Mental Health in Nursing

Theory and Practice for Clinical Settings

5th edition

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Contents

Foreword

Mental Health Nursing: Theory and practice for clinical settings, 5th edition is a text with welcome differences because it draws upon the narratives of people with lived experience of mental health issues who have been under the care and treatment of nurses. It also, bravely, brings into the open lived experience narratives of nurses who themselves have experienced trauma and mental health issues. Because of this, and because of the focus placed on recovery and the humane treatment of people who have experienced trauma and psychological distress, it is an honour to write the foreword for this text. In doing so, I hope to enthuse students and nurses to consider the important role they play in the lives of each person they treat, care for, support and work with. Whether the care is offered in primary, community, inpatient or other clinical settings, the impact nurses have on people with lived experience can have lasting, positive (or detrimental) effects on their life, sense of self, recovery and subsequent outcomes.

This edition focuses on nursing practices embedded in the *Code of ethics for nurses*, the healing power of dedicated nurses and the recognition that every person has a unique and innate value. The authors and editors recognise that great nurses contribute to people's healing and recovery and to living socially and emotionally satisfying lives, contributing to their family, workplace and community.

My career in mental health has had wide dimensions. I have been a lived experience volunteer, peer worker, manager of peer workers and a director of a large public mental health service. I founded Vision in Mind, a national systemic advocacy, consultancy and training body. I was the inaugural Deputy Commissioner with the NSW Mental Health Commission and an executive member of a large specialist community-managed organisation. For years I have written policies, issues papers, strategic plans, guidelines and protocols and have always undertaken these utilising co-design practices. I am also a person with lived experience of trauma and subsequent mental health issues. Through all these experiences I have had the personal and professional honour of working with great mental health nurses who work from a strong human rights base and use strengths-based language, and who practise empathy and holistic care with each person. Nurses working in this way regard people with mental health issues as individuals, not as a diagnosis or problematic behaviours, and do not pathologise the human experience.

High-quality mental health services and nurses work in respectful, multidisciplinary teams including all clinical staff and peer workers. The individual needs of each person in their care are central to everything good nurses do and they respect the lived experience mantra of 'Nothing about me, without me'. The power dynamic is recognised and smoothed out, providing a respectful, holistic and therapeutic alliance with the people they care for and, where appropriate, with their family.

I have also had the unfortunate and traumatising experience of working with nurses who do not practise holistic, therapeutic and empathic care. They use the nurse's station as just one tool in the unequal power dynamic they enjoy and use seclusion and restraint far more often than is needed; they see this as a win, rather than a failure of care. When I was working in the public system, I could look at the roster and know if there was going to be instances of seclusion and restraint by the particular staff who were rostered. I implore student nurses and practising nurses to work together to ensure these attitudes and outcomes do not prevail in their services. Please work within the spirit of this text and create holistic healing instead of further trauma for all people and staff involved.

Indigenous healing circles and the Open Dialogue model of care are practices that work in holistic ways utilising the community, family, kin and whānau and multidisciplinary teams working together to provide healing supports for individuals, families and communities. I would encourage all services to engage with these practices. I would also encourage nurses to become familiar with the different cultural beliefs around mental health issues and connection to country and community, spirituality and body language. Recognising all aspects of a person's needs and making allowances for these demonstrates respect and care and builds a stronger therapeutic alliance between patients/consumers/people with lived experience, their families and communities.

Until recently, the interconnection between mental and physical health was generally ignored. Doctors and nurses could often be dismissive of consumers' concerns about their physical health and attribute symptoms to 'paranoia', 'being all in their mind', 'hypochondria' or 'just attention seeking'. Discrimination has led to the physical health needs of people with mental health conditions being seen as less important than their mental health, than other people's physical health and than the community's comfort about 'the behaviour' of the person.

Also, the negative impact of mental distress and pharmaceutical treatment on people's health was underestimated and downplayed. Clinicians often point to a person's choices such as diet, lack of exercise, drugs, cigarettes and alcohol use as being the cause of people's physical health issues. However, ethical clinical treatment is transparent about the unwanted effects of prescribed psychiatric medications on people's short- and long-term health. Ethical clinical treatment is also transparent about the risks electroconvulsive therapy (ECT) may have on people's memory and physical health.

To achieve holistic care, preserving memory and the physical health of people with mental health issues must also be seen as a priority in all services including acute, stepped, community and primary healthcare settings. Ethical practices ensure people know what their treatment involves and the possible unwanted side effects of medication, which often includes obesity, metabolic syndrome and a major gap in life expectancy.

Physical illness untreated or inadequately treated increases the burden of disease on the community and on individuals and diminishes speed, likelihood of recovery and the gap in life expectancy.

The relationship between personal and family trauma, social dynamics and environmental impacts on mental and physical health are being increasingly understood. This text outlines a social and ecological approach that integrates the various influences on mental health from biological through to environmental and social. Valuable nurses recognise that the causes of mental health issues include external factors and rarely lie solely within the individual. Childhood and adult abuse, harsh environments, the impact of global warming (fire, floods, drought, earthquakes and destruction of nature), neglect and intergenerational trauma including the destruction of family and communities through war, stolen lands, stolen children, sexual abuse and poverty all contrive to undermine people's lives and wellbeing. Epidemiological studies show that mental health and addiction issues affect up to 50% of people in their lifetime. It would seem obvious by this figure that mental health issues can no longer be seen as crazy, disordered or abnormal, but rather on the spectrum of normal responses to trauma, abuse, neglect and harsh living conditions.

As this text points out, the World Health Organization recommends that mental health care should be based in primary care. While this trend is increasing in Australia and New Zealand, a large percentage of clinical and acute treatment takes place in psychiatric wards.

Throughout my career I have worked in and attended mental health settings across Australia, New Zealand and internationally amid diverse cultures with varying degrees of wealth and poverty. Some services have been exciting, empathic environments exuding hope and healing, even when resources were scarce and the facilities poor. Sadly, my excitement has often been overwhelmed with shame, anger and painful questioning as to why all clinical and community mental health services are not holistic, therapeutic, trauma-informed and person-centred/person-led environments.

I have consulted multiple stakeholders about the reasons for the variations in service quality and outcomes. While mental health certainly needs more funding and resources, contrary to popular narratives I believe the variants do not relate to resources and finances; rather, they are based in individual nurse and clinician attitudes and the collective culture of the services. This can be evidenced by comparisons between services within the same states of Australia. State public services are working under the same funding models and the same policies and protocols yet vary dramatically in culture and outcomes.

Interactions between nurses, clinical staff and people they care for are either empathic, hopeful and respectful cultures engaged in respectful multidisciplinary teams producing outcomes desired by the people accessing the service and staff, or that of a culture that has inequitable power dynamics in which nurses and clinicians primarily pathologise the human experience and see people as the diagnosis, disorder or 'problem behaviour'. The latter culture produces detrimental outcomes including higher instances of seclusion, restraint and suicide and people feeling further marginalised and traumatised by the so-called 'trauma-informed treatment and care' they receive. Such detrimental cultures are also often characterised by workplace bullying, increased staff trauma and burnout. This text speaks to the importance of respect, care and wellbeing for *all* stakeholders.

As previously mentioned, *Mental Health Nursing: Theory and practice for clinical settings* takes the brave and wonderful step of including not only the voices of people accessing services with lived experience but also nurses' stories of their own lived experience. This deserves to be applauded. While the practices of nursing and mental health peer work are very different, nurses with lived experience have a positive impact on service culture and outcomes. Nurses and clinical staff with lived experience are valued and celebrated in this text, as they should be in all workplaces.

The stigma and discrimination shown against people with mental health issues has, in the past, driven nurses to hide their lived experience. This, coupled with workplace bullying and incidents of seclusion, restraint and enforced treatment, leads to trauma for both people being 'treated' and staff, and burnout among good nurses. Cultures such as these intimidate good staff and breed fear in people who need to access mental health services. People often turn to alcohol and drugs to self-medicate and to self-harm or suicide rather than return to a service where they feel unsafe, traumatised and humiliated.

Australia and New Zealand are signatories to the United Nations' declarations and conventions on human and disability rights. Nurses who focus on human rights and the innate value and needs of each person build healing, trusting relationships and workplaces for all stakeholders. Coercion, bullying, seclusion and restraint are non-existent or rare in services focused on respectful interactions. Nurses

working in this culture see incidents of seclusion and restraint as failures of the service, rather than the fault of the person in distress.

While this text points out that current laws allow for seclusion and restraint in New Zealand and Australia, it also speaks to the need for these practices to be used as a last resort. However, lived experience advocates declare restrictive practices as abuses against human rights. I hope you will permit me to challenge all nurses to work as if seclusion and restraint were illegal and to consider alternative protocols to meet individual needs such as the support of peer workers. Peer workers use mutual experiences to connect with people and are a calming and hope-filled influence that can lead to a positive shift in the power dynamic between the multidisciplinary team and the people they care for.

The editors of this edition of *Mental Health Nursing: Theory and practice for clinical settings* have engaged chapter authors who focus on the particular aspects of ethical nursing practice. They have used vignettes written from different perspectives and consulted people with lived experience, peer workers, family/carers, clinicians and academics. The use of 'Critical thinking challenges' engages nurses in reflective thinking, learning and practice.

This text draws on lived experience, professional experience and tools to produce a learning experience based in ethical practices and the therapeutic alliances built between caring, respectful nurses and the people they treat and care for, their families and communities.

I commend this text to students and practising nurses at all stages of their careers. I thank the editors and authors for valuing lived experience and producing such a strong human rights–based, recovery-focused mental health guide to good nursing. Working in the ethical way this text demonstrates will, I hope, lead to improved outcomes, increased rates of recovery and healing, decreased rates of suicide and enforced treatment and the cessation of seclusion and restraint.

May nurses' careers be filled with a sense of pride, coupled with respect and humility as they witness how their practices and interactions with people contribute to the positive reframing of lived experience, enriched sense of self, healing and recovery and the ability to lead contributing, meaningful, respected lives.

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About the authors

Kim Foster is a registered nurse with specialist mental health nursing qualifications. She is currently Professor of Mental Health Nursing and leads the Mental Health Nursing Research Unit at the Royal Melbourne Hospital, a joint research partnership between Australian Catholic University and NorthWestern Mental Health. Kim has extensive experience as a mental health nurse academic and educator, having developed and taught mental health curricula at the undergraduate and postgraduate levels across several Australian universities and in Fiji. She has consulted to AusAID and the World Health Organization and has an international reputation as a mental health researcher, with more than 120 publications. Her key research interests include: the resilience and wellbeing of the health workforce; the resilience of individuals and families with challenging health conditions; and the experiences and needs of families where a person has mental illness.

Peta Marks is a credentialled mental health nurse and family therapist working in private practice who specialises in working with people who have eating disorders and their families. Peta has extensive experience undertaking mental health project management at the national level and as a mental health writer and subject matter expert for online learning platforms. She is currently working as the national projects manager for the University of Sydney's InsideOut Institute for Eating Disorder Research and is the lead writer for Mental Health Professionals Online Development (MHPOD).

Anthony J O'Brien graduated as a registered nurse in Dunedin in 1977 and as a psychiatric nurse in Auckland in 1982. Anthony is currently employed at the University of Waikato as an Associate Professor in mental health nursing and as a nurse specialist in liaison psychiatry with the Auckland District Health Board. Anthony's PhD research investigated variation in the use of mental health legislation, including the roles of social deprivation, ethnicity, clinical decision making and service provision. Anthony's research interests are in social issues related to mental health, police and mental health, and advance directives. In 2020 Anthony was made an Officer of the New Zealand Order of Merit in recognition of services to mental health nursing.

Toby Raeburn is a senior lecturer, nurse practitioner and social historian in mental health at Western Sydney University. His interest in research and writing emerged over the two decades he spent working among the homeless and other vulnerable groups in Sydney. Toby has a growing body of publications on topics including mental health history, homelessness and recovery-oriented practice. He is particularly passionate about the empowering potential of history. Toby believes learning and reflecting on history can improve nurses' awareness and ability to cope with the present and can also inform development of vision and purpose for the future.

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Introduction

Kim Foster, Peta Marks, Anthony J O'Brien and Toby Raeburn

We are very pleased to introduce the fifth edition of this text. This edition signals a new direction, reflected in a name change – *Mental Health in Nursing: Theory and practice for clinical settings*. This change recognises that mental health, in addition to being an area of specialist practice, is part of holistic nursing practice in every setting. In this edition we welcome three new editors who have joined Anthony O'Brien from New Zealand on the editorial team. Kim Foster is a professor from Australian Catholic University and NorthWestern Mental Health and has been a longstanding contributor to the text. She brings extensive experience as a book and chapter author and mental health nurse researcher. Peta Marks is a credentialled mental health nurse and family therapist working in private practice and for the InsideOut Institute for Eating Disorder Research as the national projects manager. Peta has significant experience undertaking mental health project management and content development for online learning platforms. Toby Raeburn is a senior lecturer and nurse practitioner from Western Sydney University who is particularly interested in the history of mental health care and recovery-oriented care. We also gratefully acknowledge the contribution of former editors Katie Evans and Debra Nizette to the fourth and previous editions of the text.

The editorial team has been thankful to partner with Jarrad Hickmott, who contributed as a lived experience consultant. With a growing reputation as a consumer advocate, Jarrad is a peer support worker at Prince of Wales Hospital in Sydney and a youth advisor to the national board of 'headspace', Australia's national youth mental health foundation. Jarrad reviewed numerous chapters and authored several lived experience commentaries throughout. The story of Jarrad's recovery journey is available in both written and video materials associated with the text. We are also sincerely thankful to the many other people with lived experience who were involved as co-authors and contributors in chapters throughout.

This fifth edition builds on the successful foundations of the previous editions. In response to the developing landscape of modern mental health care and the evolving role of nurses in mental health and other service contexts, we have taken a wider perspective on nursing in mental health. As noted, the change of title is an acknowledgement of the fact that all nurses interact with people who have mental health needs in all service contexts. With wide-ranging nursing contexts in mind, we have introduced brand new chapters in Part 3 of this edition, authored by nursing experts from a range of primary health, generalist health and specialist mental health services. We hope the scenarios in Part 3 provide students and nurses who work in diverse contexts with knowledge and confidence by providing information focused on the practical application of mental health nursing skills.

