Introduction to mental health and mental illness

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Human connectedness and the collaborative consumer narrative

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LEARNING OBJECTIVES

At the completion of this chapter, you should be able to:

1. Describe the nature and scope of a narrative approach in mental health practice.
2. Explain key concepts of trauma-informed practice and what it means in the context of person-centred care, and meaningful engagement between practitioners and consumers, carers and family members.
3. Explain key concepts such as mental health and mental illness; identify and discuss the determinants of mental health such as social, cultural, biological, environmental, employment/work and societal determinants; and discuss stigma and beliefs about mental illness and its effect on help-seeking.
4. Contextualise mental health nursing as a specialist field in which support is built in collaboration; and discuss enablers and barriers to meaningful engagement between practitioners and consumers, carers and family members.
5. Discuss collaborative practice in mental health care in the context of recovery; and discuss consumer participation, human rights, vulnerability and practical aspects of human connectedness as a means of engaging with people and communities at risk.

Introduction

consumer – a person who uses or has used a mental health service, or who has a lived experience of a mental illness

carer – a person who provides assistance, care and support for someone who has a mental illness

This chapter reflects a coming together of key issues and themes embedded in everyday work with **consumers** and **carers**. In recent times, the definition of a carer has expanded to include immediate family and friends, and also to include extended family members such as grandparents and cousins. In transcultural and other contexts, it is important to use humanistic language, in line with a recovery approach; for example, the terms 'support person/people' and 'support networks' may be preferable to the term 'carer' in mental health practice and mental health nursing. This approach provides a foundation for human connectedness and sets the consumer narrative as central to mental health practice and to mental health nursing, specifically.

PERSONAL NARRATIVE

Michael's story

My name is Michael. I'm 24 years old and single. I was recently taken to the emergency department of my local hospital, by ambulance. Apparently, my mother was concerned because she could not rouse me. I've been told that upon arrival the level of alcohol detected from my breath was pretty high, and I'd also taken some Valium tablets. Once the alcohol level in my system was reduced, I was referred to the hospital's mental health team for assessment. I spoke to a nurse, Melissa, and explained that, although I am aware of the risk of using alcohol with other drugs, I had no intention of trying to hurt myself.

I used to be a sociable, funny guy at school, with loads of friends. When I was 21, I was assaulted during a night out with friends in the city. Since then, everything seems to have been off – completely changed. I've noticed a change in my personality and behaviour. I often feel irritable and tearful, lacking energy and motivation. I feel down most days, and I've given up on finding work after I lost my job last year. I also have nightmares, so I use alcohol to get to sleep. For the past three years, I have been drinking around eight beers a night and up to 16 beers on weekend nights. To help me get to sleep, I take two to three Valium tablets most nights, and I also occasionally smoke cannabis. I know that this isn't helping but I don't know what else to do.

I talked to Melissa about how I often feel isolated from others and hopeless about my situation. At times, I've even thought of ending it all. These kinds of thoughts tend to be worse when I've been drinking and can't sleep. I explained to Melissa that I also have trouble being in crowds. I live in shared accommodation, and I visit the local supermarket for groceries once per fortnight. My brother visits me weekly; he tries to encourage me to get out of the house but I find this too stressful. I would really like to get back to being the person I used to be. I'd like to find a job and be able to catch up with my friends again, but I feel so overwhelmed and don't know how to get better.

REFLECTIVE QUESTIONS

- What are some of the signs of concern about Michael's mental health and well-being?
- Do you think some people might be at higher risk to experience mental health difficulties after adverse life events?

A narrative approach to mental health

The story of Michael – and many others within this book – is central to both the narrative and person-centred approach taken in each chapter. 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 mental health condition, their family, carers and **practitioner** through an interactive process of dialogue and information exchange. At a deeper level, narrative is a means of storytelling.

practitioner – a professional in health or human services working with people who have lived experiences of mental distress, and their carers and family members

Given the complex and dynamic nature of working with people experiencing mental illness, interprofessional cooperation is not only required but essential. In this book we refer to different professional categories: nurses, mental health nurses, practitioners, medical practitioners and health workers, to illustrate the range of interprofessional roles and contexts in which care takes place. Reference to one category is not meant to exclude additional health and human services workers whose intervention can potentially benefit people receiving care.

