Procter et al. (2014). Chapter 1

Introduction
- In transcultural and other contexts it is important to use humanistic language in line with a recovery approach e.g. ‘support person’ > ‘carer’ in MH practice/nursing
- This approach provides a foundation for human connectedness, and sets the consumer narrative as central to MH practice and MH nursing, specifically

A narrative approach to mental health
- A person-centred approach is concerned with human connectedness; the capacity for feelings to be received and understood, and lives to be revealed
- A narrative approach illuminates the needs of the person with a MH condition, her or his family, carers and clinician through an interactive process of dialogue and information exchange

Mental illness and social determinants
- Social determinants of health are the circumstances in which people are born, grow up, live and work, and the systems that are in place to deal with illness
- Mental health promotion is therefore not only the responsibility of the healthcare sector, but also of many other sectors e.g. housing, education and employment
- Social determinants of mental health can be categorised into four areas:
  - Individual: include an ability to manage feelings, thoughts and life in general, emotional resilience and an ability to deal with stress
  - Community: these include social supports, and having a good sense of belonging and an opportunity to actively participate in your community. For some people with strong cultural affiliations, understanding and responding to a MH condition largely guided and derived from self-identity through community affiliation and cultural belonging
  - Organisations: these include factors such as safe housing, employment options and educational opportunities, access to good transport and a political system that enhances MH
  - Whole societies: these include social structures in education, employment and justice to address inequities and promote access and support to those who are vulnerable

Mental illness and life expectancy
- Life expectancy from birth of people with serious mental illnesses is between 8 and 14.7 years less in men and between 9.8 and 17.5 years less among women than in the general population
- In both groups, schizophrenia has been associated with the greatest reduction in life expectancy
- Major cause of death for people with a diagnosed serious mental illness is cardiovascular disease; people with a serious mental illness are more likely to be inactive, obese and smoke, compared to the general population, it can be seen that incidents of metabolic syndrome are more common in this population group

Mental illness and substance misuse
- In situations in which mental illness is a factor, there is an emerging picture worldwide suggesting that illicit substance involvement is on the rise
- Comorbid mental health and alcohol and other drug conditions are more likely to be experienced by young people of refugee background when compared to their Australian-born peers

Mental illness and violence/aggression
- People with schizophrenia are more likely than community controls to come to the attention of police through their involvement in family violence incidents
- People with severe mental illness experience significantly more problems in interpersonal relationships, and that family members may often be the targets of violent behaviour
- Considerable and continuing stigma and prejudice associated with mental illness in the wider community

**Mental illness and risk**
- Factors that may contribute to a person’s risk of developing a mental illness include trauma and abuse, social isolation, homelessness, socioeconomic disadvantage, physical/intellectual disability and genetic predisposition
- Harmful use of alcohol and other drugs can significantly increase occurrence of mental illness
- ATSI and Maori people are more vulnerable to developing a mental illness secondary to intergenerational trauma suffered during European settlement and colonisation of Australian Governments
- First signs of mental illness may emerge in childhood, adolescence or early adulthood. Young people at risk of developing a mental illness may be those who have been bullied at school, COPMI, children linked with the criminal justice system, refugees and children brought up in a traumatic environment

**Mental illness and stigma**
- Stigma and discrimination can affect a person’s ability to seek help for mental illness
- In general, the public (and some health professionals) perceives people with mental illness as difficult, dangerous and unpredictable, and those with chronic mental health conditions (e.g. schizophrenia) are most feared
- Results in perpetual discrimination and stigma
- Stigma: a spoiled identity that discredits a person in society who possesses an attribute that makes him/her different from others and less desirable
- MH clinicians need to address the issue of stigma; support the rights of people with mental illness, and enable them to participate meaningfully in society. Community awareness from MH promotion efforts can reduce discrimination and increase opportunities for prevention and early intervention
- MH promotion focuses on increasing a person’s emotional resilience and reducing vulnerability to mental illness through the development of personal skills and self-esteem, which lead to an increased capacity to cope with life transitions and stresses