Nurses require historical knowledge in order to be informed members of the profession and to formulate views and opinions grounded in evidence. Another change in this edition is the use of historical anecdotes throughout Parts 1 and 2. The goal is that by providing a range of historical anecdotes students and nurses will become aware that their understanding of what is happening in the present day has parallels and precedents with previous historical periods. It is our hope that as readers interact with the text, awareness will grow that knowledge about mental health is open to different readings and interpretations. Reflecting on history in this way can lead to more enlightened critique and understandings.

Use of varied language is another important way this textbook reflects contemporary practice. In mental

health, nurses need to be aware of how language can influence their practice and relationships with people who experience mental ill health. Many different terms can be used to describe a person with lived experience of mental illness, including consumer, patient, client, service user and person with (or experiencing) a mental illness. You will hear all these terms (and more) in clinical practice, depending on the setting and people's preferences, and you will read them all in this text too. In this text, chapter authors use a range of terms to refer to people with lived experience, in acknowledgement that there is no universally accepted term. Most importantly, our language needs to be person-centred rather than illness-focused. For example, we might describe someone as 'a person with a lived experience of psychosis', reminding us that this is a person experiencing an illness or set of symptoms, rather than 'a schizophrenic', which is an objectifying label and implies that the disorder is the dominating feature of the individual. Our approach to language also reflects the view that although a person may experience mental distress or mental illness, they may not necessarily identify as a consumer of mental health services. In every clinical context mental health is part of nursing but may not be the primary reason the person seeks health care.

In this edition the text has been restructured into three sections. Specialist mental health nursing knowledge and skills remain a key focus, particularly in Parts 1 and 2.

Part 1 *Positioning Practice* introduces the context for nursing in mental health, describes the importance of mental health, introduces the social ecological approach to mental health in nursing that frames the text, and explores the mental health nursing knowledge, skills and attitudes needed to provide effective mental health care for individuals and their family or carers. A new chapter also addresses the need for nurses to engage in professional self-care, as this is an essential but often neglected aspect of the nursing role.

Part 2 *Knowledge for Practice* is a core feature of the text, examining specific mental health conditions that people experience, providing a comprehensive description of major mental health problems, their assessment, nursing management and relevant treatment approaches. This section specifically addresses the specialist practice of mental health nursing. It will be of particular interest to nursing students on mental health clinical placements as part of their undergraduate education, and to nurses in their first years of specialist clinical practice in mental health.

Part 3 *Contexts of Practice* is a new section of the text, with chapters demonstrating how mental health nursing knowledge and skills can be integrated into the nursing role and applied across a range of clinical settings – both generalist and mental health settings. This does not mean that mental health knowledge and skills are *only* applicable in these settings – we have included these settings because they are common clinical settings and areas where nurses frequently practice. The chapters in Part 3 have been written by clinical experts and are different in their tone and in how they have been written from other sections of the text.

Existing features of the text have been retained across chapters, including lists of useful websites, nurses' and consumers' stories, key points, key terms and learning outcomes, and critical thinking exercises and exercises for class engagement. In the Part 2 chapters, references to diagnostic classification systems of mental illness have been largely removed, in recognition that diagnosis is imprecise, contested and does not capture individuals' subjective experiences. Nurses focus on people's experiences and their responses to adversity, stress and distress, rather than to diagnoses and symptoms. Of course, diagnostic systems remain a core component of mental health services, and for that reason the Part 2 chapters, as in previous editions, include the language of diagnosis.

Including new chapters means that decisions needed to be made about the length of chapters and the relevance of previous material. In particular, there was a need to consider areas of duplication and where word length could be reduced without loss of core information. Chapters in this edition have been made more concise throughout to enhance readability and usefulness. References have been updated over the whole text, drawing on the most contemporary research and scholarship while retaining core references that situate this fifth edition within the scholarly history of mental health and nursing.

We warmly thank all the chapter authors, people with lived experience, family/carers, clinicians and academics who contributed to this edition, as well as the reviewers who have provided helpful and constructive feedback. We hope the text continues to be widely used because of its contemporary focus and integration of theory and practice.

PART 1

Positoning Practice

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CHAPTER 1

Why mental health matters

Anthony J O'Brien, Toby Raeburn, Peta Marks and Kim Foster

KEY POINTS

- There is no health without mental health.
- Mental distress and mental illness are relatively common in Australia and New Zealand, and rates vary between different population groups.
- Nurses care for people who have mental health needs in every practice setting.
- Nurses do not need to be a specialist mental health nurse to respond to mental health needs.

KEY TERMS

- Cultural safety
- Mental distress
- Mental health
- Mental health care
- Mental health legislation
- Mental illness
- Physical health
- Prevalence of mental illness
- Scope of practice
- Suicide

LEARNING OUTCOMES

The material in this chapter will assist you to:

- understand the importance of mental health in every clinical practice setting
- understand the prevalence of mental distress and illness
- identify how physical health problems can affect mental health
- discuss how mental health is seen in New Zealand and Australia's indigenous cultures
- describe the provision of mental health care.

Introduction

Mental health matters. When individuals can live socially and emotionally satisfying lives, families, communities and whole nations benefit. The term 'mental health' refers to a range of experiences that affect the health and functioning of individuals, families, communities, societies and nations. These experiences include everything from happiness and wellness through to mild distress, anxiety and long-term mental illness. The term 'mental health' is often used as a synonym for 'mental illness' but the term properly refers to a state of wellbeing, not illness. It is important to keep this distinction in mind as you read this chapter. Effects of mental ill health can extend to economic impacts through healthcare costs and loss of economic productivity. Such impacts are not just from mental illness, although mental illness does have considerable impact on employment, productivity and quality of life, but also from distress and impaired function. In Chapter 2 we outline a social ecological approach that integrates the various influences on mental health, from biological through to social. Health planners are increasingly recognising that mental health problems can also lead to physical illness, poor recovery after physical illness and impaired social functioning. Successive epidemiological studies have shown that mental health problems are relatively common, with high proportions of the population experiencing a mental health problem at some point in their lives.

Nurses care for people who may be experiencing mental ill health in every clinical setting and in the work of many social agencies such as schools, police services, social welfare services and correctional services. For this reason, mental health is increasingly regarded as an issue for all health professionals and social agencies. For nurses therefore, skills in mental health form an essential part of their clinical skill set. This chapter begins with an overview of the prevalence of mental distress and illness internationally and in Australia and New Zealand. The chapter then outlines some of the central mental health issues including the range of nursing responses available for people with mental health problems and the place of mental health in the nursing scope of practice. Reading this chapter should help you understand why mental health matters in nursing.

Epidemiology of mental distress and illness

To understand the impact of mental health problems it is important to consider their epidemiology, or distribution in the population. Distribution is measured by prevalence and incidence. Prevalence is a measure of the rate of mental illness over a given time period – for example, at a single point in time (point prevalence) or over a year (12-month prevalence). Incidence is the measure of new cases of a disorder – for example, the number of new cases in a year. Both the Australian and New Zealand governments have conducted extensive research into the prevalence of mental health problems. For both countries the most recent national epidemiological evidence on mental illness is now more than a decade old, although recent research has provided more up-to-date evidence of prevalence. The following sections review reports on the prevalence of mental distress and illness internationally and in Australia and New Zealand.

Prevalence of mental distress

Mental distress is an unpleasant mental or emotional state that can impact on enjoyment of life and on personal and social functioning. The experience of distress is a common part of life, although if severe or prolonged it can impact on health and is a risk factor for mental illness. Mental distress can be measured using standardised scales, the most common of which is the Kessler Psychological Distress Scale (K10). Using the K10, the 2015–16 New Zealand Household Survey found that 4–8% of the population experienced high levels of distress, with younger people, Māori and Pacific people and women reporting higher levels (Ministry of Health 2016). In a similar national survey Australians reported higher levels of distress, with 13% of the Australian adult population reporting very high levels (Australian Bureau of Statistics 2018).

Rates of mental distress have been reported to be high in countries as diverse as Norway, the United States and France and even higher in developing countries such as Bangladesh (Islam 2019) and in conflict zones (Jayasuriya et al. 2016; Summers et al. 2019). Distress is also common in people with physical illness – for example, people with diabetes (McCarthy et al. 2019), cancer (Gilbertson-White et al. 2017), cardiac disease (McPhillips et al. 2019) or renal disease (Damery et al. 2019) – and for people experiencing adverse events such as trauma (de Munter et al. 2020), victimisation (Thomas et al. 2016), fire (Maybery et al. 2019) or natural disaster (Inoue & Yamaoka 2017). Despite being a common experience, attempts to reduce levels of mental distress in the community are not always successful. Western countries including Australia and New Zealand have made substantial increases in mental health care provision in recent decades; however, there has been little change in population rates of distress (Tomitaka et al. 2019).

Prevalence of mental illness

According to the World Health Organization (WHO) 'mental, neurological and substance use disorders make up 10% of the global burden of disease and 30% of non-fatal disease burden' (WHO 2019), with one in five children and adolescents experiencing a mental disorder. WHO also reports that depression alone affects 264 million people worldwide and is one of the leading causes of disability (WHO 2018). Depression is also associated with higher rates of unemployment, incarceration and homelessness (Grech & Raeburn 2019).

In developed nations, total government spending on mental health is substantial. In Australia, the quantifiable costs of mental ill health and suicide in 2018–19 were estimated to be from $43 to $51 billion and include health care, education, housing and justice, with health care alone estimated at $18 billion (Productivity Commission 2019). The main societal costs related to mental illness are lost productivity, caused by high unemployment and under-employment of people with mental illness, along with impacts on quality of life and other non-quantifiable costs such as the cost of stigma. In addition, there are social participation impacts as well as the pain and suffering of family and friends who have lost a loved one to suicide.

Australia's 2019 Productivity Commission Inquiry into Mental Health identifies that the cost of lost productivity due to lower employment, absenteeism and presenteeism (working while unwell) ranges from $10 to $18 billion. Informal care costs to family and friends has been valued at $15 billion per annum. There is an approximately $130 billion cost associated with diminished health and reduced life expectancy for people with mental ill health. On an individual level, for example, the annual costs for a person who experiences psychosis in Australia have been evaluated as comprising $40,941 in lost productivity, $21,714 in health sector costs and $14,642 in other costs. Overall this amounts to four times the cost in annual health expenditure for an average Australian adult (Neil et al. 2014).

In New Zealand there are similar costs associated with mental illness. A recent inquiry into mental health and addiction (Ministry of Health 2018) received submissions on the personal, social and economic impacts of mental illness. The Ministry of Health (2017) estimates the annual cost of the burden of serious mental illness, including addiction, in New Zealand at $12 billion or 5% of gross domestic product. In addition to this economic impact there is an estimated $1.5 billion annual cost across government agencies associated with the nearly 60,000 health and disability benefit recipients whose primary barrier to work is mental illness is $1.5 billion. Poor mental health has other indirect costs – for example, the cost of housing for those who cannot work because of mental health problems. This cost is estimated at $1.2 billion over the lifetime of New Zealand's 6,700 social housing tenants receiving benefits and whose primary barrier to work is mental health is $1.2 billion (Ministry of Health 2018).

Historical anecdote 1.1: Early descriptions

Experiences of mental ill health have been described since the beginning of human history in ancient documents such as Egyptian papyri, the Indian Ramayana and the Old Testament of the Bible. The longest lasting historical theory regarding mental ill health was developed by ancient Greek philosophers Pythagoras (570–495 BCE) and Hippocrates (460–377 BCE), who proposed that the human body contains four 'humors': blood, phlegm, yellow bile and black bile. Black bile and phlegm were thought to cause mental ill health, which was believed to be more common in spring and beginning of winter when the humors were 'active'. Humoral theory dominated medical treatment for more than 2,000 years, informing the administration of several painful remedies such as blisters to the head, castor oil, solution of lilac emetic and bloodletting. Each of these 'treatments' were designed to purge the body of the 'black bile and phlegm' thought to be causing mental ill health. Today, we still see the relic of humoral theory in our modern terms 'choleric' and 'sanguine' used to describe different personality types.

Read more about it: *Davison K 2006 Historical aspects of mood disorders. Psychiatry 5(4): 115–8.*

Australian national survey of mental health

The Australian Bureau of Statistics (ABS) conducted a national survey of mental health and wellbeing in 1997 and 2007, which collected information on lifetime and 12-month prevalence of selected mental health problems among people aged 18–65 years. The following information was obtained from the survey report (ABS 2008).

Almost half of all Australians who were surveyed reported a mental health problem at some point in their life, and one in five (20%) experienced a mental health problem within the preceding 12 months. Analysis of survey results showed that anxiety disorders (14%) were the most commonly experienced type of mental health problem in Australia, with the most frequently reported anxiety disorder being post-traumatic stress disorder (6%) followed by social phobia (5%). Affective disorders were reported by 6% of respondents, with the most common affective disorder being depression (4%). Substance use disorders affected 5% of respondents, the most common being harmful use of alcohol, reported by 3% of respondents.

The survey also highlighted significant connections between mental and physical conditions; 11.7% of respondents had both a mental and physical health problem, and 8.5% reported two or more mental disorders. In line with prevalence of discreet mental health problems, the most common comorbidity was anxiety disorder and a physical condition (6%). Comorbidity compounds the

impact of individual disorders, resulting in higher rates of relapse, greater impairment, higher use of health services and higher risk of suicidal behaviour.

The survey also showed the gendered distribution of mental disorder in Australia. Women (22%) were more likely to experience mental disorders than men (18%). Compared with men, women reported higher rates of anxiety disorder than men (18% vs 11%) and higher rates of affective disorders (7% vs 5%). Men had more than twice the rate of substance use disorders (7%) compared with women (3%). Rates also varied across age groups, with younger people more likely to have a mental illness than older people. Just over a quarter (26%) of people aged 16–24 reported a mental disorder compared with 6% of those aged 75–85. Substance use disorders were more common among younger people (13%) than in other age groups, while anxiety disorders were more common in people aged 35–44, with a reported rated of 18%. Family and housing status were other factors associated with rates of mental disorder. One-third (34%) of people living in one-parent families reported a mental health problem compared with 19% of those living in couple families. More than half of those who had ever been homeless had a mental health problem, almost three times the rate of those who had never been homeless. Mental health problems were more common in unemployed people (29%) and in people who had ever been incarcerated (41%).

