorate after treatment which enables clients to focus on feelings that are too powerful for them. If some readers believe that the Mental Health Act 1983 needs changing, the way is to join the relevant national group and petition for a change in the law. Ignorance of the law is no defence, and in the meantime we have to work within its confines.

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