**Mental health nursing as a specialist field**
- MH nursing focuses on meeting the mental health needs of the consumer, in partnership with family, significant others and the community; designed to be therapeutic by:
  - Supporting, advocating for consumers to optimise health status in a manner congruent with their explanatory model and life situation
  - Encouraging consumers to take an active role in decisions about their health care
  - Genuinely involving family, significant others and communities in the care and support of consumers
  - Being proactive in the care, support of consumers, in support of citizenship and human rights

**Importance of trust in MH nursing**
- Mistrust is often a key reason people disengage from MH services
- Trust is fundamental for effective, contemporary MH service delivery

**Mental state assessment**
- Mental state examination is designed to assess the mental state of a person objectively, and to collect valid data related to the person’s current situation and background; allows the opportunity to develop a
therapeutic relationship through building a deeper understanding of the person’s experience, and then working to formulate a treatment plan in collaboration with the person and his/her family/carer

- Assessment interview = an interactive, collaborative process with opportunities to:
  - Develop a relationship with the person
  - Establish trust
  - Promote professional closeness and collaboration
  - Identify and explore issues and concerns relevant to the consumer experience
  - Identify how the person’s resources might help him/her overcome distress

**Recovery**

- Recovery: the active process of people with mental illness moving toward achieving wellbeing and a satisfying life, despite the presence of mental illness; not generally viewed by people with a mental illness as a return to a previous state, since experiences of living with mental illness (treatment, hospitalisation, stigma) have changed their lives irrevocably
- Recovery is often a transformative process of accepting the presence of mental illness and in redefining the self as more than a mental illness
- A person seeking to be in recovery assumes responsibility for his/her own mental health, in partnership with family, carers and mental health clinicians; recovery is not in isolation, but with assistance from key others
- Optimism is therapeutic as it facilitates the processing of negative information, gives rise to thorough and flexible ways to be supportive and promotes the development of coping and problem-solving skills
- Having roles and routines provide a sense of purpose and goals around which everyday life can be structured
- Recovery is not linear and continues to occur even when symptoms recur

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**Week 1.1: Introduction to Mental Health and Illness**

- Introduce the concepts of mental health and mental illness
  - WHO: “Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”
  - Mental health = an integral, essential component of health
    - The ability to cope with and bounce back from adversity, to solve problems in everyday life, manage when things are difficult and cope with everyday stressors
    - Good mental health is possible through a supportive social, friendship and family environment, work-life balance, physical health, and, in many instance, reduced stress and trauma
  - Kittleson (1989): 4 major components of mental health
    - High self esteem
    - Effective decision making
    - Value awareness
    - Expressive communication skills
  - Raphael (1993): contextual and social issues (e.g. workplace; education; macro-economic; social forces; resilience: coping, physical health, wellbeing)
  - Contemporary definitions of mental health include positive constructs + social determinants
    - “a state of emotional, psychological and social wellness evidenced by satisfying relationships, effective behaviour and coping, positive self-concept and emotional stability” (Evans & Brown, 2012)
“a definition that encompasses positive constructs, not just the absence of symptoms is important because it enables mental health and mental illness to be viewed as distinct, rather than a polarised dichotomy” (Barkway, 2013; Freshwater, 2006)

- Mental health problem: diminished cognitive, emotional or social abilities but not to the extent that the criteria for mental illness are met
- Mental illness: a clinically diagnosable disorder that significantly interferes (temporarily or permanently) with an individual's cognitive, emotional or social abilities; diagnosis is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD)

Mental illness is characterised by the presence of any one or more of the following symptoms:
- Delusions
- Hallucinations
- Serious disorder of thought form
- Severe disturbance of mood
- Sustained or repeated irrational behaviour (NSW Mental Health Act, 2007).