Rates of psychotic disorder were examined in the 2010 Survey of High Impact Psychosis, Australia's second national psychosis survey (Morgan et al. 2012). That survey reported a 12-month prevalence of psychotic disorder of 4.5 in 1,000. Of those diagnosed with a psychotic disorder the most common diagnosis was schizophrenia spectrum disorder (63%). While the overall rate might seem relatively low, especially compared with the rates of depression and anxiety, the impact of psychotic disorder can be profound. Morgan et al. reported that 49.5% of those with a psychotic disorder had attempted suicide over their lifetime, 63.2% experienced significant social impairment and 78.5% were unemployed. The relationship between mental and physical illness is marked, with 54.8% of this sample having metabolic syndrome and therefore at significant risk of developing type 2 diabetes and cardiovascular disease.

Te Rau Hinengaro: the New Zealand mental health survey

Te Rau Hinengaro,[1] the New Zealand Mental Health Survey (Oakley Browne et al. 2006) aimed to describe the mental health state of the entire New Zealand population. Like its Australian counterpart, the survey did not collect data on psychotic disorders. Specific objectives of Te Rau Hinengaro were to describe:

- the one-month, 12-month and lifetime prevalence rates of major mental disorders among those aged 16 or older living in private households, overall and by sociodemographic correlates
- patterns of and barriers to health service use for people with a mental disorder
- the level of disability associated with a mental disorder.

The survey reported a 44.6% lifetime prevalence of mental disorder, with a 12-month prevalence of 20.7%. The latter figure is very close to the 20% 12-month prevalence reported in Australia. In addition to overall prevalence, the survey presented specific findings on age, gender, ethnicity and socioeconomic status.

Mental disorders are more common in young people in New Zealand, with younger people reporting a higher prevalence of disorder in the past 12 months and more likely to report having ever had a disorder. In terms of gender, females reported higher prevalence of anxiety disorder, major depression and eating disorders than males, whereas males reported substantially higher prevalence for substance use disorders than females. Social disadvantage is also associated with mental disorders, with higher rates for people who are disadvantaged in terms of educational qualification, household income or social deprivation. Comorbidity of mental disorders is common, with 37.0% of those experiencing 12-month mental disorders having two or more disorders. Mood disorders and anxiety disorders are most likely to co-occur. The survey also noted that rates of mental and physical comorbidity are high and cause compounding disability, but these rates of comorbidity are not reported in Te Rau Hinengaro.

The prevalence of disorder in any period is higher for Māori and Pacific people than for the 'Other' composite ethnic group. For disorder in the past 12 months the prevalence rates are 29.5% for Māori, 24.4% for Pacific people and 19.3% for 'Other', which indicates that Māori and Pacific people have a greater burden due to mental health problems. Much of this burden appears to be due to the youthfulness of the Māori and Pacific populations and their relative socioeconomic disadvantage.

Suicidality was also reported in Te Rau Hinengaro. Of the New Zealand population, 15.7% reported ever having thought seriously about suicide. In total, 5.5% had ever made a suicide plan and 4.5% had ever made an attempt. These rates are comparable with those of several other developed countries. In the 12 months preceding the survey, 3.2% experienced suicidal ideation, 1.0% made a suicide plan and 0.4% made a suicide attempt. Higher rates of suicidality were reported for women, younger people and for people experiencing social deprivation. Individuals with a mental disorder had elevated risks of suicidal behaviour, with 11.8% of people with any mental disorder reporting suicidal ideation, 4.1% making a suicide plan and 1.6% making a suicide attempt. It is important to remember, however, that many of the individuals reporting suicidal thoughts, plans and even attempts will not have sought professional support. Others will have attended a primary care service for a physical health problem but will not have reported their suicidal thoughts.

[1]The term 'Te Rau Hingengaro' means 'the many minds'.

Critical thinking challenge 1.1

Epidemiological studies show that mental illness and addiction problems are relatively common in our communities, with up to 50% of people experiencing a mental illness (including addiction) in their lifetime. And yet the belief persists that mental illness is uncommon and experienced by only a small minority of people. Why does the belief persist that only a small minority of people experience mental illness? What effect does this belief have on nurses and other primary care clinicians who regularly see many patients with mental health and addiction problems?

Physical and mental health

In 1954 Dr Brock Chisholm, the first Director-General of WHO, stated that 'without mental health there can be no true physical health' (Kolappa et al. 2013). Conversely, it has been argued that 'there is no true mental health without (physical) health' (Kolappa et al. 2013).

Health is defined in the WHO constitution as:

> A state of complete, physical, mental and social wellbeing and not merely the absence of disease or infirmity.
>
> (WHO 2014, p. 1)

As can be seen from the above quote, people are holistic beings with both physical and mental health needs. However, generalist and mental health services are often separated, which has led to an artificial divide between physical and mental health care. This means that the mental health needs of patients in generalist health settings can be overlooked. Similarly, the physical health of people with mental illness in mental health settings may not be prioritised.

People with mental illness have higher rates of physical illness than the general population and do not always receive adequate screening, assessment and treatment for their physical health (Te Pou o Te Whakaaro Nui 2014a; 2017). In addition, people with mental illness have high rates of chronic physical illness, which contributes to higher morbidity and mortality rates. It is therefore important in every practice setting that nurses respond to both the physical health and mental health needs of people with mental illness. Both Australia and New Zealand have strategies to address the health disparities experienced by people with mental illness. The *Equally Well* consensus statements (Mental Health Commission of NSW 2016; Te Pou o Te Whakaaro Nui 2014b) express the commitment of multiple organisations to improving the physical health of people with mental illness. These statements reflect the view that mental health is 'everybody's business', including the whole health sector as well as social agencies, employers, housing providers and police. The physical health of people with mental illness is discussed in detail in Chapter 18.

Nowhere is the relationship between mind and body more evident than in the area of chronic conditions. People with mental illness experience chronic disease at greater rates than the general community in areas including but not limited to respiratory disease, cardiovascular disease, diabetes, chronic pain and cancer. People with mental illness experience a reduction in life expectancy of up to 25 years (Firth et al. 2019), with a meta-analysis of research reporting that up to 14.3% of deaths worldwide, approximately 8 million deaths each year, are attributable to mental disorders (Walker et al. 2015). People with the more enduring forms of psychotic illness struggle to have even their most basic physical health needs met and experience very poor access to regular physical review by a general practitioner and health promotion services (e.g. smoking cessation programs and cancer screening). This lack of appropriate health care contributes significantly to increased risk of chronic disease and premature death.

The relationship between physical and mental health is also important in understanding causes and treatment of physical illness. For example, depressive illness can precede a physical disease. It has been linked to diseases such cardiovascular disease, stroke, colorectal cancer, epilepsy, chronic obstructive pulmonary disease and type 2 diabetes (Olver & Hopwood 2013). In addition, people with any chronic physical disease tend to feel more mental distress than do healthy people (Nasif 2015). Poor physical health brings an increased risk of depression (Caneo et al. 2016), as do the social and relationship problems that are common among chronically ill patients (Gürhan et al. 2019). Understanding the relationship between physical and mental health is crucial for nurses in order to develop strategies to reduce the incidence of co-existing conditions and support those already living with mental illnesses and chronic physical conditions. Everyday behaviours with the potential to positively or negatively affect physical and mental health include sleep, diet, alcohol/drug use and physical exercise (White et al. 2014).

Assisting patients to manage their physical health and mental health is a role for all nurses. Simple ways we can observe a person's physical health status include taking note of their body shape, skin, central adiposity, weight, height, body mass index, blood pressure, heart rate, cholesterol, blood sugar levels, abdominal circumference and fitness level. See Chapter 18 for further nursing strategies.

Critical thinking challenge 1.2

Metabolic syndrome is a cluster of risk factors that predicts development of type 2 diabetes and cardiovascular disease. Rates of metabolic syndrome are high in people taking antipsychotic medication, yet nurses in mental health and primary care settings do not always provide routine screening for metabolic syndrome. Consider your own area of practice or your current clinical placement. Are mental health consumers in that area screened for metabolic syndrome? Do nurses consider this to be part of their practice? If consumers are screened, what interventions are used to reduce the risk of metabolic syndrome?

Self-harm and suicide

In addition to mental disorders, self-harm and suicidality are behaviours that nurses commonly encounter in settings such as primary care and emergency departments, as well as mental health services. Rates of suicide have increased in recent years in both Australia (Harrison & Henley 2014) and New Zealand (Ministry of Health 2019), and for every person who completes suicide there are many more who self-harm (Chan et al. 2016). Self-harm can vary from cutting to relieve distress, to overdoses of prescribed or over-the-counter medication and potentially lethal attempts at suicide. Depression is a common mental disorder and is associated with self-harm and suicidal thoughts.

In general hospital settings patients may sometimes express a sense of hopelessness when faced with ill health, pain, lost function or an adverse prognosis. Such patients may then entertain passive suicidal thoughts – ideas that they would be better off dead or a wish that they would die from their illness. Passive suicidal thoughts are relatively common and may respond to the listening skills and validation of an empathic nurse (Mortier et al. 2018). If passive suicidal thoughts worsen and develop into active suicide plans, the nurse may need to consider referral to a mental health specialist.

Although suicide is statistically rare, it leaves emotional ripple effects on the lives of hundreds of thousands of friends and relatives of people who complete suicide each year. Research suggests many people who complete suicide had recent contact with a health professional (Rhodes 2013), indicating that those considering suicide are not always receiving the psychological support they seek. Certain population groups are at higher risk of suicide. These groups currently include men and young people. In fact, suicide is the leading cause of death in adolescents and young adults in Australia (Australian Institute of Health and Welfare 2019); men over the age of 85 have the highest suicide rate of all age groups (Burns 2016). Other groups that have been identified as being at higher risk of suicide include people from rural and remote communities and Aboriginal and Torres Strait Islander people (Wilson et al. 2018).

Mental health care

Australian mental health service delivery is guided by a national mental health strategy that comprises a national policy and a national plan (the *Fifth National Mental Health and Suicide Prevention Plan* was published in 2017), as well as a statement of rights and responsibilities (Commonwealth of Australia 2012). Each of the states and territories develops and reforms services in accordance with this national strategy. In New Zealand, the Ministry of Health provides national direction for mental health services. In both countries the aim is to provide mental health care to people in the least restrictive environment. In keeping with this, mental health care is provided in a wide range of clinical settings from generalist health settings and primary care, through to specialist mental health services, with the preferred setting for service delivery being in the community wherever possible.

WHO recommends that mental health care should be based in primary care. This is because general practice is usually the first point of contact for people seeking assistance for all health problems – including mental health problems – and a significant number of people with severe mental illness and high care needs receive their mental health care from a general practitioner working in a primary care setting and/or a psychiatrist working in private practice. In addition, the high prevalence of comorbid illnesses and the side effects of psychotropic medications make the need for a strong and well-established links with general practice important. A systematic review by Perkins et al. (2017) identified that generalist healthcare providers in Australia, including nurses, undertake recognition and identification of illness, assessment and care planning, patient education, pharmacotherapy, psychological therapies (and other therapies), ongoing management, physical care and referral for people with mental health problems.

The 'stepped care' model of mental health care is an evidence-based, staged system that includes a hierarchy of interventions that are matched to a person's needs – ranging from least to most intensive (Australian Government Department of Health 2019; Te Pou o Te Whakaaro 2012). Box 1.1 provides some descriptors around the intervention hierarchy in the stepped care model.

In a stepped care arrangement, it's not necessary to start at level 1. The care that people need depends on the severity of their problems, the impact of their experiences on their functioning and how any problems identified may have responded to initial (first-line) interventions. For example, for some people interventions such as relaxation training, sleep hygiene and moderating use of alcohol may be effective in reducing mild anxiety, while others might need specialist assessment, psychological therapy or pharmacological treatment. In addition to improving access to mental health care, as well as detection, early intervention and outcome for consumers, stepped care aims to improve the efficiency and effectiveness mental health service delivery.

Within mental health services, there are many settings in which a nurse may practise (see Chapter 27). The most common of these include inpatient services in general hospitals, crisis teams, community mental health teams and recovery-focused services. Specialist mental health services are delivered in mental health settings by health professionals with specialist mental health qualifications and training, including mental health nurses, psychiatrists, psychologists and mental health–trained social workers and occupational therapists.

Increasingly, people with a lived experience of mental illness are undertaking peer worker roles across primary care, community and inpatient settings (Crane et al. 2016). The essence of these various roles is to provide support based on mutual respect, shared responsibility and mutual agreement about what support is needed (Cleary et al.

Box 1.1 Stepped care model of mental health care in primary health

Level 1: Self-management – for people with no or mild mental illness, designed to prevent the development of illness (or prevent illness from progressing) and focused on helping individuals to manage symptoms themselves. This might include pamphlets about mental health and wellbeing, workbooks about a specific problem or online self-help programs.

Level 2: Low-intensity services – for people with mild to moderate mental illness and might include guided self-help or brief psychological interventions designed to last for a few short sessions.

Level 3: Moderate-intensity services are for people with mild to moderate mental illness but provide more structured, frequent and intensive interventions.

Level 4: High-intensity services are for people with more severe mental illness that is persistent or episodic, but that doesn't carry a high level of risk, complexity or disability. This includes high-intensity services and intensive interventions that might include multidisciplinary support.

Level 5: Acute and specialist community mental health services are for people with severe and persistent needs and those with complex multiagency needs or conditions that include high levels of risk, disability or complexity. These services include intensive team-based specialist assessment and intervention provided by mental health professionals across disciplines.

2018). Similarly, community-managed organisations (also known as non-government organisations or 'NGOs') are increasingly playing a key role in providing support to people with a lived experience of mental illness – through direct service delivery (Balagopal & Kapanee 2019). They complement existing mental health services and strengthen community supports and partnerships. The main types of support provided include: accommodation support and outreach; employment and education; leisure and recreation; family and carer support; self-help and peer-support; helpline and counselling services; and promotion, information and advocacy. While it is critical for nurses to work in an integrated way with community-managed organisations, it is important to remember that NGOs do not provide whole-of-life services, but rather stepping stones for those people who choose to use them. The aim is for people to develop naturally occurring supports within the community or to use other created supports that are accessed by all members of the community.

NURSE'S STORY 1.1

Anna

I undertook my nursing training at a regional base hospital in the mid-1970s. At that time, we lived in nurses' quarters. We had a month-long placement at the local psychiatric hospital and the psychiatric nurse trainees had a placement with us. I had not considered psychiatric (as it was called then) nursing at the time. During my third and final year of training I had a relationship breakup. It was very traumatic for me, mostly because it was so sudden. My then boyfriend was particularly nasty and made some very unkind comments about my appearance. I became quite depressed.