Storytelling is a profoundly human capacity. Both the teller and listener work together – in interaction – to build meaning. The listener experiences the reality of being the narrator and actively contributes to the storytelling. A narrative is thus constructed in cooperation, based in shared experience and knowledge (Michel & Valach, 2011). Such activity is central to the practice of mental health nursing. This is because the discourse itself involves stories that together become a joint action.

The alternative to a narrative approach is application of a structured or mechanistic style of engagement and interaction. Rather than creating a forum for the sharing of various perspectives and possibilities, this approach is largely monologic. In an interview situation (for example) the interviewee is asked a list of questions. Learning is by a predetermined 'case study' that is defined by a distinctive feature, disease or condition. There is an absence of knowing the person, who they are and what they stand for and, in some instances, the person is lost completely. In this situation, a person's life is subjected to being impersonally processed, with little opportunity to contribute a perspective on what actually lies behind their situation, life difficulty or aspiration to live a healthy and socially engaged life.

A narrative approach in the context of this book has special meaning. By combining the best evidence in mental health with the opportunity to know and understand the human connections that can and should be made in mental health care, this book adopts an all-encompassing approach to engaging with, responding to and supporting people with mental illness. It signals a change in the nature and context of learning by promoting alternative points of view and lived experience in mental health. Each chapter encompasses relevant information pitched at a level suited to an undergraduate student while simultaneously making sense of the consumer's and/or carer's voice and experience. The consumers, carers and practitioners who have contributed to this book have changed their names to protect their anonymity. Each has had a direct experience in recovering from mental illness, using mental health services or providing mental health support. This form of writing is valuable for both student and academic readers, as it draws from key evidence in the field as well as our relationship to it. The desired outcome of narrative thinking is for the chapters and adjunctive learning materials to reveal a new story through conversational partnership between the student and the text. Dominant themes are examined, discussed and, where necessary, challenged. If the student can empathically put themself in the place of the person

with a mental illness, then it will be possible to move beyond current thinking toward new and fresh thinking. This task can be made more productive through reflective questions and thinking about opportunities for translation to practice.

TRANSLATION TO PRACTICE

How can we start thinking about a narrative approach to mental health care?

A narrative approach to mental health care invites the person, practitioners and carers to cooperate in building an understanding of what care means for the person in a given context and situation. To consider how these approaches might look like in practice, reflect on the following questions:

- What questions would you ask a person about their experiences of mental health conditions? What do you think would be important to know?
- Based on your own experiences in health or mental health services, what would you like a nurse, mental health nurse or other practitioner to know about the way you are feeling about your current condition?
- What are some of the challenges for practitioners and other health workers in adopting a narrative approach to mental health care? Why do you think this happens?

Trauma-informed practice

A narrative approach to understanding mental health is closely aligned with the idea of trauma-informed practice. Put succinctly, trauma-informed practice means that services and professionals (including managers and supervisors) engage with consumers and carers in a trauma-informed manner. This assumes that many people seeking a service could potentially have experienced significant trauma at some point in their lives. It does this to help prevent an escalation of distress and deterioration in behavioural, emotional, physical and psychological well-being. Health and human services are guided by the goal of achieving optimal health and well-being for the consumer, underpinned by best practices regarding safety, agency, connection, belonging, meaning, identity, justice, dignity and value. Professional groups work from the premise of universal understanding, whereby the workers assume that all people accessing a service have experienced some form of trauma. In this context, trauma is defined as 'the personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss and/or the witnessing of violence, terrorism and/or disasters' (National Association of State Mental Health Program Directors Centre for Trauma Informed Care (NCTIC), 2015). Such events are usually repetitive, intentional, prolonged and severe, which means that the effect of trauma can be pervasive and complex.