Overview prevalence of mental illness in the Australian population

- Adults
  - 1 in 2 people (16-85 years) likely to experience mental illness in lifetime
  - 1 in 5 people affected by some form of mental illness in any year
  - Prevalence varies; highest in young adult years
  - Mental illness impacts people differently
  - 3% of adults have severe disorders (diagnosis, chronicity, disability)

- Young people
  - Majority of mental illnesses begin 15-25 years
  - 1/3 of young people have an episode by 25 years
  - Even 'mild' mental health problems can have profound effects on social, emotional, physical, cognitive development

Identify prevalent and non-prevalent mental disorders

- Prevalent mental disorders
  - 20% of adult population experience symptoms within 12-month period
  - Anxiety disorders: 14.4% of adults
  - Affective disorders: 6.2% of adults
  - Substance use disorders: 5.1% of adults

- Non-prevalent mental disorders
  - Psychotic disorders/psychoses
  - Principal functional psychoses
- Only 1-2% of the adult population are affected by the psychoses. Majority have schizophrenia. Account for ~80% of mental health care expenditure

- Disability and comorbidity
  - Mental illness accounts for 27% of the burden of non-fatal disease (measured by total years of life lived with a disability)
  - People with mental illness are more likely to have poor physical health; reduced QoL; inadequate access to services
  - Levels of psychiatric distress and disability are rising; acuity of mental illness and disorder are increasing

- **Outline models of human behaviour**
  - A range of models have been developed to explain human behaviour and mental illness; used to suggest:
    - Reasons for observed behaviour and causes of abnormal behaviour
    - Models of prevention and treatment strategies
    - Appropriate roles for patient and therapist

  - **Biomedical Model**
    - Behaviour influenced by physiology
      - Normal behaviour = equilibrium in the body
      - Abnormal behaviour = pathological body or brain function
      - Focus is to classify and cure/treat illness
    - Mental illness is associated with:
      - Nervous system disorders
      - Structural brain changes
      - Endocrine dysfunction
      - Genetic transmission of mental illness; twin studies (Gottesman); Stress-Diathesis model

  - **Psychological Models**
    - Psychoanalytic
      - Human thoughts and behaviour determined by unconscious processes, developmental factors, and family relationships
    - Sigmund Freud (1856-1939)
      - Mental life is divided into unconscious forces: id (primitive); ego (cognitive); superego (conscience)
      - Personality development occurs through childhood psychosexual developmental stages; at each stage child’s behaviour is driven by need to satisfy sexual, aggressive drives
      - Ego-defence mechanisms are used unconsciously to reduce anxiety; anxiety is a reaction to external, realistic dangers experienced by the ego but is also a reaction to danger experienced through internal struggles/reactions to moralistic situations (super-ego) and neurotic reactions to unconscious impulses (id)

  - Behavioural
- Behaviourism founded by Watson (early 1900s): objective study of observable human behaviour (vs examining the mind)

- Basic assumptions:
  - Personality determined by prior learning
  - Human behaviour is changeable across life span
  - Behaviour changes are caused by environmental changes

- Major forms of learning:
  - Being rewarded or not (Pavlov’s classical conditioning)
  - Association with another event (Skinner’s operant conditioning)
  - Imitation (modelling)

- Mental distress – learned habits – maladaptive responses
  - **Cognitive**
    - People are active participants in the environment; they absorb, process and respond to information
    - People use cognitive structures:
      - Schemata
      - Make conscious choices
    - Behaviour results from an interplay of external and internal events
      - Our cognitions are based on schemata (attitudes or assumptions) developed from previous experiences (how we think about a situation influences how we behave in that situation)
      - Problem behaviour (mental illness) results from cognitive distortions and faulty thinking

- **Sociological/Social Model**
  - Focus is on the person in the context of their society as a whole
  - Causes of abnormal behaviour/mental illness life in broader social forces
    - Social situations can predispose a person to mental illness e.g. poverty, family instability
    - Social, economic, environmental inequality linked to poor mental health
    - Inequality = catalyst for unhelpful cognitive, emotional responses
      - \( \rightarrow \) physiological changes; decreased social status; deterioration of social relationships
      - \( \rightarrow \) unhelpful behavioural responses; unhealthy lifestyle; social withdrawal