Living in nurses' quarters might lead you to think that everyone would have noticed me getting more and more unhappy, but shared living with hundreds of student nurses also provided quite a lot of anonymity. I went about my shifts and stayed in my room most of the time. I didn't confide in my parents. My mother had suffered from depression and hypochondriasis for many years and I didn't want to burden her or my dad. I didn't want to be like her. I pretended nothing was wrong.

Over the next few months I joined a gym and started going more and more often. I also started dieting, purging and using diuretics. I lost a lot of weight. The depression lifted (I didn't have any formal treatment), but I was getting very thin. I loved it and was proud of my body. By this time, we were also gearing up for the statewide final exams. I was able to handle the stress by working out. My weight was 45 kg and I had a BMI of 17. This was now considered a problem, but not for me.

After a few months one of the gym instructors asked me out and I agreed. That was the turning point. He said that I was looking unwell and he preferred it when I was fit but at a healthy weight. I was very fearful of becoming fat. He encouraged me to change to a 'lifters' high-protein diet and worked with me and encouraged me. I steadily gained weight but not fat. The relationship didn't last, but we have remained good friends ever since.

I moved interstate after my graduate year and tried to get a job at a general hospital in a large regional town, without success. I then considered psychiatric nursing. Although I wasn't previously interested, my personal journey created a curiosity and a greater understanding of the issues that people with mental health problems face and the courtesy stigma that is attached to people who are associated with people with a mental health problem. I am pleased I made the decision. I have never looked back.

Critical thinking challenge 1.3

Nurses meet people with mental health and addiction problems in every clinical setting. For some people, their mental health needs can be met within a general health setting, such as primary care or in a medical ward of a general hospital. Others need referral to a specialist mental health service. How would you assess the mental health needs of a patient in a general health setting? When would you consider referral for a specialist mental health assessment?

Cultural considerations

Australia and New Zealand are culturally diverse countries originally peopled by indigenous populations. Following colonisation and migrant settlement over two centuries, both countries now embrace multiple cultures, although the dominant culture in both countries reflects a Western worldview and values. This dominant worldview has been found to be inadequate in the face of the cultural diversity of both countries.

The indigenous peoples of Australia and New Zealand experience high rates of mental disorder that reflects the history and modern legacy of colonisation (Tapsell et al. 2018; Trueman 2013). 'Mental illness' is a Western construct, however, and so for many indigenous people represents Western ideas of the individual and the relationship between the individual and society. These ideas may be profoundly different from those of people from non-Western cultures. Indigenous Australians and New Zealand Māori have views of health and illness that are informed by their wider cultural beliefs and that support practices unique to those cultures. The way people express mental distress and illness will reflect their cultural beliefs. In New Zealand, for example, the phenomenon of *whakamaa* (shame, self-abasement, shyness, excessive modesty and withdrawal describe some aspects of this concept) is unique to the Māori culture (Tauranga & Moore 2018). For Australian Aboriginal people, individuals who spend long periods of time away from their country (place of birth/Dreaming) can be vulnerable to episodes of unwellness due to their weakened spiritual link with country and community (Vicary & Westerman 2004). Symptoms of a cultural syndrome known as 'longing for country' commonly includes feelings of weakness, nausea and general 'sickness' and somatic complaints, identity confusion and disorientation, which if cultural background is not considered may be misinterpreted by clinicians reliant on Western interpretations as forms of clinical depression or anxiety. Not being able to go home and settle these feelings can lead Aboriginal Australians to further health deterioration. The importance of country might partially explain the profound effect prison has on many Aboriginal people and the high rate of deaths in custody among Australian Aboriginals compared with Westerners (Vicary & Westerman 2004). Connection with land is central to many indigenous people and is often related to issues of mental health.

The increasing ethnic and cultural diversity of Western societies means that diverse individuals attend Western health services with presentations influenced by cultural beliefs and practices different from those of clinicians trained in Western models. Nurses respond to this diversity by developing an understanding of the diversity of cultures in their own societies and by developing cross-cultural communication skills (O'Brien et al. 2017). Services also attempt to provide clinicians from the cultural group of the service user and, in some cases, develop specialty services based on a culturally specific model of treatment. Collaborations between traditional and Western practitioners in mental health care have been further described by NiaNia et al. (2017).

Critical thinking challenge 1.4

Consider the cultural influences on your own identity. What insights does your cultural experience give you into the experience of people from cultures other than your own? In what ways does your cultural background limit your understanding of the cultures of others? What skills and strategies can you use to ensure barriers to cross-cultural communication are effectively addressed?

Cultural safety and mental health care

Nursing is about people of all cultures. Consumers and nurses have diverse cultural backgrounds, and while this diversity makes for rich and rewarding experiences it also brings the possibility of misinterpretations and misunderstandings. Experiences of distress and emotional conflict are embedded in cultural beliefs and traditions, so it is important that every nursing encounter is regarded as one that occurs with the cultural contexts of the nurse and consumer. The populations of Australia and New Zealand are characterised by increasing cultural diversity, and it is important that this diversity is acknowledged by nurses. Australian professional standards for mental health nurses recognise the need for nurses to work with consumers from all cultures (Australian College of Mental Health Nurses 2010), and New Zealand standards require nurses to provide care that is culturally safe (Te Ao Maramatanga 2012). The term 'cultural safety' (kawa whakaruruhau) was developed by New Zealand nurse Irihapeti Ramsden and can be considered the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on their own cultural identity and recognises the impact of their own cultural identity on

their nursing practice.[2] The concept of cultural safety has been widely adopted across many countries and health settings (Kurtz et al. 2018) and has been suggested as a model for Australian healthcare standards (Laverty et al. 2017). More recently there has been increasing recognition that individuals carry multiple cultural and other identities (Kang & Bodenhausen 2015), making cultural safety a more complex construct but also one that is more sensitive to the realities of nurses' and consumers' multiple cultural beliefs, values and practices. For this reason, the Nursing Council of New Zealand's definition of 'culture' extends to 'age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability' (Nursing Council of New Zealand 2011, p. 5). As can be seen from that definition, culture is seen as construct that applies to many possible identities. A key to cultural safety is the nurse's own self-awareness and sensitivity to the impact of their cultural identity on the care they provide to others. As we have discussed above, the mental health experience of indigenous Australians and New Zealanders is shaped by the historical and contemporary experience of colonisation. Awareness of this history and how it continues within contemporary society is a critical aspect of cultural safety if nurses are to avoid reinforcing the colonial relationship within their nursing practice. This historicising approach provides a foundation for culturally safe practice with all the diverse cultures of Australia and New Zealand. Cultural safety does not require that nurses 'understand' the cultures of all consumers and communities. Such an approach is naïve and risks the nurse assuming cultural expertise they do not have.

[2]Adapted from a definition provided by the Nursing Council of New Zealand (2011).

CASE STUDY 1.1
Zahra

Zahra is a 30-year-old Somalian woman who police found wandering on a busy road. They were unable to engage her in conversation and were also unclear as to whether she was under the influence of alcohol or drugs. They took her to a mental health facility where mental health clinicians were asked to assess her.

The mental health team approached Zahra and introduced themselves. At that moment Zahra became more aware of her surroundings and became agitated. She kept repeating that she was not a prisoner and not to hurt her. Her English was limited but her meaning was clear to all. The mental health team attempted to calm her and requested that the police remain in the area but be unseen. This had a short-term calming effect.

Using an interpreter, the mental health team undertook their assessment and mental state examination. It became evident that Zahra was using multiple substances including cannabis and alcohol. She stated that she was using these substances more and more because they helped her forget the past.

Zahra had experienced terrible hardship including rape, being separated from her family and living in a detention centre for 3 years. As a result, she developed post-traumatic stress disorder.

Many refugees have experienced and witnessed appalling conditions, often perpetrated by people in authority. In Zahra's case staff could not have predicted her response. However, when working with refugees, nurses must be mindful of the possibility of traumatic stress and the associated sequelae, including substance use.

Historical anecdote 1.2: Ancient treatments

Communities as early as 5000 BCE associated mental ill health with mythological and spiritual beliefs such as demonic possession, sorcery and curses. Archaeologists have found the remains of prehistoric human skulls that had holes chipped into them using stone instruments (a treatment known as trephining) in the belief that by opening the skull an evil spirit, thought to be inhabiting a person's head and causing mental ill health, might be released and the individual would be cured. Some who underwent such procedures appear to have survived and lived for many years afterwards as trephined skulls of early humans show signs of healing. Pressure on the brain may have also been incidentally relieved.

Read more about it: *Prioreschi P 1991 Possible reasons for neolithic skull trephining. Anecdotes in Biology and Medicine 34(2): 296–303*

Mental health legislation

Mental health is unique within the healthcare environment in providing legislation that can compel people to accept treatment and, in some cases, to remain in hospital. Treatment without consent under mental health legislation is known as 'compulsory treatment' or 'civil commitment'. Informed consent is normally considered fundamental to providing care in every clinical setting, and treatment without consent is considered unethical. The usual rationale for providing compulsory treatment under mental health

legislation is given in terms of risk to the person with mental illness or to another person. It is not enough for risk to be present; the risk must be due to mental illness. Examples include impaired judgement due to mania that might lead people to take actions that are very unsafe, suicidal thoughts together with intentions to act due to depression, or thoughts of harming others in response to voices telling the person to act in a harmful way. These high-risk situations are exceptional and require clinicians to act within the definitions of mental disorder contained in legislation. The purpose of compulsory treatment is to protect the person or others from potential harm. In addition to compulsory treatment in hospital, mental health legislation can also compel patients to accept treatment in community settings under a community treatment order. Although mental health legislation limits some rights of consumers it also provides protections through the right to consult a lawyer and to appeal to a court for a review of legal status. Several Australian states have amended their mental health legislation in recent years to give greater effect to human rights through processes such as supported decision making and advance directives. Mental health legislation is further explored in Chapter 8.

Mental health and the scope of nursing practice

In Australia and New Zealand nursing is regulated by statutory bodies that determine the responsibilities and obligations of nurses. One of the main mechanisms of statutory bodies is through statements of the scope of nursing practice (Lubbe & Roets 2014). Another mechanism is through statements of competencies, which are descriptions of the skills every nurse is expected to demonstrate. Nurses are legally and professionally responsible for working within their nursing scope of practice and for meeting all competencies of their regulatory bodies. There is no regulated scope of practice for mental health nursing in either Australia or New Zealand. Instead the scope is stated in broad terms and applies in every clinical setting.

The Nursing and Midwifery Board of Australia (www.nursingmidwiferyboard.gov.au) cites the following International Council of Nurses scope of practice statement:

> Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings.

The Nursing Council of New Zealand also identifies a broad scope of practice for nurses (available at www .nursingcouncil.org.nz):

> Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health [...]. This occurs in a range of settings in partnership with individuals, families, whānau and communities.

Statements of the scope of nursing practice make it clear that mental health care is every nurse's business. Together with the competencies for practice, they encompass the whole range of health care, meaning that nurses are expected to appropriately respond to the full range of needs of all patients. When we understand how common mental health issues are in the community, and how commonly people experience both mental and physical health problems, it is clear that there is a professional obligation for nurses to respond to the whole person, including their physical and mental health needs. The nursing scope of practice clearly reflects that obligation.

Nursing and mental health

As a nurse you will meet people with mental health issues in every area of clinical practice, from primary care through to specialist settings such as intensive care and surgery, and in prisons, schools, workplaces and aged care services. Mental health is both a specialised field of nursing practice and a fundamental part of every nurse's scope of practice. Yet you do not need to be a mental health specialist to respond to people's mental health needs. Fundamental mental health knowledge and skills can be used by all nurses, regardless of setting (O'Brien 2014).

Caring for people's mental health is a vital part of nursing. Patients in every clinical setting have mental health needs that may or may not contribute to their reasons for accessing health services. For many people nurses work with, mental health care is about helping a person maintain a sense of social and emotional wellbeing and seeking to optimise their mental health, which they normally experience as being positive. For others, mental health care may involve some short-term assistance to overcome mild experiences of mental health challenges such as anxiety or low mood. Nurses also commonly care for people who have long-term experience of mental illness such as schizophrenia or bipolar disorder that requires support of varying levels of intensity over many years. It is important for nurses to consider the whole of each person's health needs. Just as a patient with a long-term mental illness might present to their general practitioner with asthma or high blood pressure, a patient with a chronic physical illness such as diabetes might experience episodes of low mood or anxiety.

Responding to a person's mental health needs requires a variety of nursing skills including listening, exploring emotional issues and troubling thoughts, showing empathy, offering encouragement and building on strengths. See Chapter 2 for a discussion of holistic mental health nursing practice and therapeutic mental health nursing skills. Such actions can be incorporated into regular nursing care; they do not have to wait until other needs have been attended

to. A nurse who practises holistically will be aware of the needs of each person at the time, will be open to discussing emotional and physical health issues and be comfortable in responding in an informed and helpful way. This may involve seeking guidance from other professionals or making a referral to a specialist service. Such referral or advice seeking is an integral part of the nurse's practice and an acknowledgement of the scope of nursing practice. Mental health is part of the core business of every nurse, whether by the direct care the nurse provides or by referral to a specialist service.

CONSUMER'S STORY 1.1

Maria

I had a difficult childhood and found myself on the streets at the age of 13 doing what I had to do to survive. I married young to a violent man and had four children. I didn't start using drugs until I was in my mid-40s when I was told that speed (methamphetamine) wasn't addictive! Before too long I was injecting and had a $300 a day habit. I even injected it into my neck when I couldn't find a vein in my arm. I was always chasing the dragon (trying to get that incredible feeling of elation experienced at the first taste). I was a junkie, and nothing mattered more than getting my next hit. Not even my kids. Eventually I realised I had a problem, so I walked down to my local GP and asked for some help. I was told they didn't work with people like me. I was stunned but I walked further along the street to another GP and was standing at the reception desk asking if someone would see me when one of the doctors, who just happened to be standing near the desk, invited me into his office right there and then. He referred me to the mental health nurse working at the practice and I saw both of them for the next several years. She (the mental health nurse) would see me at home even when I didn't want to see her! There were times when I wouldn't see her because I'd started using again and I was too ashamed to look her in the eye. But she kept coming back. After 10 years of addiction I've now been clean for more than 2 years. I now have a 'normal' life. I work two jobs but, more importantly, I have a pretty good relationship with my kids and a fantastic relationship with my three gorgeous grandkids. And now I've been cigarette-free for almost 11 months.