Universal understanding of trauma as a potential feature in the life of a person with a mental health condition arises from the highly influential Adverse Childhood Experiences (ACE) study (Felitti et al., 1998). The ACE study involved a comprehensive survey of more than 13 000 participants to identify adverse experiences of psychological, physical or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The study reported that people often

experience more than one category of ACEs. Multiple ACEs were linked to the presence of multiple risk factors for poor health outcomes later in life. Noticeably longer exposure to ACEs increased the likelihood of risk factors for several of the major causes of death in adulthood (Felitti et al., 1998; Felitti, 2002).

With such significant evidence, the underlying assumption within trauma-informed care is a universal precaution to 'do no harm' (Muskett, 2014), and with the purpose of preventing, ameliorating and not exacerbating the negative effects of trauma. Taking into account the work of Elliot and colleagues (2005) and the National Centre for Trauma Informed Care (NCTIC; 2015), a trauma-informed practitioner, program, organisation or system is one that:

- realises the widespread effect of trauma on the development and coping strategies of the individual, and potential paths to recovery
- recognises signs and experiences of trauma in consumers, families, staff and others involved in the system
- strives for therapeutic relationships that develop safety and trust in the individual (that is, non-traumatising, comforting relationships)
- demonstrates respect for the individual's need for safety, respect and acceptance
- emphasises the person's strengths by focusing on adaptations rather than symptoms; resilience rather than a reliance on pathology alone
- works towards maximising the individual's choice and control over their recovery
- responds by fully integrating knowledge about and implications of trauma into policies, procedures and practices
- actively seeks to resist re-traumatisation.

Defining mental health and mental illness

Mental health

Mental health is an overall state of well-being and functioning. It is closely related to the ability to cope with and bounce back from adversity, solve problems in everyday life, manage when things are difficult and cope with everyday stressors. Mental health is made possible by a supportive social, friendship and family environment, work–life balance, physical health and, in many instances, reduced stress and trauma.

A survey by the Australian Institute of Family Studies over 12 years (2001–12) of more than 27 000 people aged between 15 and 90 years enquired into participants' satisfaction with common life events. The study revealed that, overall, Australians were content with their lives (Qu, de Vaus & AIFS, 2015). Participants were asked to give a score on a scale of zero to 10 (maximum score) to indicate their happiness and contentment across their life events. The average score across domains was seven. Similarly, a mean score of 7.4 was observed in a nationally representative sample in 2017 (Park, Joshanloo & Scheifinger, 2019). This suggests that, overall, Australians have been happy and content with their lives in the recent past. However, several million people are living with a mental illness.

The most recent data on prevalence estimates of mental illness, based on a diagnostic tool, is from the 2007 National Survey of Mental Health and Wellbeing. The study estimated that, of the 16 million Australians aged 16–85 years in 2007, almost half (45 per cent, or 7.3 million) would experience a mental condition at some point in their lives (Australian

Bureau of Statistics (ABS), 2007). This percentage would now correspond to 8.7 million people (Australian Institute of Health and Welfare (AIHW), 2019). Each year, an estimated one in five (approximately 3.9 million in 2017) Australians present with a mental disorder (ABS, 2007; AIHW, 2019). It is also estimated that in 2019–20, 4.4 million patients (approximately 17 per cent of the Australian population) received a mental-health related prescription, and in 2018–19, $10.6 billion was spent on mental-health related services (AIHW, 2021a). Another indicator of the effects of mental health conditions is the burden of disease. This is a measure of the estimated effects of different health conditions in terms of years of life lost or years of life lived with disability/impaired functioning. In 2018, Australians suffered a greater burden of living with illness (52%) than from premature death (48%). Anxiety (6.4 per 1000) and depression (5.8 per 1000) conditions were the second cause of non-fatal burden, behind coronary heart disease and lung cancer (AIHW, 2021b). This means these are the second-largest conditions that prevent people from living meaningful, fruitful and productive lives.

Mental illness

Mental illness is a clinically diagnosable condition that significantly interferes with an individual's cognitive, emotional and/or social abilities (Department of Health, 2009). The diagnosis of mental illness is generally made according to the classification systems of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (American Psychiatric Association (APA), 2013) or the International Classification of Diseases (ICD) (World Health Organization (WHO), 2013a; Department of Health, 2009). Mental illness affects people of all ages, nationalities and socio-economic backgrounds, and affects the lives of many people in our communities, as well as their families and friends. The experience of mental illness is common, with the most recent national data from diagnostic tools indicating that 45 per cent of the population (aged 16 years and older) in Australia and 40 per cent in Aotearoa New Zealand have experienced a mental illness at some point in their lives (ABS, 2007; Oakley Browne, Well & Scott, 2006). Moreover, approximately one in five adults in Australia and Aotearoa New Zealand experience a mental illness each year (ABS, 2007; Oakley Browne et al., 2006).