- **Biopsychosocial Model**
  - First described by George Engel (1997, 1980)
    - Developed the model as an alternative to biomedical model
    - Broad based systemic approach to construction of illness
  - Mind, body, environment interact to cause health and illness:
- Biology, genetics, pathogens, precipitate and contribute to illness
- Psychological and behavioural components including poor self-control, inadequate stress management, emotional turmoil, and negative thinking cause health problems
- SES, culture, poverty, technology, relationships, religion/spirituality can influence health
  - Biological, psychological, social and spiritual aspects are not equal; effects will depend on the individual's unique circumstances

- **Introduce principles of mental health nursing**
  - **Holistic approach**
    - In providing care, each dimension of personhood is taken into account
    - Background, culture, system of beliefs, sexuality etc. are considered along with physical, psychological, social aspects of experience
    - The whole complexity of the human experience is explored
  - **Person-centred framework**
    - Focus on the individual and their experiences/stories, needs and aspirations; together with needs of partners, families
    - Aim to support person to achieve full potential
    - Empower person to identify and address individual needs – active participant in treatment
  - **Therapeutic relationship**
    - Core of MH nursing
    - Relationship between nurse and consumer that enables change: physical, mental, psychological, emotional, social, spiritual in or for the person
    - Promotes personal growth, development, maturity, and fulfilment of potential, improved functioning and coping with life, and best possible health outcomes
    - Key aspects include:
      - Understanding and empathy
      - Being there
      - Individuality
      - Providing support
      - Demonstrating respect
      - Clear boundaries
      - Self awareness
      - Being genuine
      - Promoting equality
    - A therapeutic relationship is defined by therapeutic communication; communication techniques used by nurses to engage a person and enable them to make personal change
  - **Recovery-focused care**
    - Focus on hopes, goals for future, optimism, living life to the full
    - Reduced focus on symptoms, illness; increased focus on individual strengths and wellness
    - Enable consumers to move beyond negative consequences of their condition
  - **Work of MH nurses include:**
    - Assessment
    - Risk management
    - Education
    - Counselling
    - Support
    - Therapeutic psychosocial interventions
    - Physical/pharmacological interventions
    - Health promotion and illness prevention
    - Working with individuals and families,
Week 1.2: Mental Health Promotion and Illness Prevention

Determinants of mental health

- Multiple social, psychological, biological factors influence the MH of a person
- Persistent socio-economic pressures are recognised risks to MH for individuals, communities
- Poor MH also associated with rapid social change, external/environmental stressors, physical ill-health
- There are also specific psychological, personality factors that make people vulnerable to mental disorders
- Some biological aspects (including genetic factors and neurotransmitter imbalances) are associated with mental illness

Spectrum of interventions

- Mental health promotion
  - Aims to protect, support, sustain the emotional and social wellbeing of the population; applicable across the entire spectrum of MH interventions and is focused on the promotion of wellbeing rather than illness prevention/treatment
  - Initiatives involve individuals in the process of achieving positive MH, enhancing QoL and narrowing the gap in health expectancy between countries and groups; it is an enabling process, done by, with, and for the people
  - Social participation: active involvement of individuals, groups in relationships that contribute to a social richness in their lives
    - Encompasses social responsibility, social rights
    - Includes social support
  - Emotional processing: awareness and respect for our own and others’ emotions; encouraging development of our emotions
    - Involves expressing emotion, and listening for others’ emotions
  - Self-management skills: varied, holistic, and proactive ways of