Chapter summary

Mental health matters because mental health problems are prevalent in our society, have significant personal, social and economic impacts, present in every clinical setting, and form part of the nursing scope of practice. Mental health is part of health. Mental health problems impact on the course and severity of physical health problems and are associated with worse health outcomes. Mental health consumers experience high rates of physical health disorders, are less likely to have physical health issues attended to and die younger than those in the general population. People with physical illnesses experience worse mental health than those without illness, and mental health problems adversely affect treatment, recovery and quality of life. Nurses have opportunities to use mental health skills to improve consumers' mental and physical health.

Responding to the mental health needs of patients is a professional obligation of nurses. Nurses do not need to be specialists to respond to patients' mental health needs. Fundamental mental health nursing skills such as listening, validating and responding empathically will help meet the mental health needs of patients in all clinical settings. Nurses can also learn and develop skills in specific therapeutic modalities. In some cases, nurses will feel they need to ask for further advice about a patient's needs or to refer the patient to a mental health specialist. Every nurse is not a *specialist* mental health nurse, just as every nurse is not a specialist in diabetes care, coronary care or primary care. But just as mental health is part of health, mental health is part of every nurse's scope of practice.

EXERCISES FOR CLASS ENGAGEMENT

After reading this chapter discuss the following scenarios in small groups.

SCENARIO 1

Mental health is part of the scope of practice of every nurse. However, the mental health needs of consumers in general health settings (such as medical and surgical wards and primary care) are frequently overlooked. Discuss the possible barriers to nurses in general settings responding to consumers' mental health needs. Make a list of the six most important barriers. Consider individual, system and policy-level barriers.

SCENARIO 2

Taking the list made in discussing scenario 1 above, identify strategies that would help nurses in addressing the identified barriers. The strategies may need support from others to implement.

SCENARIO 3

Many individual, social and political factors can influence mental health. Conversely, mental distress and illness can impact on employment, social organisation and the economy.

1. Identify five social factors that can influence a person's mental health.
2. For each factor discuss how that factor can be addressed.
3. Identify five social impacts of mental distress or illness.
4. For each factor discuss how the impact of mental distress or illness could be reduced.

SCENARIO 4

Rebecca is a 32-year-old woman who has been feeling increasingly tired and 'strung out' after the birth of her first child 5 months ago. When she visits her GP to ask for medication to help her sleep the GP asks a primary care nurse to interview Rebecca and assess her mood, safety and sleep. Rebecca is surprised to learn that the nurse considers she may be depressed.

1. What initial support and intervention could be considered for Rebecca?
2. What areas of assessment would you consider in interviewing Rebecca?
3. What would you consider before recommending to the GP that Rebecca is prescribed medication for her mood?
4. At what point would you consider referring Rebecca to a specialist mental health clinician for further assessment and treatment? (Refer to the outline of stepped care on page 11).

Useful websites

Australian Bureau of Statistics Mental Health Australia: https://mhaustralia.org/.

Australian Government Department of Health *PHN mental health tools and resources*: http://www.health.gov.au/internet/main/publishing.nsf/content/phn-mental_tools.

Black Dog Institute, Australia: https://www.blackdoginstitute.org.au/.

Health Navigator New Zealand: https://www.healthnavigator.org.nz/health-a-z/m/mental-illness/.

Mental Health Australia: https://mhaustralia.org.

Mental Health Commission, Australia: https://www.mentalhealthcommission.gov.au/.

Mental Health Coordinating Council: http://www.mhcc.org.au/about-mhcc/.

Mental health data and statistics (New Zealand): https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/mental-health-data-and-stats.

Mental health data, Australia: https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Health_Data.

Mental Health Foundation of New Zealand: www.mentalhealth.org.nz.

Wellplace New Zealand: https://wellplace.nz/facts-and-information/mental-wellbeing/mental-health-in-new-zealand/.

References

Australian Bureau of Statistics (ABS), 2008. National Survey of Mental Health and Wellbeing: Summary of results. Cat. No. 4326.0. Commonwealth of Australia, Canberra.

Australian Bureau of Statistics (ABS), 2018. National Health Survey First results. Australia 2017–18. Commonwealth of Australia, Canberra.

Australian College of Mental Health Nurses, 2010. Standards of Practice for Mental Health Nursing in Australia. Canberra, Australian College of Mental Health Nursing.

Australian Government Department of Health, 2019. PHN Mental Health Flexible Funding Pool Programme Guidance: Stepped Care, Canberra: Australian Government Department of Health.

Australian Institute of Health and Welfare, 2019. Deaths in Australia. Cat. no. PHE 229. Canberra: AIHW. https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia. (Accessed 9 February 2020).

Balagopal, G., Kapanee, A.R.M., 2019. Lessons learnt from NGO approaches to mental healthcare provision in the community. In: Mental Health Care Services in Community Settings. Springer, Singapore, pp. 185–204.

Burns, R.A., 2016. Sex and age trends in Australia's suicide rate over the last decade: something is still seriously wrong with men in middle and late life. Psychiatry Res. 245, 224–229.

Caneo, C., Marston, L., Bellón, J.Á., et al., 2016. Examining the relationship between physical illness and depression: is there a difference between inflammatory and non inflammatory diseases? A cohort study. Gen. Hosp. Psychiatry 43, 71–77.

Chan, M.K., Bhatti, H., Meader, N., et al., 2016. Predicting suicide following self-harm: systematic review of risk factors and risk scales. Br. J. Psychiatry 209 (4), 277–283.

Cleary, M., Raeburn, T., West, S., et al., 2018. Two approaches, one goal: how mental health registered nurses perceive their role and the role of peer support workers in facilitating consumer decision-making. Int. J. Ment. Health Nurs. 27 (4), 1212–1218.

Commonwealth of Australia, 2012. Mental health statement of rights and responsibilities 2012. Canberra, Commonwealth of Australia.

Crane, D.A., Lepicki, T., Knudsen, K., 2016. Unique and common elements of the role of peer support in the context of traditional mental health services. Psychiatr. Rehabil. J. 39 (3), 282.

Damery, S., Brown, C., Sein, K., et al., 2019. The prevalence of mild-to-moderate distress in patients with end-stage renal disease: results from a patient survey using the emotion thermometers in four hospital trusts in the West Midlands, UK. BMJ Open 9 (5), e027982.

Davison, K., 2006. Historical aspects of mood disorders. Psychiatry 5 (4), 115–118.

de Munter, L., Polinder, S., Haagsma, J.A., et al., 2020. Prevalence and prognostic factors for psychological distress after trauma. Arch. Phys. Med. Rehabil. 101 (5), 877–884.

Firth, J., Siddiqi, N., Koyanagi, A., et al., 2019. The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. Lancet Psychiatry 6 (8), 675–712.

Gilbertson-White, S., Campbell, G., Ward, S., et al., 2017. Coping with pain severity, distress, and consequences in women with ovarian cancer. Cancer Nurs. 40 (2), 117.
Grech, E., Raeburn, T., 2019. Experiences of hospitalised homeless adults and their health care providers in OECD nations: a literature review. Collegian 26 (1), 204–211.
Gürhan, N., Beşer, N.G., Polat, Ü., et al., 2019. Suicide risk and depression in individuals with chronic illness. Community Ment. Health J. 55 (5), 840–848.
Harrison, J., Henley, G., 2014. Suicide and hospitalised self-harm in Australia: trends and analysis. Injury research and statistics series. Canberra: AIHW.
Inoue, M., Yamaoka, K., 2017. Social factors associated with psychological distress and health problems among elderly members of a disaster-affected population: subgroup analysis of a 1-year post-disaster survey in Ishinomaki area, Japan. Disaster Med. Public Health Prep. 11 (1), 64–71.
Islam, F.M.A., 2019. Psychological distress and its association with socio-demographic factors in a rural district in Bangladesh: a cross-sectional study. PLoS ONE 14 (3), e0212765.
Jayasuriya, D., Jayasuriya, R., Tay, A.K., et al., 2016. Associations of mental distress with residency in conflict zones, ethnic minority status, and potentially modifiable social factors following conflict in Sri Lanka: a nationwide cross-sectional study. Lancet Psychiatry 3 (2), 145–153.
Kang, S.K., Bodenhausen, G.V., 2015. Multiple identities in social perception and interaction: challenges and opportunities. Annu. Rev. Psychol. 66, 547–574.
Kolappa, K., Henderson, D.C., Kishore, S.P., 2013. No physical health without mental health: lessons unlearned? Bull. World Health Organ. 91, 3–3A.
Kurtz, D.L.M., Janke, R., Vinek, J., et al., 2018. Health sciences cultural safety education in Australia, Canada, New Zealand, and the United States: a literature review. Int. J. Med. Educ. 9, 271–285.
Laverty, M., McDermott, D.R., Calma, T., 2017. Embedding cultural safety in Australia's main health care standards. Med. J. Aust. 207 (1), 15–16.
Lubbe, J.C., Roets, L., 2014. Nurses' scope of practice and the implication for quality nursing care. J. Nurs. Scholarsh. 46 (1), 58–64.
Maybery, D., Jones, R., Dipnall, J.F., et al., 2019. A mixed-methods study of psychological distress following an environmental catastrophe: the case of the Hazelwood open-cut coalmine fire in Australia. Anxiety Stress Coping 33 (2), 216–230.
McCarthy, M.M., Whittemore, R., Gholson, G., et al., 2019. Diabetes distress, depressive symptoms, and cardiovascular health in adults with type 1 diabetes. Nurs. Res. 68 (6), 445–452.
McPhillips, R., Salmon, P., Wells, A., et al., 2019. Cardiac rehabilitation patients' accounts of their emotional distress and psychological needs: a qualitative study. J. Am. Heart Assoc. 8 (11), e011117.
Mental Health Commission of NSW, 2016. Physical health and mental wellbeing: evidence guide, Sydney, Mental Health Commission of NSW.
Ministry of Health, 2018. He Ara Oranga. Report of the Government Inquiry into Mental Health and Addiction, Wellington: Ministry of Health.
Ministry of Health, 2016. Annual Update of Key Results 2015/16: New Zealand Health Survey. Wellington: Ministry of Health.
Ministry of Health, 2017. Briefing to the Incoming Minister of Health 2017: The New Zealand Health and Disability System. Wellington: Ministry of Health.
Ministry of Health, 2019. Every life matters – He Tapu te Oranga o ia tangata: suicide prevention strategy 2019–2029 and suicide prevention action plan 2019–2024 for Aotearoa New Zealand. Wellington: Ministry of Health.
Morgan, V.A., Waterreus, A., Jablensky, A., et al., 2012. People living with psychotic illness in 2010: the second Australian national survey of psychosis. Aust. N. Z. J. Psychiatry 46 (8), 735–752.
Mortier, P., Cuijpers, P., Kiekens, G., et al., 2018. The prevalence of suicidal thoughts and behaviours among college students: a meta-analysis. Psychol. Med. 48 (4), 554–565.
Nasif, J., 2015. The emotional impact of chronic illness. J. Psychol. Clin. Psychiatry 3 (6), 00177.
Neil, A.L., Carr, V.J., Mihalopoulos, C., et al., 2014. Costs of psychosis in 2010: findings from the second Australian National Survey of Psychosis. Aust. N. Z. J. Psychiatry 48 (2), 169–182.
NiaNia, W., Bush, A., Epston, D., 2017. Collaborative and Indigenous Mental Health Therapy. Tataihono – Stories of Maori Healing and Psychiatry. Routledge, New York.
Nursing Council of New Zealand, 2011 Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice. Wellington. Nursing Council of New Zealand.
O'Brien, A., 2014. Every nurse is a mental health nurse. Nurs. N. Z. 20 (8), 2.
O'Brien, A.J., DeSouza, R., Baker, M., 2017. Providing culturally safe care. In: Chambers, M. (Ed.), Psychiatric and Mental Health Nursing. The Craft of Caring. Routledge, London, pp. 419–430.
Oakley Browne, M.A., Wells, J.E., Scott, K.M., et al., 2006. Lifetime prevalence and projected lifetime risk of DSM-IV disorders in Te Rau Hinengaro: the New Zealand Mental Health Survey. Aust. N. Z. J. Psychiatry 40 (10), 865–874.
Olver, J.S., Hopwood, M.J., 2013. Depression and physical illness. Med. J. Aust. 199, S9–S12.
Perkins, D., Williams, A., McDonald, J., et al., 2017. What is the place of generalism in mental health care in Australia?: A systematic review of the literature. Australian Primary Health Care Research Institute. Available at: https://openresearch-repository.anu.edu.au/handle/1885/119238.
Prioreschi, P., 1991. Possible reasons for neolithic skull trephining. Perspect. Biol. Med. 34 (2), 296–303.

Productivity Commission, 2019. Mental Health, Draft Report, Australian Government, Canberra.
Rhodes, A., 2013. Youth suicide in Canada: distinctions among boys and girls. Healthc. Q. 16 (3), 11–13.
Summers, A., Leidman, E., Periquito, I.M.P.F., et al., 2019. Serious psychological distress and disability among older persons living in conflict affected areas in eastern Ukraine: a cluster-randomized cross-sectional household survey. Confl. Health 13 (1), 10.
Tapsell, R., Hallett, C., Mellsop, G., 2018. The rate of mental health service use in New Zealand as analysed by ethnicity. Australas Psychiatry 26 (3), 290–293.
Tauranga, M., Moore, D., 2018. Adult Māori patients' healthcare experiences of the emergency department in a district health facility in New Zealand. Int. J. Indig. Health 13 (1), 87–103.
Te Ao Maramatanga (New Zealand College of Mental Health Nurses), 2012. Standard of Practice for Mental Health Nursing in New Zealand. Auckland: Te Ao Maramatanga.
Te Pou o Te Whakaaro Nui, 2017. The physical health of people with mental health conditions and/or addiction. Evidence update: December 2017. Auckland: Te Pou o Te Whakaaro Nui.
Te Pou o Te Whakaaro Nui, 2014a. The physical health of people with a serious mental illness and/or addiction: an evidence review. Te Pou o te Whakaaro Nui, Auckland.
Te Pou o Te Whakaaro Nui, 2014b. Take action to improve physical health outcomes for New Zealanders who experience mental illness and/or addiction. A consensus position paper. Auckland: Te Pou o Te Whakaaro Nui.
Te Pou o Te Whakaaro, 2012. Talking Therapies: Where to Next? Te Pou o te Whakaaro Nui, Auckland.
Thomas, H.J., Chan, G.C., Scott, J.G., et al., 2016. Association of different forms of bullying victimisation with adolescents' psychological distress and reduced emotional wellbeing. Aust. N. Z. J. Psychiatry 50 (4), 371–379.
Tomitaka, S., Kawasaki, Y., Ide, K., et al., 2019. Distribution of psychological distress is stable in recent decades and follows an exponential pattern in the US population. Sci. Rep. 9 (1), 1–10.
Trueman, S.W., 2013. Contextualizing mental health nursing encounters in Australian remote Aboriginal communities: part 2, client encounters and interviews. Issues Ment. Health Nurs. 34 (10), 772–775.
Vicary, D., Westerman, T., 2004. That's just the way he is': some implications of Aboriginal mental health beliefs. Aust. e-J. Adv. Ment. Health 3 (3), 103–112.
Walker, E.R., McGee, R.E., Druss, B.G., 2015. Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. JAMA Psychiatry 72 (4), 334–341.
White, J., Hemingway, S., Stephenson, J., 2014. Training mental health nurses to assess the physical health needs of mental health service users: a pre-and post-test analysis. Perspect. Psychiatr. Care 50 (4), 243–250.
Wilson, A., Reilly, R., Mackean, T., 2018. Analysis of factors associated with Aboriginal and Torres Strait Islander suicide in Australia: a scoping review. Transcult. Psychiatry Manuscript submitted for publication.
World Health Organization (WHO), 2019. Mental health. who.int/news-room/facts-in-pictures/detail/mental-health.
World Health Organization (WHO), 2014. Constitution of the World Health Organization, Geneva: WHO.

