Introduction to mental health and mental illness: 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 Identify and discuss the determinants of mental health such as social, cultural, biological, environmental, employment/work and societal determinants; determinants of inequity; and evidence and population datasets.
3 Explain key concepts such as mental health and mental illness; recovery; consumer participation; human rights; vulnerability; collaborative practice in mental health; and practical aspects of human connectedness as a means of engaging with people and communities at risk.

4 Explain key concepts of trauma-informed practice, what it means in the context of person-centred care and meaningful engagement between practitioners and consumers, carers and family members.
5 Discuss issues related to the everyday experiences of consumers and carers, including enablers and barriers to meaningful engagement between practitioners and consumers, carers and family members.

Multiple-choice questions

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 may also 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 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 on 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 in crowds. I currently 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.

Multiple-choice question
Critical thinking question

A narrative approach to mental health

The story of Michael – and many others contained 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, her or his 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

Storytelling is a profoundly human capacity. Meaning is accomplished through an interaction between the teller and the listener. The listener enters into the world of narrator, constructs and helps in the telling of the story; thus, a narrative is jointly accomplished, according to shared knowledge and interaction (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 his or her 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 alternate 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 herself or himself in the place of the person with a mental illness, then it will be possible to

Short-answer question

move beyond current thinking toward new and fresh thinking. This task can be made more productive through the use of reflective questions and thinking about opportunities for translation to practice.

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 all people seeking a service have experienced significant trauma at some point in their life. 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' (NCTIC, 2015). It is noted that such events are usually repetitive, intentional, prolonged and severe, which means that trauma's effect can be pervasive and complex.

Universal understanding of trauma as a likely feature in the life of a person with a mental health condition arises from the highly influential Adverse Children's 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 seven categories of adverse childhood experiences were strongly interrelated, and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life. The researchers also found a strong relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.

With the results so significant, the underlying assumption within trauma-informed care is a universal precaution to 'do no harm' (Muskett, 2014); with the purpose of preventing, ameliorating and not exacerbating the negative effects of trauma. Combining the work of Elliot and colleagues (2005) and the 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 (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.

Video
Connecting with practice

Defining mental health and mental illness

Mental health

Mental health is 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. 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 recent Australian Institute of Family Studies survey over 12 years of more than 27 000 people aged between 15 and 90 years, enquiring into their satisfaction with common life events, reveals that overall Australians are content with their life (Qu, de Vaus & AIFS, 2015). Participants were asked to give a score on a scale of zero to 10 (maximum score) indicating their level of happiness and contentment across their life events. The average score across domains was seven. It was 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 disorder at some point in their life. One in five (20 per cent, or 3.2 million) Australians has had a mental disorder in the past 12 months (ABS, 2007). This data suggests that while Australians overall are happy and content with their lives, there are several million people living with a mental illness.

Mental illness

Mental illness is a clinically diagnosable condition that significantly interferes with an individual's cognitive, emotional and/or social abilities. 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). Mental illness affects men, women and children of all ages, nationalities and socio-economic backgrounds, and affects the lives of many people in our community, their families and friends. The experience of mental illness is common, with the most recent national data indicating that 45 per cent of adults (aged 16 years and older) in Australia and 40 per cent in 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 New Zealand experience a mental illness each year (ABS, 2007; Oakley Browne et al., 2006). In both Australia and New Zealand, mental illness is more commonly experienced by young people, with prevalence of mental illness typically being highest for those individuals 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/disease by an individual) is quite high. For example, of those individuals in 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;

Oakley Browne et al., 2006). Despite the relatively high prevalence of mental illness among Australian and New Zealand adults, approximately two-thirds 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).

Rates of mental illness among Aboriginal and Torres Strait Islanders are currently undetermined, although recent data from the 2008 Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples survey (ABS and Australian Institute of Health and Welfare, 2011) indicate that Indigenous Australians are twice as likely as non-Indigenous Australians to report either high or very high levels of psychological distress, which indicate a higher probability of mental illness. Similarly, the 12-month prevalence of mental illness of Māori and Pacific peoples is 29.5 per cent and 24.4 per cent respectively (compared to 21 per cent for the New Zealand population; Oakley Browne et al., 2006), also indicating a higher incidence of mental illness among these individuals.

Multiple-choice questions

Common mental illnesses

Reflective of the mental health conditions most commonly experienced across the lifespan, an overview of anxiety conditions, affective conditions, schizophrenia, eating conditions and substance disorders are discussed here. Subsequent chapters provide further information about these and other conditions as relevant to specific demographic groups.