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<th>Social, Environmental, and Economic Determinants of Health</th>
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<td><strong>RISK FACTORS</strong></td>
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<td>Access to drugs and alcohol</td>
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<td>Displacement</td>
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<td>Isolation and alienation</td>
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<td>Lack of education, transport, housing</td>
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<td>Neighbourhood disorganisation</td>
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<td>Peer rejection</td>
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<td>Poor social circumstances</td>
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<td>Poor nutrition, Poverty</td>
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<td>Racial injustice and discrimination</td>
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<td>Urbanisation</td>
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<td>Violence and delinquency</td>
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<td>War</td>
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<td>Work stress, unemployment</td>
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<td><strong>RISK FACTORS</strong></td>
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<td>Academic failure/scholastic demoralisation</td>
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<td>Attention deficits</td>
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<td>Caring for chronically ill or dementia patients</td>
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<td>Child abuse and neglect</td>
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<td>Chronic insomnia</td>
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<td>Communication deviance</td>
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<td>Emotional immaturity and dyscontrol</td>
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<td>Excessive substance use</td>
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<td>Exposure to aggression, violence, trauma</td>
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<td>Family conflict or family disorganisation</td>
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<td>Low social class</td>
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<td>Mental illness</td>
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<td>Neurochemical imbalance</td>
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<td>Parental mental illness</td>
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<td>Parental substance abuse</td>
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<td>Perinatal complications</td>
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<td>Personal loss – bereavement</td>
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<td>Poor work skills and habits</td>
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<td>Reading disabilities</td>
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<td>Sensory disabilities or organic handicaps</td>
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<td>Social incompetence</td>
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<td>Stressful life events</td>
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<td>Substance use during pregnancy</td>
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coping with stress that involve an internal locus of control

- Involves having access to resources
  - Self esteem: relates to our underlying belief about our worthiness and significance as a person in our own right
    - Includes the idea of intrinsic self worth, and that we are more than the sum of our success and failures
  - Environmental quality: incorporates the absence of negative influences and culturally appropriate environmental factors
    - Good housing, public transport, aesthetically pleasing building and landscaping, and proximity to nature

- Mental illness prevention
  - Aims at reducing incidence, prevalence, recurrence of mental disorders, the time spent with symptoms, or the risk condition for a mental illness, preventing or delaying recurrences, and also decreasing impact of illness in the affected person, their families and the society
  - Focuses on reducing the risk factors for mental disorder and enhancing protective factors

- Early interventions: target people displaying early signs, symptoms of a MH problem and people experiencing a first episode
- Treatment: made up of early intervention + application of evidence-based treatments for individuals with diagnosed disorders
- Continuing care: comprises interventions for individuals whose disorders continue or recur; aim is to prevent relapse or recurrence of symptoms, and to maintain optimal functioning
- Relapse prevention: interventions in response to early signs of recurring mental disorder for people who have already experienced a mental disorder

- Risk and protective factors
  - Interventions to prevent mental ill-health aim to counteract risk factors and reinforce protective factors along the lifespan in order to disrupt those processes that contribute to human mental dysfunction
  - Risk factors: associated with increased probability of onset, greater severity, longer duration of major health problems
  - Protective factors: conditions that improve people’s resistance to risk factors and disorders; they modify, ameliorate or alter a person’s response to some environmental hazard that predisposes to a maladaptive outcome
  - Risk and protective factors operate at individual or group levels

- Mental illness prevention interventions
  - Universal: targeted at the general public or whole population group; aimed at preventing MH problems for everyone
    - E.g. pre-natal support programs; anti-bullying school programs
  - Selective: aimed at individuals or population subgroups with a higher risk of developing a MH problem or illness than the general population
    - E.g. support for children of parents with mental illness; post-natal support programs
  - Indicated: for those at very high risk of developing MH problems (may have minimal but detectable signs, symptoms)
    - E.g. refugees; victims of violence; post-natal support for mothers with birth complications
Promotion and prevention in clinical practice

- Health promotion and illness prevention are core aspects of nursing work (often targeting individuals and small groups)
- In clinical practice, strategies aimed at increasing protective factors and reducing risk are not illness specific
- Risk factors can apply to a range of mental health problems/illnesses
- Strategies that promote MH can be protective across a range of illnesses
- There is a need for broad application of promotion and prevention strategies that will be informed, influenced by:
  - Knowledge of major stages of the life span
  - Understandings of developmental and broader social issues
  - Clinical context/practice settings and relevant evidence-based approaches