CHAPTER 2

Nursing and mental health in context

Kim Foster, Peta Marks, Anthony J O'Brien and Toby Raeburn

KEY POINTS

- Developing therapeutic relationships is the key to effective nursing practice in mental health.
- Together, nurses and mental health consumers develop therapeutic alliances as a basis for consumers' growth and recovery.
- A social ecological approach to mental health nursing practice provides a framework for holistic practice.
- Self-awareness, insight and reflexivity are fundamental skills for nursing practice in mental health.
- Nursing practice occurs in the broader context of mental health, including the social determinants of mental health.

KEY TERMS

- Caring
- Compassion
- Empathy
- Healing
- Hope
- Professional boundaries
- Recovery
- Reflection
- Self
- Self-awareness
- Self-disclosure
- Social determinants
- Social ecological
- Spirituality
- Therapeutic alliance

LEARNING OUTCOMES

The material in this chapter will assist you to:

- describe the social ecological approach to mental health nursing practice
- identify the social determinants of mental health
- describe therapeutic relationships and how they are developed in the context of a person's mental health
- describe the three components of empathy
- define self-awareness and describe a strategy for developing self-awareness.

Introduction

Mental health nursing is one of the most interesting and challenging areas of nursing practice. The challenge of mental health nursing is working with people who are experiencing mental and emotional distress and may doubt themselves, the environment and the people around them. The reward of this work is often the satisfaction of using knowledge and skill to provide a context of safety and care where trust in self and others can be re-established. Mental health nursing requires a fusion of personal characteristics, professional knowledge, experience and clinical and interpersonal skills. People with mental illnesses have complex and sometimes long-term needs. They may engage in frequent and regular encounters with the healthcare system or have a one-off experience that brings them in to contact with mental health services or providers. The long-term and cyclic nature of some mental illnesses means that the therapeutic relationships between mental health nurses and consumers can last for long periods. The relationship will also vary in intensity as consumers move along a continuum between periods of high dependence at one end (in acute phases when they are experiencing acute distress or illness) and independence at the other (when their symptoms are less troublesome or their mental illness has resolved).

This chapter outlines the social ecological framework for mental health nursing practice that frames the text. This is a holistic framework for practice and the various elements of the framework are described: therapeutic relationships and consumer–nurse partnership; personal and contextual factors influencing practice; identities including gender and culture (nurse and consumer); and the context of practice (including social determinants of health and major approaches to mental health care – recovery-oriented care and trauma-informed care). The remainder of the chapter explores the interpersonal relationship as the foundation of effective mental health nursing practice and the knowledge, attitudes and skills needed to work with people in mental distress. Key concepts and issues that are fundamental to effective and safe mental health nursing practice are introduced. Holistic and skilful mental health nursing requires a sound knowledge of human physiology, health and illness, as well as a biopsychosocial understanding of mental illnesses and their treatments, including pharmacology. In addition, to practise effectively nurses working in mental health need to be open-minded and reflective and to have developed an understanding of concepts such as compassion, empathy, spirituality and hope. Personal qualities such as responsiveness, self-awareness and insight are essential for effective therapeutic relationships. Nurses in all settings care for the mental health and wellbeing of consumers, and mental health skills are required of all nurses and can be applied in all clinical settings.

Social ecological approach to mental health nursing practice

In this text we take a social ecological approach to mental health nursing practice. A social ecological perspective refers to the dynamic interactions between a person and their environment that influence their health and wellbeing. This person–environment interaction involves a number of factors and processes. Mental health can be understood as involving a person's physical, mental, emotional and spiritual characteristics and the interactive processes that occur between them and their environment or ecology (including their social and family context). This includes being able to access available resources that help sustain their mental health (Ungar 2011) and support their recovery such as human resources and supports including family and friends, healthcare resources including nursing care and mental healthcare (hospital or community-based) and practical resources such as financial support and housing. A social ecological or holistic perspective is relevant to understanding mental health and mental health nursing practice because mental health problems can challenge people in, and are challenged by, every aspect of their life. Similarly, nursing practice is shaped by our personal characteristics and skills and the health service context we work in. This dynamic person–environment interaction involves personal and contextual factors that influence nurses' practice and their relationships with consumers.

Therefore, from an ecological perspective nursing practice includes:

- nurses' personal characteristics (e.g. their personality, interpersonal style, cultural and gender identity, and nursing knowledge, attitudes and skills)
- therapeutic relationships and interpersonal interactions between nurses and consumers
- cultural and practice context within which a nurse and consumer are based
- available people and resources that can be accessed to support consumers' recovery.

Fig. 2.1 provides a diagrammatic representation of all these elements and their interactions. The following section outlines each of the elements.

Social determinants of health

In relation to the context or environment of mental health, the social determinants of health are the social and economic circumstances within which we are born and live (World Health Organization (WHO) 2018). These determinants are shaped by the distribution of power and resources in society and can lead to health inequities because they have a direct influence on the prevalence and severity of mental health conditions, which can extend across the life course (WHO 2018).

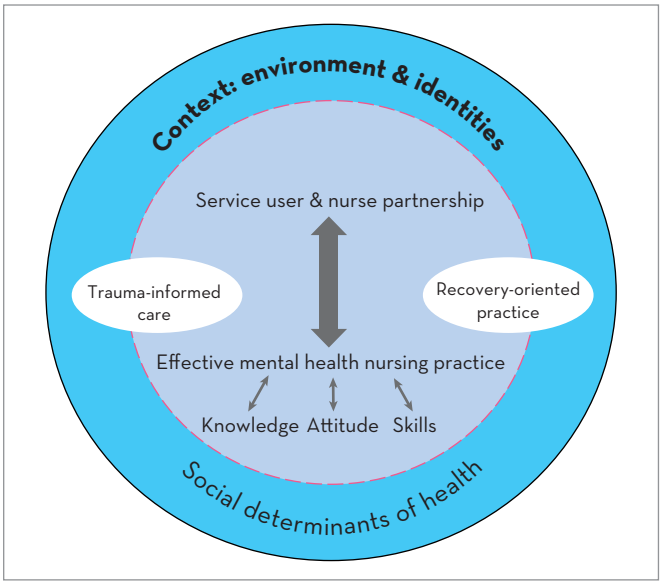

Figure 2.1
Social ecological approach to mental health nursing practice

In respect to mental health, key social determinants that directly influence health and quality of life include:

- mental health stigma
- poverty
- violence
- forced migration
- insecure living conditions including homelessness (WHO 2018).

Because mental ill health is strongly determined by these factors, mental health problems are not able to be improved by mental health treatments alone. The social factors that have contributed to these problems also need to be addressed and, wherever possible, eliminated. Social determinants can be either proximal or distal. Proximal factors are those that act directly to influence health (e.g. ongoing trauma), whereas distal factors act more indirectly (e.g. social deprivation). There is a need for targeted reduction of social determinants. To reduce the burden of mental ill health, Lund et al. (2018), using an ecological framework, identified the proximal and distal social determinants that are risk and/or protective factors for mental ill health according to five domains (see also Table 2.1):

- demographic
- economic
- neighbourhood
- environmental
- social and cultural.

An ecological approach to nursing therefore requires that nurses understand and address the social contexts within which people live. Nurses working clinically do not necessarily have the capacity to influence, prevent or intervene with all these factors, but it is vitally important when working with mental health consumers, and as relevant for the person, that these factors are taken into consideration and identified as part of history taking and assessment. As part of the work of the multidisciplinary team, a number of these factors can be directly addressed to help decrease risk and increase protection against further ill health – for example, negotiating adequate housing for consumers (and ensuring people are not discharged if they have nowhere to go), helping to build social support for consumers who are isolated and providing psychological support for the psychological impacts of trauma and associated distress such as a trauma-informed approach to care. An ecological approach to nursing also requires that nurses understand the environments within which they practice.

TABLE 2.1 Social and cultural determinants of mental disorders

DOMAIN	PROXIMAL	DISTAL
Demographic	Age Gender Ethnicity	Community diversity Population density Longevity Survival
Economic	Income Debt Assets Financial strain Relative deprivation Unemployment Food security	Economic recessions Economic inequality Macroeconomic
Neighbourhood	Safety and security Housing structure Overcrowding Recreation	Infrastructure Neighbourhood deprivation Built environment Setting Safety and security
Environmental	Natural disasters Industrial disasters War or conflict Climate change Forced migration	Trauma Distress
Social and cultural	Community social capital Social stability Cultural	Individual social capital Social participation Social support Education

Adapted from Lund et al. 2018

Contexts of mental health: environment and identities

In terms of the contexts within which nurses practise it is important for nurses to understand that the models of care and the health service approach within which they work directly influence their practice. Equally, nursing practice can influence and shape the environments within which we work. People admitted to hospitals can pose unique ethical challenges to nurses because they may experience episodes of mental ill health that necessitate compulsory admission under mental health legislation, removing part or all of their autonomy due to considerations of risk and safety. Involuntary admission often makes it difficult for nurses to apply recovery-oriented approaches that seek to provide people with choice and opportunity to develop strengths. Working in such challenging environments means that nurses need not only have an up-to-date working knowledge of health conditions and interventions but also need to be able to empathise with the difficulties consumers face as they navigate their recovery from experiences of mental ill health within what are often disconnected and under-resourced healthcare systems (Cleary et al. 2018a).

CULTURAL, SEXUAL AND SPIRITUAL IDENTITIES

The concept of identity

Identity can be thought of as an individual's enduring sense of themselves as a person. It is the answer people give to the question: 'Who am I?' Psychologists have traditionally defined identity in individualistic terms, with an emphasis on developing stable personality traits. However, identity is deeply influenced by belonging to, or difference from, significant social groups – for example, cultural groups, religious faiths and peer groups. By identifying with the values and beliefs of a social group we come to define our own unique sense of who we are. Others have argued that identity is inherently unstable, constantly in transition and made up of multiple components or identities. Some examples of identity are outlined below, but it is important to remember that individuals will have multiple identities and that these may change over the course of their lives. Nurses should not presume to know what a consumer's identities are and should not expect individuals to conform to stereotyped ideas about what a particular identity means to an individual.

Cultural identity

Cultural identity refers to a person's sense of belonging to one or more cultural groups. For indigenous Australians and New Zealanders, indigenous culture may be their most important source of identity, but they may also identify, through ancestry or association, with non-indigenous cultures. Most healthcare providers support consumers to declare their own cultural identity, and clinicians should respect this statement. Cultural identity is an important source of beliefs, values and practices that impact on mental health and assist individuals to develop their own frameworks of recovery. For nurses it is important that we reflect on our own cultural identities and how they may influence our interactions with consumers. We cannot be knowledgeable or skilled in all the cultures of the consumers of health services, but it is important that we respectfully acknowledge consumers' culture and address cultural preferences.

Spiritual identity

Mental health theorists have a long tradition of scepticism towards spirituality and religion. Individualistic models of mental health (e.g. rational emotive therapy) have valued rationalism over faith and belief and have seen spirituality as a source of pathology, rather than a resource for mental health. The increasing diversity of our communities challenges this view and leads to spirituality and religious faith being regarded as central to identity and to psychosocial functioning. While clinical support can help people manage distress and develop coping strategies, spirituality can provide a sense of hope and acceptance in the face of seemingly insurmountable life problems. Although spirituality is often associated with religious faith, many people have a non-religious worldview while still maintaining spiritual beliefs and values. Others have both religious and non-religious worldviews. As nurses we will not always share the spiritual beliefs of consumers. However, as with cultural identity, it is important that consumers feel their spiritual beliefs and values are recognised as an important part of their identities and that they are supported in maintaining their spirituality as part of their recovery.

Gender identity

Gender is another source of identity where previous mental health practice has treated difference as pathology and sought to impose compulsory treatment on individuals whose gender identity and sexual preferences did not fit dominant social norms. From being perceived as a fixed function of biology (individuals were assigned either male or female gender at birth, with no anticipation of change), gender is now seen as a fluid, socially constructed concept. A range of terms reflects the changing perspectives on gender in contemporary society, reflected in the term 'LGBTIQ+', which incorporates the range of gender identities nurses will encounter. Specific terms for gender include bisexual, trans, gay, gender diverse, queer, intersex and cis-gender. Gender should not be confused with sexual preference, which refers to an individual's gender preferences in intimate relationships. Preferences are not necessarily fixed and can change in the course of psychosocial development. As a nurse you will meet people with gender identities and sexual preferences different from your own. It is important that you become comfortable with relating to gender diverse consumers, as gender and

sexuality can often be a source of distress due to stigma and prejudice.

Identity, stress and mental illness

While a strongly developed sense of who we are as a person is important to our mental health, identity can also be a source of stress for those whose identities are disvalued and subject to stigmatising views and prejudice. The term 'minority stress' (Spittlehouse et al. 2019) refers to the experience of stigma and discrimination encountered by people in relation to their identity. This can relate to culture and ethnicity, religious affiliation, gender and sexuality and other aspects of identity. Discrimination can create a hostile environment in which minority stress leads to symptoms of mental illness including depression, anxiety, suicidal ideation and harmful substance use. People who are subject to one form of marginalisation are more likely to also experience other forms of marginalisation, a concept referred to as 'intersectionality' (Grzanka & Brian 2019). Nurses encounter many consumers who experience one or more forms or marginalisation and need to be aware of how these experiences shape the person's health experience and the responses of clinicians. Supporting consumers to negotiate contested identities enhances their mental health and helps build resilience for living in an environment in which stigma and discrimination are regrettably common.

