MENTAL HEALTH

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SAFEGUARDING COMMUNITIES – REDUCING CONFLICT

Mental Health and Mental Illness

It is useful to think of mental health as a point on a continuum. Good mental health is when we feel well and able to cope with changing circumstances. Poor mental health is when we feel anxious, stressed and less able to cope. At the extreme of the continuum is serious mental illness.

Most of us are at different points on the continuum at different times. The following is important to remember:

- One in six women and one in nine men will seek professional help for mental distress at one time in their life.
- All of us are likely to be affected by mental distress at some point, either when we experience mental distress ourselves or through a relative, friend or neighbour.
- 25-33% of appointments with General Practitioners are for emotional or mental health problems.
- 30-40% of absences from work are due to emotional or mental health problems.
- The most common form of mental distress is depression. Twice as many women as men are treated for depression.
- Most people suffering from some kind of mental distress live in the community; only a small number are admitted to a psychiatric hospital.

Mental Health Issues for Mediators

It is important to approach the mediation process in the same way as for any other client. Mediators must use their own judgement and consult their supervisor if necessary to discuss and agree appropriate action.

Cases involving mental distress may be more difficult to mediate because the mediator(s) have to decide:

- if the person is able to understand what is required of them and their neighbour for mediation to work
- if he/she is able to understand any agreement that they reach
- if he/she is able to keep an agreement which is based on future behaviour

Mediation is appropriate if it enables people to talk about their difficulties in a safe environment. An agreement can be drawn up as a statement of intent about how a person intends to behave in the future and the process has a positive outcome for all concerned provided we are careful not to put vulnerable people at a disadvantage and are realistic about possible outcomes.

Questions To Consider (What indications do you have that there may be mental health problems?)

- Do you and your co-mediator feel anxious about the client's behaviour, appearance or surroundings?
- Is there a high level of inconsistency/unpredictability in what they are saying or how they are behaving?
- Are there aspects to the client's story or description of events which seem bizarre, highly distorted or very unlikely?

If There Is Cause For Concern:

- Is it appropriate to ask the client if there is any support available e.g. friend, neighbour, advocate?
- Is it appropriate to ask the client whether it would be useful for you to contact their GP/nurse?
- If you are really concerned, do you need to make excuses, leave, and inform your supervisor?

Personal Safety

Mediators need to know if a client's behaviour or perception of reality would be a real threat to themselves or other people. You should be aware of and comply with your agency's guidelines on personal safety at all times. For further information on personal safety see *SCMC Briefing Paper Personal Safety For Mediators*.

Drug Misuse

Much of the above can also apply to drug and substance abuse, although it is important to remember that most people suffering from mental health difficulties are not drug misusers and people who use drugs do not necessarily have mental health problems. See SCMC Briefing Paper, Alcohol and Drug Misuse.

Mental Health Disorders

Mental health disorders encompass a wide range of diverse illnesses, which have been given a variety of diagnostic labels. The nature and severity of disability, if any, will vary and individual circumstances should be focused on rather than the diagnosis

The use of labels to describe mental illness or disorder is contentious and great care should be taken before "labelling" a person as being "mentally ill". A wide range of factors affects our mental health and the causes are not yet fully understood. All of us suffer from stress, sleeping badly, irritability, fears and mild feelings of "depression" from time to time without being classified as mentally ill. Confirmation of any diagnosis and appropriate assessment must be done by a doctor or mental health care worker. Much so-called mental illness does not in fact affect the understanding or ability to implement actions agreed upon. Care must therefore be taken not to marginalise persons who may appear to be affected by mental illness, particularly because of personal fears or

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prejudices. It should not be assumed that, because someone has been diagnosed as mentally ill, they are unable to take part in any mediation.

The classifications outlined below are for general information only and do not attempt to describe all the symptoms or behaviours that may result from each or any of them. Further information and guidance, if necessary, should be obtained from your mediation supervisor. The source material for the information contained in this fact sheet is *"The Disability Handbook"* (Second Edition – The Stationery Office) although the views expressed herein do not necessarily reflect those of the authors of that publication.

The Psychoses

Psychoses are severe forms of mental illness which affect the whole personality, create a severe burden on the affected person and may cause loss of touch with reality, disordered thought processes, delusions, and lack of insight into mood and behaviour.

Schizophrenia

People affected may demonstrate the above symptoms and may be socially withdrawn, have slowed thought process and loss of initiative. 70% of people obtain relief of symptoms using appropriate medication, 20% will require long term structured care, 50% will live relatively independent lives and 30% will make a complete recovery.

Severe Depressive Disorder

Depression becomes a recognisable illness when the degree of mood change is out of proportion to the circumstances and is unduly prolonged. Mood is likely to be worse in the morning with feelings of misery, self–blame and hopelessness, but can sometimes improve throughout the day.

The Neuroses

The effects are less severe than with the psychoses and the affected person will not lose touch with reality or experience disturbed thought processes. All will however suffer from anxiety and, possibly panic attacks. The magnitude of change of mood, its duration and effects rarely result in significant or prolonged symptoms. Examples of these are Post-Traumatic Stress Disorder, Phobias, and Compulsive or Obsessive Behaviour e.g. ritualistic behaviour and panic attacks. Symptoms may persist for months or years.

Another feature of the neuroses is Personality Disorders. This occurs where one personality trait becomes dominant e.g. a person who is passive and readily compliant may become "dependent" or if a person is anti-social by nature, they may become "Psychopathic" i.e. impulsive with a failure to learn from the experience of life. Such people rarely pose a danger to the person or public, although they may have a difficulty in co-existing in an orderly fashion and may be disruptive in behaviour. Equally they may not.

A further category of neurosis is Dissociative Disorder, otherwise known as "hysteria". Physical illness is suggested but arises from unconscious psychological mechanisms. Hypochondria are an example. Most people will recover within months and it must be emphasized the behaviour of people affected is neither conscious nor deliberate.

The Dementias

Dementia is an acquired progressive impairment of overall mental function affecting memory, understanding and personality. It occurs mainly in older groups – 5% of people over 65, 20% over 80. Short-term memory is affected, as is the ability to orientate in time and space. Understanding and judgement may also be affected. Dementia is progressive.

Learning Disability

As it is an entirely separate condition and in no sense a "mental illness", a separate briefing paper has been prepared on issues around Learning Disability – see *SCMC Briefing Paper no.7 Learning Disabilities*.

Relevant Legislation

Mental Health (Scotland) Act 1984 (as amended)

Mental Health (Care and Treatment) (Scotland) Act 2003

This is a complex area and the legislation around areas of mental health is changing. Mediators should discuss any issues around a party's mental health with their line manager.

Further Reading

The Health Education Board for Scotland (HEBS) Library, The Priory, Canaan Lane, Edinburgh EH10 4SG (Tel. 0845 912 5442) has a wide and varied range of up to date material.

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