Week 1 Tutorial


- People who use mental health services have important contributions to make to service development
  - Principle of ‘user involvement’ embodied in legislation and policy across the Western world
  - Endorsed by various professional associations, including peak nursing bodies
  - Arguments that service users, carers are well placed to identify the qualities, skills, abilities which constitute best practice
  - However, service users have been afforded limited opportunity to express their views about treatment and what supports recovery
- Brief acute inpatient care is an integral component of mental health systems in developed countries
- Hospitalisation of people for treatment of mental illnesses, sometimes involuntarily, might serve diverse functions for individuals and/or society
  - Contributing to containment of risk
  - Provision of safety
  - Crisis management
  - Assessment
  - Enabling (re)integration in the broader community
- However, effectiveness of inpatient care is uncertain; patients are inconsistently satisfied with care.
- Optimisation of the process and outcome of hospitalisation is an ethical imperative. However, this is more easily said than done; contemporary psychiatric inpatient units (PIU) are dynamic systems located within complex socio-political environments
  - Operation of PIU is shaped by myriad of ethical, legal, social factors
  - Professional roles and staff mix, and characteristics of people admitted necessarily affect dynamics
  - In Aus, legislation requires treatment in the least restrictive environment, reflecting govt endorsement of the ‘recovery approach’, policy obliges MH services to provide enabling environments and empower individuals to work towards personally-meaningful goals
- People admitted to PIU are typically acutely unwell, often distressed, have complex needs
  - Already vulnerable and entering regulated environments and transient communities
o Encountering people with whom they have little in common (except diagnosis of mental illness)
o Smooth operation of the units is dependent on structure and conformity; patients subjected to constraints on movement, regulation of ADLs, and are constantly observed
o Research demonstrates that patients’ experiences of care are mixed; many feel bored, unsafe; MH nurses are perceived as inaccessible

- Analysis demonstrated that the ‘excellent MH nurse’ is a complex construct
  o Personal qualities, interpersonal skills, professional resources, environmental factors all influence delivery and experience of MH nursing care
  o Best ‘recovery oriented’ practice MH nursing is grounded in an empathetic approach, underpinned by respect and a friendly demeanour; best achieved through diligent attention to self-care and reflexive practice

- Service users’ perspective
  o People hospitalised for treatment of mental illnesses want to feel cared about and be treated compassionately
  o Respect, manifest in the manner in which duties and interactions are enacted, is fundamental to optimising the experience of hospitalisation
  o Service users want to see and sense that MH nurses are genuinely curious about their personal life stories and experiences; they want to be recognised and treated holistically (not as a collection of controllable symptoms)
  o Excellent MH nurses make it their business to learn about each person’s hopes, goals, strengths, and aspirations, and to do what they can to encourage progress along the ‘recovery path’
  o Nurses should introduce themselves at the beginning of each shift, explain their role, make time to talk with them during the shift
  o Respect = refraining from inappropriate discussions about service users generally
  o Service users want to know what you know about them – communication about the process of care should be clear, honest and frequent

- Carers’ perspective
  o Carers can contribute substantially to inpatient care, easing the burden on nursing staff and hastening recovery of service users if they are appropriately supported and engaged
  o Meeting carers’ personal needs for information and/or support will promote engagement in care and better outcomes

- MH nurses’ perspectives
  o Being clear about and promoting rights and responsibilities of service users is considered crucial to establishing the relationship that is fundamental to effective practice
  o Nurses should provide sufficient guidance to enable service users to negotiate ward routine and practices to establish what is not negotiable and are not left wondering what is acceptable
  o Centrality of collaborative teamwork to effective, empathetic nursing practice
  o Professional differences of opinion about care processes should be managed sensitively
  o Best practice is only possible when nurses are self-aware and manage their own mental health well

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**How is it possible to have a mental illness and still have good mental wellbeing?**

- Management of condition
- Letting the individual define what mental wellbeing is to them
- Accepting the illness