Historical anecdote 2.1: Stigma and mental illness

In his 1963 book *Stigma: Notes on the Management of Spoiled Identity*, sociologist Erving Goffman identified three types of stigma, each of which led to disvalued identity. Goffman argued that people with mental illness experience character stigma as they are perceived as weak, unreliable and possibly dangerous, and social stigma through which disvalued aspects of being labelled 'mentally ill' lead to the person being seen as associated with a disvalued group. Goffman's work led to a focus on the negative effects of stigma on people with mental illness, including the internalisation of stigma by which individuals come to believe the negative stereotypes of the dominant social group. Goffman also argued that people who work in mental health, such as nurses, are subject to 'courtesy stigma' because their identity is influenced by their association with a socially disvalued group.

Read more about it: *Goffman E 1963 Stigma: notes on the management of spoiled identity. Prentice-Hall, Englewood Cliffs*

Working within recovery-oriented and trauma-informed approaches to care

A significant amount of research has explored outcomes experienced by people with mental illness over the past 100 years. Most of these studies have used an approach to understanding recovery developed by mental health professionals referred to as 'clinical recovery' (Slade et al. 2012). This concept considers mental illness as a health condition that is in need of clinical treatment. As such, in common with recovery from most physical illnesses, working from this perspective involves the expectation that recovery should include a substantial reduction of symptoms and restoration of function in work and relationships. This conceptualisation has enabled researchers to measure recovery in terms of 'hard' data such as numbers of people who cease needing medication, avoid hospitalisation or regain paid employment. Studies that have used the paradigm of clinical recovery suggest little improvement has been made in rates of recovery over the past 100 years. For example, a meta-analysis that reviewed the results of 50 studies published between 1921 and 2010 suggested that only 13% of people with schizophrenia experience recovery (Jääskeläinen et al. 2012). Despite the poor outcomes identified in this research, people with a lived experience of mental illness (consumers) often have more hopeful stories to tell about their recovery journey.

As people with lived experience of mental illness have gained political influence over the past few decades, they have challenged the concept of clinical recovery and models of care that focus on medical treatment alone (Cleary et al. 2018b). This has led to a review of how recovery from mental illness is understood. People with lived experience have emphasised that recovery is a personal journey (i.e. personal recovery) and that many people who are labelled or diagnosed with a mental illness have a substantial history of trauma. The next section of this chapter overviews recovery-oriented and trauma-informed care approaches that have been developed to support people with mental illness in their personal recovery. These approaches are increasingly used in mental health care and can be used by nurses to support people who are experiencing mental distress or illness.

RECOVERY-ORIENTED CARE

The concept of 'personal recovery' emerged from the consumer movement that developed in the second half of the 20th century to advocate for the rights of people living with mental illness. In their view, recovery was more about a personal developmental journey rather than just a health condition in need of clinical treatment (Warner 2010). There is no single definition of mental health recovery;

however, one of the most commonly used explanations was written by Bill Anthony (1993), who described it as:

> A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as a person grows beyond the catastrophic effects of mental illness.
>
> Anthony 1993, p. 15

Beginning with personal accounts of recovery journeys published by people with a history of mental illness such as Deegan (1988) and Leete (1989), a large body of literature has developed describing the lived experience of mental health recovery. Personal narratives are essential to recovery-informed perspectives and for determining what is important for any individual in their journey of recovery. Case study 2.1, about the recovery of Mary O'Hagan, a prominent international consumer 'survivor', educator and consultant, illustrates the tension between what people say is important to them and what professionals and the system focus on. This tension is underscored by the fact that although many people find meaning in their 'madness', the people they turn to for support view it primarily as pathological and something to be managed and medicated. Table 2.2 draws a distinction between recovery-informed practice and traditional practice.

CASE STUDY 2.1

Mary O'Hagan's story

In common with so many people who experience mental distress, Mary describes her madness as the loss of self, the solid core of her being. While this core is not evident during times of madness, it returns stronger, renewed and ready to go again. Madness is a crisis of being that is a part of the full range of human experience. Mary explains:

> My self is the solid core of my being. It is like an immutable dark sun that sits at the centre of things while all my fickle feelings, thoughts and sensations orbit around it. But my self goes into hiding during madness. Sometimes it slides into the great nothingness like a setting sun. Sometimes it gets trampled in the dust by all the whizzing in my body and mind ... Sometimes my madness strips me bare but it is also the beginning of renewal; every time I emerge from it I feel fresh and ready to start again.

Mary had to make friends with rather than fight her madness, to get to know, understand and respect it – a complex process.

> My madness was like a boarder coming to live in my house, who turned out to be a citizen from an enemy country. Knowing I might not get rid of him meant I had to make peace with him and learn to understand his language. Once I got to know the boarder, he was no longer the stereotypical enemy, but a complex character that deserved some respect.

Mental health professionals did not find any value in helping Mary to understand the meaning in her madness. Nor did they allow her to tap into her own power, her own resourcefulness. Mary's experience of care within mental health services was one of being 'skilled in lowered expectations' – for example, repeatedly being told that things such as studying or working would be too stressful and she would not be able to do them. The way mental health care was provided to Mary encouraged passivity rather than autonomy. She found the capacity to tap into her own resourcefulness only by coming across the consumer/survivor literature that inspired her. She was then able to find and use her own power to get out of the cycle of madness. Mary went on to be appointed as a mental health commissioner in New Zealand and has been an international consultant on mental health since that time.

What was most difficult for Mary was not the symptoms but how people regarded her. In retrospect her madness was a place of beauty and difficulty, madness filled with soul. Mary talks about the terrible suffering and the desperate struggle of her madness, but she also talks about the richness in her experience that she could interpret as filled with purpose and meaning. She wanted acceptance of her reality. For Mary, the best thing people could have done was to be kind and accept her reality – a basic human response.

We encourage you to visit Mary's website at ***www.maryohagan.com*** *to learn more about her story.*

EXERCISE FOR CLASS ENGAGEMENT

Is Mary O'Hagan's experience an isolated one? Is it an 'old' story that would not happen today?

In 2012 Glover presented the stories of two women and their personal experiences of mental distress managed in Australia by involuntary inpatient admissions. The women's perceptions of their care included that they were not helped to make sense of their experiences, felt stripped of their power and were not responded to as people but as 'diagnostic categories'. Their experiences were described using the language and meaning of the professional knowledge base; their own meaning and language for their experiences were not encouraged or valued. What makes Glover's work so powerful is that while both women

TABLE 2.2 Key differences between recovery-informed and traditional practice

RECOVERY-INFORMED PRACTICE	TRADITIONAL PRACTICE
• Person is central • Driven by a human rights agenda • Connecting with and maintaining meaningful roles, relationships and community is key; many things contribute to recovery • Looks for possibilities and promotes hope • Collaborative risk management with the person • Learns from people's narratives of recovery	• Illness and symptoms are central • Driven by the medical model • Propensity for person's life to revolve around and be taken over by illness • Looks for constraints and sets limits and lower expectations • Focuses on risk control by others • Personal narratives not a focus of care
• The person has expertise gained from their experience of mental health challenges • Medication is a small part of management; types and doses are titrated for the individual • The person is the change agent • Takes a stance of 'unknowing' and curiosity to help uncover the meaning people make of their experience • Empowering for the person to be acknowledged for their expertise • Promotes self-directed care requiring the active involvement of the person • Explores what is important to the person; recognises unique experience and takes spirituality into account • Connects with the person's strengths and draws on them to overcome challenges • Choice and ability to connect with a broad range of services in community • Peer support or peer-run services are essential • Trauma-informed care asks: 'What has happened to you?'	• The professional is the expert on the person's experience • Treatment of symptoms, usually with medications, is the main form of intervention • The program is the change agent • Takes a stance of 'knowing' and looks for confirmation of symptoms to make a diagnosis • Symptoms are more important than personal meaning • Promotes passivity and compliance • Recovery primarily involves the active involvement of others • Informs people about illness and what is important to them to manage it; spirituality not taken into account • Focuses on deficits to treat and manage • Choice of services can be limited • Peer support limited or non-existent • Not trauma-informed – the background issues ('What is wrong with you?') are more important
• Recovery is moving beyond premorbid functioning towards thriving and developing a new sense of self • Non-linear process • Timeframes meaningless – ongoing process • Crisis is a time of learning how to thrive; an active recovery space	• Recovery is, at best, returning to a premorbid level of functioning • Linear process of interventions • Recovery is the end point of the process • Crisis is viewed as a relapse and failure

had very similar experiences, one story took place in 1985 and the other in 2010. The latter occurred at a time when services were promoting their model of care as 'recovery-informed', leading Glover to ask, what has actually changed in the past 25 years?

In 2011 Leamy et al. undertook a systematic literature review to identify experiences commonly associated with personal recovery. After screening more than 5,000 papers, the authors identified five processes common in personal recovery: connectedness; hope and optimism; identity; meaning in life; and empowerment (Leamy et al. 2011). Not only have experiences associated with personal recovery been well explored but the concept is increasingly incorporated into government mental health policies, including Australia's national mental health service policy and framework for recovery approaches to service provision (Commonwealth of Australia 2013) and the *Fifth National Mental Health and Suicide Prevention Plan* (COAG Health Council 2017). Concepts of recovery have also influenced mental health policy in New Zealand (Mental Health Commission 2012). In respect to mental health recovery, there are five key domains that health professionals and mental health services are expected to practise within:

- promoting a culture and language of hope and optimism
- putting the person first and at the centre of practice and viewing their life holistically
- supporting personal recovery and placing it at the heart of practice
- organisational commitment and workforce development for skilled practitioners and an environment that is conducive to recovery
- action on social inclusion and social determinants of health, mental health and wellbeing (Commonwealth of Australia 2013).

To better understand the sort of practices promoted in government guidelines, Le Boutillier et al. (2011) undertook a qualitative analysis of 30 recovery policy documents from governments in England, Scotland, Ireland, Denmark, New Zealand and the United States. The study found that the policies promoted four common practice domains including organisational commitment, supporting personally defined recovery, working relationship and promoting citizenship. Despite these findings, the authors concluded that a key challenge for mental health services is the continued lack of clarity about what constitutes service-level recovery-oriented practice (Raeburn et al. 2017). This lack of clarity has remained an ongoing knowledge gap, with researchers such as Slade et al. (2015) observing that while government policy may promote the concept of personal recovery, evidence regarding how recovery practices are implemented and whether (and how) this is achieved in practice within individual services is lacking.

Greater collaboration and co-design of services, service planning, policy and research by people with a lived experience of mental illness is required for better recovery-oriented care (Gordon & O'Brien 2018). This requires a purposeful shift away from paternalistic and authoritative ways of treating people towards more mutually respectful person-centred care (Reid et al. 2018). Consumers and carers understand the inadequacies and opportunities that exist within the health and mental health system (Banfield et al. 2018) – after all, they are the ones who are attempting to navigate it! Transforming the health and mental health system to be fully recovery-oriented requires genuine integration of lived experience perspectives, addressing discrimination and factors that inhibit consumer participation at all points in the healthcare continuum.

Trauma-informed care

An essential component of a recovery-oriented approach is to practise within a framework that recognises that many people experiencing mental health challenges have a background of trauma. A trauma or traumatic event can be described as a distressing event – for example, a severe physical injury or a specific experience that triggers mental and emotional distress. Trauma is often linked with loss and grief. Experiences of loss and grief are a universal part of human life. Loss can be described as an event where something that belongs to you and is either precious or has meaning for you has been taken away or destroyed. This encompasses a range of losses, from a 'minor' loss such as losing your wallet to a 'devastating loss' such as losing your home and all your belongings in a bushfire. Bereavement generally refers to being deprived of an object or a person – usually used in the context of losing someone you love through death. Grief has been defined as 'the response to the loss in all of its totality – including its physical, emotional, cognitive, behavioural and spiritual manifestations – and as a natural and normal reaction to loss' (Hall 2014, p. 182).

Research demonstrates clear links between trauma and the onset of a range of mental health problems (Green et al. 2018). This makes it imperative for nurses to be sensitive to the vulnerabilities and potential triggers that may give rise to re-traumatisation and to be aware that this could impede recovery.

While a single-incident traumatic event such as a severe car accident, an unexpected death of a close family member or natural disaster results in disruption to a person's life, it does not necessarily result in crisis. Such an event does, however, signal *a potential risk of impending crisis*. A person's reaction to and perception of the event and the nature of the trauma may lead to an acute crisis state when the person's ability to cope is overwhelmed. In contrast to popular ideas, research indicates that the majority of people exposed to a traumatic event recover after an initial period of destabilisation. After a period of adjustment and recovery, some people will describe positive changes such as a renewed appreciation for life and loved ones, personal growth and enhanced coping strategies (van Weeghel et al. 2019).

A large American study called the Adverse Childhood Experiences (ACE) study began in the late 1990s (Felitti et al. 1998). Participants were asked to report on adverse events experienced during childhood. Adverse childhood events included: experiencing psychological, physical or sexual abuse as a child; living with a mother who was being abused; or living in a household where there were people who abused substances, were suffering from mental illness, were suicidal or had ever been in prison. Researchers found that the more of these adverse events a child experienced, the greater the burden of physical illnesses such as chronic obstructive pulmonary disease and heart disease and mental illnesses such as depression. The researchers for the study have continued to collect data documenting the health status from these initial participants (see the useful websites list at the end of this chapter for more details). These findings have been confirmed in subsequent research, demonstrating that early adversity has lasting impacts – increasing the risk of both physical and mental illness over the course of the person's life (Javier et al. 2019). Children exposed to trauma are less likely to develop resilience and have a more than 50% increased risk of depression (Jones et al. 2018).

Despite the negative effects of trauma and mental ill health, the human brain has a remarkable ability to adapt. Research (some of which dates back more than 100 years) has demonstrated how individuals with significant brain damage arising from physiological disorders such as stroke (cerebral vascular accident) and traumatic brain injury can recover and regain function that seemed to have been lost as a result of the damage (Turolla et al. 2018). The mechanism for this process is the brain's capacity to generate new brain cells (neurogenesis) and to establish alternative neural pathways. The term 'neuroplasticity' was introduced in the 1960s as a way of understanding the reorganisation of neuronal anatomy affecting the structure and function of the brain in response to many external and internal events (Voss et al. 2017).