Anxiety conditions

Anxiety conditions generally involve excessive feelings of tension, distress or worry, expressed through psychological and physical symptoms (APA, 2013). These can include diagnosis of generalised anxiety, obsessive compulsive disorder, social phobia, panic disorder, agoraphobia, specific phobia and post-traumatic stress disorder. With generalised anxiety being the most commonly experienced anxiety condition, key diagnostic criteria include excessive worrying about events or activities (for example, work or school performance), difficulty controlling the worry and a number of other symptoms including restlessness, fatigue and difficulty concentrating (APA, 2013). Panic disorder is also common and often brings people to medical attention due to the associated physical symptoms. It is best demonstrated by recurrent, sudden and unexpected panic attacks (APA, 2013). Anxiety is the most common type of mental health condition in Australia and New Zealand, affecting 14 per cent and 15 per cent of people aged 16–85 years, respectively (ABS, 2007; Oakley Browne et al., 2006). In both countries, women are more likely to have experienced anxiety than men (18 per cent compared to 11 per cent in Australia, and 19 per cent compared to 11 per cent in New Zealand; ABS, 2007; Oakley Browne et al., 2006). These conditions are most commonly experienced by women aged 16–54 years in Australia (21 per cent; ABS, 2007) and women aged 16–24 years and 25–44 years in New Zealand (18 per cent each; Oakley Browne et al., 2006).

Affective conditions

Affective or mood conditions involve a disturbance in mood or a change in affect, and diagnoses include major depressive condition, dysthymia and bipolar affective illness (APA, 2013). Major depression is associated with depressed mood, low self-esteem and reduced energy or activity over a period of at least two weeks (APA, 2013). Bipolar illness involves episodes of mania, either alone or with depressive episodes (APA, 2013). Manic episodes may be characterised by a period of reduced need for sleep, increased activity or restlessness

and disinhibited behaviour (APA, 2013). Postnatal depression is another affective condition, experienced by some women in the postpartum period. Key diagnostic criteria are similar to those for major depression, but may also include worries about leaving the home, or about the baby's health and/or the mother's ability to cope with caring for the baby (APA, 2013). Affective illnesses are experienced by 6.2 per cent of Australians aged 16–85 years, with a slightly higher prevalence in women (7.1 per cent) than men (5.3 per cent; ABS, 2007). Similarly, these conditions are more common among females (9.5 per cent) than males (6.3 per cent) in New Zealand, and are most prevalent in the 16–24-year age bracket (12.7 per cent; Oakley Browne et al., 2006).

Schizophrenia

Schizophrenia interferes with regular brain functioning, hindering a person's ability to think, feel and act. This condition is characterised by a range of cognitive, behavioural and emotional dysfunctions, with key diagnostic criteria including the presence of at least two of the following: delusions (that is, fixed beliefs that are not amenable to change in light of conflicting evidence); hallucinations (perception-like experiences that occur without external stimulus); disorganised speech (frequent derailment/incoherence); grossly disorganised/catatonic behaviour (childlike silliness, unpredictable agitation); negative symptoms (diminished emotional expression); and impaired functioning in major areas of life, such as work, interpersonal relations or self-care (APA, 2013). Although less common than anxiety and affective conditions, schizophrenia is the most commonly experienced psychotic condition in Australia, more often among males and with the first episode typically occurring before the age of 25 years (Morgan et al., 2011).

Eating conditions

Eating conditions involve persistent thoughts and disturbances related to eating, eating-related behaviour and body weight, and are more commonly experienced among young women (APA, 2013). Although less prevalent than the other mental illnesses, eating disorders can bring people to the attention of medical professionals due to the associated physical symptoms. This is particularly true for anorexia nervosa, which is characterised by limited food intake, with key diagnostic criteria including: restricted energy intake relative to physical requirements, resulting in significantly reduced body weight; intense fear of weight gain or persistent behaviour to prevent weight gain; disturbances in the way in which body weight or shape is experienced; undue influence of body weight or shape on self-evaluation; or persistent lack of recognition of the seriousness of the current low body weight (APA, 2013). Other eating disorders include bulimia nervosa (food intake followed by purging) and overeating (compulsive overeating).

Substance misuse

Substance misuse conditions may be defined as dependency or harmful use of alcohol or other drugs. These conditions are slightly less prevalent than other types of mental illnesses, affecting 5.1 per cent of the adult population in Australia and 3.5 per cent in New Zealand (ABS, 2007; Oakley Browne et al., 2006). In Australia, substance misuse conditions are more common in men aged 16–24 years (13 per cent; ABS, 2007). Similarly, in New Zealand, these conditions account for 2 per cent of the female and 5 per cent of the male population, and are most common in the 16–24-year age bracket (9.6 per cent; Oakley Browne et al., 2006).

