'My' clients?

Peter Bates, Editor

Mental health services that adopt a stronger inclusion focus have a bunch of new tasks to address. One of these is updating the traditional rules about who is a 'client'.

For example, the College of Occupational Therapy advise that their members can only work with people with the knowledge and agreement of a doctor. Should something go wrong, the professional body and potentially the whole governance roof might fall down on the head of the worker unless they were covered in this way. This rule may work in traditional services where mental health staff restrict their contact to 'clients' or 'carers'. Formal assessment mechanisms are available for both categories of people, and clear processes allow staff of any discipline to decide who to help.

In an inclusive world, this is more difficult. Even in the traditional system, there are tiny examples of the problem. The annual coach trip to the seaside is sometimes thrown open to family and friends. If the coach crashes, then how will officialdom view the situation of the passengers who are neither clients, carers nor staff?

In an inclusive world, staff are moving towards a community focus, as illustrated by the following example. In Manchester, regeneration funds have been used by a charity to employ a mental health worker to do groupwork with the express purpose of building neighbourhood friendships. The group is open to any member of the general public, whether they use psychiatric services, have other social or health problems or not. The role of the worker as a therapist is played down in order to draw in people who dislike the idea of receiving formal help and to promote the mutual support ethos of the group. Meetings are advertised around the mental health community to ensure that a majority of members turn out to have mental health issues, so that mental health funding is not siphoned into other areas. Other people who attend the group are members in their own right, rather than being seen as volunteers assisting the staff to work with the members who have mental health issues.

The groupwork could be seen to form part of a treatment package for members who are already in contact with mental health services, although the low-key nature of the worker's role creates a risk that assessment and treatment may be delivered without consent. It can be viewed as casefinding and preventative work with those group members who are not currently receiving mental health intervention, but have current or emerging mental health difficulties. When the group session moves into the provision of general mental health promotion information, then there is a precedent in health promotion work with the general public. But what about the occasions when the worker finds herself actively contributing to individualised problem-solving discussions with group members who, if formally assessed, would not be entitled to state help? Does the risk and governance strategy of her employer and professional body continue to offer the worker protection?

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The same issues arise each time a worker assists someone with a mental health need to access a workplace, friendship network or leisure group. Each time there is the potential for the mental health worker to bump up against co-workers, friends and co-participants. Each time, there is the potential for that contact to become an intervention in its own right.

The reality of an inclusive world is that all mental health staff, and not just Occupational Therapists, will from time to time find themselves making an active intervention with people who are neither clients nor carers. This reality may be masked by ambiguous information about the activity, especially if it is just called a 'drop in' or 'community-based activity', and the governance issues may be overlooked until a crisis puts the work into the spotlight.

Inclusive staff are actually working in a manner that is more akin to community development. This is less of a problem for local authority employees where there is a long community work tradition, but NHS and professional health bodies will need to make some adjustments to their formal position on which activities are acceptable. The very concept of 'profession allied to medicine' may need reform. How about 'profession allied to community'?

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