According to the most recent diagnostic information, in both Australia and Aotearoa New Zealand, mental illness is more commonly experienced by young people. The prevalence of mental illness is typically highest in people aged between 16 and 24 years. This includes the experience of anxiety and depression, conditions associated with substance misuse and longer-term conditions such as anxiety, chronic and recurrent depression and schizophrenia. Comorbidity (the experience of more than one condition or disease simultaneously by an individual) is quite high. For example, of those individuals in Aotearoa New Zealand who experience an illness over 12 months, 37 per cent experience more than one (Oakley Browne et al., 2006). The most likely co-occurrence is of anxiety and mood conditions (Oakley Browne et al., 2006). In both countries, women are more likely to experience mental illness than men, and this is largely accounted for by the higher incidence of anxiety conditions among women (ABS, 2007, 2018; Ministry of Health, 2015). Despite the relatively high prevalence of mental illness among adults in Australia and Aotearoa New Zealand, between 61 and 65 per cent of people with a 12-month or longer mental health condition do not receive treatment for their mental illness (ABS, 2007; Oakley Browne et al., 2006). In Australia, however, an

increase in treatment rates has been observed, with a rise from about 36 per cent in 2007 to approximately 46 per cent in 2009–10 (ABS 2007; Whiteford et al., 2014).

Rates of mental illness among Aboriginal and Torres Strait Islander peoples are currently undetermined. However, the 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (AIHW, 2015) indicates that Indigenous people are 2.7 times more likely than non-Indigenous Australians to report either high or very high levels of psychological distress, which indicates a higher probability of mental illness. Similarly, the 12-month prevalence of mental illness among Māori and Pacific Islander peoples is 29.5 per cent and 24.4 per cent, respectively (compared to 21 per cent for the broader Aotearoa New Zealand population; Oakley Browne et al., 2006); this also indicates a higher incidence of mental illness among individuals in these populations.

Contemporary approaches

As is sometimes seen in the popular media, cinema and TV, people with a mental illness are typically portrayed as only having an illness; one that is best managed away from the community and subject to closed institutional care and, in some instances, inhumane treatment. While it is important to communicate factors associated with diagnostic categories, nowadays the practice of mental health care in Australia and Aotearoa New Zealand places a strong emphasis on human rights, personhood, advocacy, care in the least restrictive environment, early intervention and safety for people with a mental illness.

Let's take the story of Michael and relate it to events in South Australia as an example of a contemporary approach. On 1 July 2010, a new Mental Health Act took effect in South Australia, the *Mental Health Act 2009* (SA), with the broad purposes of protecting the rights and liberties of people with mental illness; ensuring that their dignity and liberty are retained as far as may be consistent with their protection; protecting the public; and the proper delivery of services. The Act also aims to ensure the accessibility and delivery of specialist treatment, care, rehabilitation and support services for people with mental illness, and the creation of appropriate and effective processes for engagement between consumers and service providers, including transportation and orders for community treatment, detention and treatment. For a person like Michael, the Act means that staff must engage with him in a meaningful and collaborative way in the design of a care plan to enable Michael's full recovery with dignity (Mendoza et al., 2013). Michael must also be supported through provision of appropriate transportation, should it be required under the Act for him to receive compulsory in-patient treatment.

Social determinants of mental health

The 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 support them to deal with illness (Commission on Social Determinants of Health, 2008). These circumstances are all shaped by wider societal factors, and by the social and economic conditions in which people live. Mental health promotion is therefore not only the responsibility of the healthcare sector, but also of many other sectors such as housing, education and employment (World Health Organization (WHO) and Calouste Gulbenkian Foundation, 2014).

According to Keleher and Armstrong (2005), the social determinants of mental health can be categorised into four areas (see Table 1.1).