Suicide and self-harm

Although not defined as mental illnesses, it is important to recognise that people who experience mental illness are at increased risk of suicide and self-harming thoughts, feelings and behaviours. These behaviours can include hanging, jumping from high heights, motor vehicle accidents, overdose and/or self-poisoning, drowning, use of firearms, contact with sharp objects (cutting) and burning. In Australia, more than 2800 deaths in 2014 were attributed to intentional self-harm (ABS, 2016), and in 2012 close to 550 people died by suicide in New Zealand (Ministry of Health, 2015). Rates of self-harm are even higher. In Australia, there were in excess of 27 000 hospitalisations due to intentional self-harm between 2012 and 2013 (Pointer, 2015), and more than 3000 self-harm related hospitalisations in New Zealand in 2012 (Ministry of Health, 2015). In both countries, rates of suicide are often higher among males, whereas self-harm is more commonly experienced by females (ABS, 2016; Ministry of Health, 2015). For both suicide and self-harm, rates are considered an under-reporting of the true number, largely due to stigma, the difficulty in determining cause of death and the often private nature of these behaviours.

Being aware of these behaviours is important in recognising the deep distress that people may be experiencing, and the need for health workers to respond appropriately to suicide and self-harm is being increasingly recognised. Programs such as Connecting with People in the United Kingdom (Cole-King et al., 2013) and the Collaborative Assessment and Management of Suicidality in the United States (Jobes, 2012), emphasise the importance of compassion, empathy and collaboration for reducing the effects of suicide and self-harm. These align well with a narrative approach to engaging with people experiencing mental illness.

Contemporary approaches

As is sometimes seen in the popular media and cinema, people with a mental illness are portrayed as having an illness only; one that is best managed away from the community, 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 New Zealand has 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 recent 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 liberty of people with mental illness; ensuring that their dignity and liberty is retained as far as is 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 more 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 him in a meaningful and collaborative way in the design of a current care plan to enable 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.

Mental health and social determinants

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 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 health care sector, but also of many other sectors such as housing, education and employment (Keleher & Armstrong, 2005).

The social determinants of mental health can be categorised into four areas:

Individual: These include an ability to manage feelings, thoughts and life in general, emotional resilience and an 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: These include social supports, social connectedness, having a good sense of belonging and an opportunity to actively participate in your 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.

Organisations: These include 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 workplaces known to support people in mental distress.

Whole societies: These include social structures in education, employment and justice to address inequities and promote access and support to those who are vulnerable (Keleher & Armstrong, 2005).

Keleher and Armstrong (2005) suggested that mental health promotion is able to enhance supportive social conditions and create positive environments for the health and well-being of populations, communities and individuals. Mental health promotion can influence determinants of mental health and address inequities through the implementation of multi-level interventions across a wide number of sectors, policies, programs, settings and environments (Keleher & Armstrong, 2005; Barry & Jenkins, 2007).

The mental health practitioner acts as an advocate for people with mental illness accessing services in housing, education and employment, the aim of which is to develop beneficial outcomes in a way that enables the consumer to retain as much control as possible over how it is carried out. The expectation of consumer advocacy is individual empowerment. The mental health practitioner stands alongside the consumer, to strengthen her or his voice and to enhance resilience (Department of Health and Ageing, 1998).

Multiple-choice questions

Mental illness and life expectancy

Mental illness can have a significant effect on life expectancy. A recent systematic review and meta-analysis of 148 English-language studies found that people with a mental illness have a mortality rate 2.22 times higher than the general population, with an estimated eight 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 mental illness diagnosis, with a greater risk for mortality among those diagnosed with psychoses, mood disorders and anxiety. A recent Australian survey of people living with

psychotic illness (n = 1825) (of whom just under 50 per cent had a diagnosis of schizophrenia) found that in the previous month 33 per cent 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 for people with a diagnosed mental illness is not suicide, as many believe, but cardiovascular diseases. While mental health practitioners are well practised at assessing the risk of self-harm, they are less familiar with assessing the 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 are more common in this population group (Parish, 2011). It must be noted that, collectively, 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 (Saha, Chant & McGrath, 2007).

The largest proportion of non-communicable disease deaths for 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 are 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). The prevalence of metabolic syndrome in people with a diagnosis of schizophrenia is approximately three times higher than in the general population (De Hert et al., 2009).

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 (Saha et al., 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, practitioners need to listen carefully to the needs of consumers and act to reduce the incidence of cardiovascular disease.

Mental health practitioners work at the intersection of mental and physical health, and have a vital role to play in lifting standards of physical care. Mental health practitioners 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 by having a more direct role, such as assessing physical symptoms, liaising with medical practitioners and specialists, and providing physical health advice on important issues such as diet, exercise and sleep.

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