Table 1.1 The four social determinants of mental health

Social determinant	Description
Individual	A person's ability to manage their feelings, thoughts and life in general, their emotional resilience and ability to deal with stress. Adequate rest, sleep and proper nutrition also contribute to an overall sense of well-being and ability to cope.
Community	A person's social supports, social connectedness, having a good sense of belonging and an opportunity to actively participate in their community. For some people with strong cultural and social affiliations, understanding and responding to a mental health condition is largely guided and derived from self-identity through community affiliation and cultural belonging.
Organisation	Factors such as safe housing, employment options and educational opportunities, access to good transport and a political system that enhances mental health. This also includes mentally healthy workplace practices known to support people in mental distress.
Whole society	Social structures that exist in education, employment and justice to address inequities and promote access and support to people who are vulnerable.

Source: Adapted from Keleher and Armstrong (2005).

Keleher and Armstrong (2005) suggested that mental health promotion can enhance supportive social conditions and create positive environments for the good mental health and well-being of populations, communities and individuals. Mental health promotion requires action to influence determinants of mental health and to address inequity through the implementation of effective, multi-level interventions across a wide number of sectors, policies, programs, settings and environments (Keleher & Armstrong, 2005, p. 13).

The mental health practitioner acts as an advocate for people with mental illness in accessing services in housing, education and employment, with the aim of developing beneficial outcomes in a way that enables the consumer to retain as much control as possible over how it is carried out.

TRANSLATION TO PRACTICE

Understanding the social determinants of mental health can help us guide our practice

Nabil is a 36-year old man with a Syrian background who presents for consultation due to physical and mental health concerns. He reports having lost 5 kilograms in the past two weeks, along with his appetite, and being sleep deprived for two nights. Nabil is on unpaid leave and is concerned about maintaining his job as his ability to concentrate is affected. He has recently divorced, which contributes to his feelings of isolation (his main source of support was his former wife's family). Nabil discloses that he had lived in a refugee camp for three years and recently nightmares and flashbacks about this experience have become more frequent. Nabil reports feeling like he has no control of what is happening around him. He also discloses having diabetes and not being able to properly monitor his diet or medication.

Consider what factors at the individual, community, organisation and societal levels could have contributed to Nabil's mental health difficulties. What kind of support at each level could improve Nabil's sense of well-being? Consider the specific intervention and services in your response.

The practitioner understands how stigma might prevent consumers from taking up opportunities to engage with available resources. The expectation of consumer advocacy is thus individual empowerment. The mental health practitioner stands alongside the consumer, to strengthen their voice and to enhance their resilience (Department of Health, 2013).

Mental illness and life expectancy

Mental illness can have a significant effect on life expectancy. A systematic review and meta-analysis of 148 English-language studies reported that people with a mental illness had a mortality rate 2.22 times higher than the general population, with an estimated 8 million worldwide deaths per year being attributable to mental illness (Walker, McGee & Druss, 2015). The review found a median reduction in life expectancy of 10.1 years for people with a diagnosis of mental illness, with a greater risk for mortality among those diagnosed with psychoses, mood disorders and anxiety. An Australian survey of people living with psychotic illness (n = 1825) (of whom just under 50 per cent had a diagnosis of schizophrenia) reported that, in the previous month, 33 per cent of participants did not have breakfast on any day of the week (Morgan et al., 2011). In the same survey, 41.5 per cent ate only one serving or less of vegetables a day, and 7.1 per cent did not eat any vegetables at all (Morgan et al., 2011).

Since nutrition is inextricably linked to physical health, it is not surprising that the major cause of death in people with a diagnosed mental illness is not suicide, as many believe, but cardiovascular diseases. While mental health practitioners are well-practised in assessing risk of self-harm, they are less familiar with assessing risk of cardiovascular disease. Given that 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 the incidence of metabolic syndrome is more common in this population group (Parish, 2011). It must be noted that, in addition to the effects of second-generation anti-psychotic medications, inactivity, overweight and obesity are also the results of psychotropic medication. In this circumstance, poor physical health is associated with the combined elements of the mental health condition as well treatment by psychotropic medication (Correll, Detraux, De Lepeleire & De Hert, 2015).

The largest proportion of deaths due to non-communicable disease in people diagnosed with a mental illness is closely associated with metabolic syndrome, namely cardiovascular diseases (48 per cent), followed by cancers, chronic respiratory diseases and diabetes, which alone is directly responsible for 3.5 per cent of deaths. Behavioural risk factors, including tobacco use, harmful use of alcohol, physical inactivity and an unhealthy diet, are estimated to be responsible for about 80 per cent of coronary heart disease and cerebrovascular disease. Behavioural risk factors for metabolic syndrome are associated with four key metabolic changes: hypertension, obesity, hyperglycaemia and hyperlipidaemia (WHO, 2012). A large-scale, systematic review and meta-analysis reported that approximately one in three patients diagnosed with schizophrenia present with a metabolic syndrome (Mitchell et al., 2013).

The combined and cumulative nature of diet, lifestyle and treatment factors have substantial effects on both quality of life and life expectancy. A systematic review covering studies from 25 countries concluded that people with schizophrenia have a standardised mortality ratio for all-cause mortality of 2.58, or 2.5 times the risk of dying (Saha, Chant & McGrath, 2007). Also important is the knowledge that the physical health care needs of people with a mental illness are often neglected by health care workers, due to stigma. Often, physical complaints

are disregarded by practitioners who label the consumer as anxious or somatically focused. Given the vast amount of evidence that people with a mental illness are more likely to suffer poor cardio-metabolic health (Correll et al., 2015), practitioners need to listen carefully to the needs of consumers and act to reduce the incidence of cardiovascular disease.

Mental health practitioners and nurses work at the intersection of mental and physical health, and they have a vital role to play in improving standards of physical care. Mental health workers have an important role in monitoring how medications affect consumers and their physical health needs. Psychotropic and other forms of medication can cause, or at least contribute towards, adverse physical health effects, including premature disability and death. There is tremendous scope to improve the quality of physical care for people with a severe mental illness through direct care practices, such as including questions about health symptoms in standard health assessments, sharing information between medical practitioners and specialists, and offering advice on diet, exercise and sleeping habits, when necessary (Happell et al., 2011).

At the same time, many people with mental health conditions are not formally engaged with mainstream mental health services in an integrated and sustainable way (Mendoza et al., 2013). Collaborative practice in mental health must be inclusive of this group and may occur through other health contacts such as primary care and community health services. Health promotion activities, illness prevention and early intervention are all ways in which the mental health practitioner, together with the multidisciplinary team, can provide the best care to people with a mental illness who are at risk of developing life-threatening conditions (Happell et al., 2011).

Mental illness and substance misuse

Among people diagnosed with mental illness, there is an emerging picture worldwide suggesting that illicit substance involvement is on the rise (WHO, 2013b). Boredom among young people and increased exposure to substances such as cannabis, amphetamines and methamphetamines are believed to have contributed to the breakdown of traditional, community-based groups (such as clubs and societies), which foster belonging and encourage peer support and community involvement (Procter, 2008). Referred to as 'comorbidity' or 'dual diagnosis', the co-occurrence of a mental health condition and a substance misuse condition is both complex and widespread. It is well established that drug and alcohol misuse is commonly experienced by people with a mental health condition. According to the Australian National Mental Health and Wellbeing Survey (ABS, 2007) 63 per cent of Australians who reported that they had misused drugs nearly every day within the previous 12 months had also experienced a mental health condition in the same time period. More recently, in 2016, people who reported drinking at risky levels were 1.2–1.3 times as likely to self-report having received a mental health diagnoses or mental health-related treatment. The same risk was 2.5 times higher among those who reported smoking daily. Mental health conditions or very high levels of psychological distress are especially common among people who engage in illicit drug use. People who use methamphetamines, for example, are three times as likely to self-disclose a mental health diagnosis when compared to the non-illicit drug using population (AIHW, 2017).

Comorbid mental health and alcohol and other drug conditions are more likely to be experienced by young people with a background involving trauma, including being a refugee, when compared to their Australian-born peers. Studies have shown that significant barriers