You will recall from your nursing education that the brain consists of three parts that develop from the bottom up. The parts 'talk' to one another via trillions of neural pathways. The 'reptilian brain' (brain stem) is responsible for the automatic functions such as breathing, heart rate and survival. The 'mammalian brain' (limbic system) is responsible for emotions and memory; it is about survival and safety. The 'primate brain' (cerebral cortex) is responsible for higher order tasks such as thinking, learning, decision making, reasoning, organising, planning, meaning making, gaining control over emotions and language. When people experience trauma and/or severe emotional stress, it can be much harder to engage the cerebral cortex. Instead they 'loop' in the limbic cortex and this builds stronger neural pathways, making it more likely they will experience distressing emotions in the future when challenges arise. The key here is the absolute necessity for people to feel safe so they can effectively engage with others in their ongoing care (Oral et al. 2016). Consider when people come into care in an inpatient unit. Personal safety is an important basis for effective nursing care. Often, people will be frightened of the inpatient environment, including acute mental health units, particularly if it is their first experience of admission to a mental health care setting. It is important to take time to find out how the person feels and what they need to feel safe and secure. It may be listening to them or helping them consider strategies they could use to increase feelings of safety – for example, calling for help if someone enters their room. Do not assume that the person experiencing mental distress will feel safe in the healthcare setting just because you feel comfortable in the environment as a nurse.

The essentials of trauma-informed care include recognising the following (Sweeney et al. 2018):

- Trauma and its effects have been historically unrecognised in the design of mental health systems. To counteract this, it is necessary to take a universal precaution approach that assumes that all people who seek mental health care may have experienced trauma.
- Services need to ensure early assessment of trauma history and supervision for staff in responding sensitively and appropriately to disclosures of trauma.
- Reiterating the necessity for the person to feel safe, nurses can respond by helping the person to lower their distressing emotions – for example: sitting, listening or walking with the person; using basic mindfulness or relaxation techniques; and ensuring a calm environment can all help. When this occurs, people are more likely to be able to engage their thinking brain and find ways that work for them to feel safe.
- Impacts of trauma can affect how people react to potentially helpful relationships. Building trust is essential so you can work with the person. Remember, trauma often occurs when a person's trust in people or situations has been severely violated. Nurses need to understand how trauma and abuse may have shaped difficulties in relationships and affect therapeutic relationships.
- Coercive interventions may re-traumatise people. Be mindful that nurses are often seen as figures of authority. Using the power that comes with this to exercise control over the person to do what you think they 'should' do will most likely be counterproductive, be seen as coercive and may even re-traumatise the person. Recognise the person's strengths and support them by collaboratively developing a care plan that affirms their preferences for care and how they can manage distress.
- Avoid interventions that may be perceived as shaming and humiliating. Nurses are responsible for maintaining the dignity and individual rights of the person at all times and providing services in ways that are flexible, individualised, culturally competent, respectful and based on best practice.
- There is a strong need to focus on what *happened* to the person rather than pathologising the person as a result of their presenting symptoms (where the focus is on *what is wrong* with the person). Nurses need to develop an understanding of presenting behaviour and symptoms in the context of past experiences.

In summary, trauma-informed services are informed by three key principles to guide practice (Muskett 2014):

- People need to feel connected, valued, informed and hopeful about their recovery from mental illness.
- Staff understand the connection between childhood trauma and adult mental health issues is understood.
- Staff practice in empowering ways with consumers and their family and friends and other services to promote consumers' autonomy.

While these principles focus on the needs of consumers and their family and friends, a trauma-informed approach to care can also provide support for managing workplace stress (Isobel & Edwards 2017). Trauma-informed practice does not replace recovery-oriented practice but is complementary and provides another perspective from which people (staff and consumers) may view recovery and therapeutic engagement.

NURSE'S STORY 2.1

Katrina's story of choosing mental health nursing

I did not start my nursing education with a plan to work in mental health nursing. Like many of my fellow students I thought about paediatric nursing, or maybe cardiac nursing. I enjoyed all my clinical placements and my greatest pleasure was talking to consumers in whatever setting they were. I found the most interesting theoretical study was of understanding people from a psychological, sociological and cultural perspective: how people came to be like they were; how they responded to health and illness and stress. My understanding

about mental illness had been coloured by common community attitudes, by media depictions of psychiatric hospitals, and by the experience of an aunt being forcibly admitted for treatment. It was not really talked about in the family and I am not sure if anyone visited while she was in hospital.

There have been two 'lightbulb moments' that led me to choose to work in mental health following graduation. The first was a visiting lecturer who was a 'mental health consumer', someone who had experienced mental illness and its treatment. I left that tutorial with a mixture of feelings: sadness for the experience of stigmatisation; admiration for the bravery to speak up and for the resilience to re-establish a life that was satisfying; an awful awareness of the way my family had silenced my aunt by acting like her experience had not happened; and a new compassion for people with mental illness.

When it came to my mental health clinical placement I was rather anxious. I really did not know what to expect. My mental health clinical placement was a second 'lightbulb moment'. I found the consumers had interesting stories to tell and that they wanted to tell me about their lives. I watched the staff as they interacted with consumers. I admired their capacity to remain calm and to intervene early when someone became upset. The staff taught me a lot about how mental illness is manifest and experienced and what treatments were used. I enjoyed the interdisciplinary discussions and felt that nurses' observations about consumers were taken seriously.

I have now been working in an acute mental health inpatient unit for a year and I have found this time to be a steep learning curve. The biggest challenge has been developing an understanding of me and how I respond to various people and situations. At times I found myself getting upset or angry with consumers if things did not go according to my plan and I really needed to make sure I did not get into negative talk with other staff who were also frustrated. I attend group clinical supervision sessions every 2 weeks and this is helpful in keeping us focused on the person and their needs. The group has provided a safety net that we can use between sessions. I had a preceptor assigned when I first started and that helped with day-to-day skill development. I have an informal arrangement with a mentor who is an experienced nurse that I identified as someone I want to emulate in my practice. She has been very supportive in helping me identify knowledge that I need to gain, what further education would be helpful, where my career path might lead and what kind of clinical experience would be beneficial to me. I would like to work on one of the community mental health teams in the future.

Effective mental health nursing practice

A central element of the social ecological framework for practice is effective mental health nursing practice. To practise effectively in their roles, mental health nurses need sound theoretical knowledge of mental health and illness and associated treatments, positive attitudes towards mental illness and people living with mental illness, and effective mental health nursing skills. In their practice, mental health nurses consider the person's physical, psychological, social, cultural and spiritual healthcare needs; that is,they take a holistic or comprehensive approach.

A holistic approach to mental health nursing includes knowledge and skills in:

- preventative and early intervention strategies for mental health and mental illness
- biological processes that may underpin mental illness
- the impacts of social determinants of health on the development and course of mental illness

Historical anecdote 2.2: We were convicts

The first nurses involved in mental health care in Australia were convict nurses assigned to care for patients sent to Castle Hill and Liverpool 'lunatic asylums' in colonial New South Wales. In spite of their pioneering role, contemporary nurse historians often skip over them without any acknowledgement. Such a generalised approach to nursing history may be tied to a desire to eradicate the memory of a so-called 'convict stain' from modern nurses' professional identity. It perpetuates a tradition started in early healthcare journals that promoted the myth that nursing in Australia was 'rescued' by Lucy Osbourne and her Nightingale nurses in 1863. Nurses prior to Osbourne were characterised as 'gamps', which was a reference to the fictional character of the coarse, fat, drunken nurse 'Sarah Gamp' in Charles Dickens' novel, *Martin Chuzzlewit*. In contrast, early convict nurses such as Martha Entwistle at Castle Hill Lunatic Asylum and Mary Coughlen at Liverpool Lunatic Asylum were resilient women who overcame traumatic experiences in their own lives while caring for others in harsh colonial environments, short of adequate resources, during an era of fast-paced industrial and technological change. We should be more proud of our convict nursing roots.

Read more about it: *Raeburn T, Liston C, Hickmott, J, Cleary M 2018 Life of Martha Entwistle: Australia's first convict mental health nurse. International Journal of Mental Health Nursing 27(1): 455–63*

- the importance of social connections and relationships for mental health and illness
- spiritual belief and faith and its relationship to mental health
- cultural practices and beliefs and their relationship to mental health
- communication and interpersonal relationship knowledge and skills
- the physical health care of people with mental illness
- psychological processes associated with mental health and illness
- psychotherapeutic approaches and strategies for mitigating mental distress and mental illness
- the physiological effects and side effects of psychotropic medications and physical treatments for mental illness.

Therapeutic relationship – consumer and nurse partnership

As nurses we bring our knowledge and attitudes to mental health/illness, our identities (e.g. cultural and gender) and our values, knowledge, experience and skills in nursing. This shapes how we develop a therapeutic relationship with consumers. The therapeutic relationship is the foundation of effective mental health nursing practice (Browne et al. 2012). We consider this relationship to be one of equal partnership. Partnership involves working with the consumer and their family/carers to provide support in a way that makes sense to them, including sharing information and working with consumers and carers in a positive way to help them reach their goals (Commonwealth of Australia 2010). The therapeutic relationship is underpinned by the nurse's use of self. Key knowledge and skills for an effective therapeutic relationship include developing a therapeutic alliance, self-awareness and empathy.

Lived experience comment by Jarrad Hickmott

The framing of nursing around the therapeutic use of self and therapeutic alliance is very important. A lot of times it can be difficult to maintain these aspects in an environment where a heavily medicalised model is dominant. Discussing the very human side of nursing and the different domains of life that interplay with the mental ill health of consumers is very enriching and of great benefit.

Therapeutic use of self

Therapeutic relationships are the central activity of mental health nursing. The therapeutic relationship provides a healing connection between the nurse and consumer through a caring, emotional connection, narrative and anxiety management, and this process can have a powerful neurobiological impact on the mental health of the person (Wheeler 2011). Therapeutic relationships are the foundation upon which all other activities are based. Mental health nursing is therefore primarily an interpersonal process that uses self as the means of developing and sustaining nurse–consumer relationships. Therapeutic use of self involves using aspects of the nurse's personality, background, life skills and knowledge to develop a connection with a person who has a mental health problem or illness. Nurses intentionally and consciously draw on ways of establishing human connectedness in their encounters with service users. The process is based on a genuine interest in understanding who the consumer is and how they have come to be in their current situation – separating the person from the illness (Wyder et al. 2017). Lees et al. (2014, p. 310) describe therapeutic engagement as the 'establishment of rapport, active listening, empathy, boundaries, relating as equals, genuineness, compassion, unconditional positive regard, trust, time and responsiveness' and suggest that most of these elements need to be present for engagement to occur.

The purpose of using self therapeutically is to establish a therapeutic alliance with the service user. Service users in mental health services may not only be experiencing frightening symptoms or perhaps overwhelming mood changes or overwhelming thoughts and feelings, they may also be experiencing alienation and isolation. Service users may be fearful of talking to others about their symptoms or difficulties because they fear being rejected and seen as 'crazy', or they may have had experiences of rejection because of their mental illness that make it difficult for them to form relationships. Studies of service users' experiences of mental health services provide evidence that being understood and listened to in a thoughtful, sensitive manner confirms their humanity and provides hope for their future (Gunasekara et al. 2014). In the process of using self therapeutically, the nurse develops a dialogue with the service user to understand their predicament. Service users need to feel safe enough to disclose personal, difficult and distressing information. It is in the way in which the nurse conveys genuine interest, concern and desire to understand that a therapeutic alliance can be established. How the nurse relates to, and what prior understandings they bring to, the encounter will affect this relationship (Wyder et al. 2015).

Studies of the experiences of both mental health nurses and service users of mental health services overwhelmingly attest to the importance of therapeutic relationships. Consumers have identified the need to feel compassionately cared for, to have meaningful contact with nurses, to be listened to, and for nurses to know them as people and understand their predicament (Gunasekara et al. 2014; Lees et al. 2014; Stewart et al. 2015; Wyder et al. 2015; Wyder et al. 2017). Similarly, studies of nurses' experiences identify that they see therapeutic engagement as the hallmark of good practice in mental health settings (Cleary et al. 2012; McAndrew et al. 2014).

Empathy and therapeutic use of self

The ability to empathise with service users is underpinned by caring and compassion and is positively linked with the ability to develop therapeutic relationships and the desire to alleviate suffering. As indicated earlier, the ability to engage empathically with consumers is highly valued. Empathy is not merely a feeling of understanding and compassion. Empathy, as used in the therapeutic relationship, is linked to intentional actions that are aimed at reducing the person's distress. Empathic interactions have a number of components:

- First, empathy involves an attempt to understand the person's predicament and the meanings they attribute to their situation. This means the nurse makes a conscious attempt to discuss with the person their current and past experiences and the feelings and meanings associated with these experiences.
- Second, the nurse verbalises the understanding that they have developed back to the person. The understanding that the nurse has of the service user's situation will be at best tentative; we can never really know what life is like for another. However, the process of seeking to understand, and of conveying the desire to understand, creates the opportunity for further exploration in a safe relationship. In addition, maintaining the stance of trying to understand rather than making assumptions averts the tendency to make judgements about the person and their behaviour.
- Third, empathy involves the service user's validation of the nurse's understanding. One of the most important aspects of developing the therapeutic relationship through empathic understanding is that the nurse can convey to the person a desire to understand. This level of empathic attunement allows the service user to participate in identifying those aspects of their illness and healthcare experience that are problematic.

The therapeutic alliance

The value of a therapeutic alliance, developed through therapeutic use of self, has been clearly identified from the perspective of nurses and service users in international studies (Zugai et al. 2015). A therapeutic alliance is characterised by the development of mutual partnerships between consumers and nurses and has been linked with greater consumer satisfaction with care (Zugai et al. 2015). Several studies have indicated that a therapeutic alliance can have a significant impact on consumer outcomes and that it is possibly one of the most important factors contributing to the effectiveness of a mental health service (Cleary et al. 2012; Stewart et al. 2015). People who have a positive relationship with their clinician have better outcomes (Pilgrim et al. 2009). However, a therapeutic relationship alone may not be sufficient to sustain health improvements, and so a combination of both therapeutic relationships and the technical skill of specific therapeutic approaches may provide the best outcomes (see, for example, Smith & Macduff 2017).

Historical anecdote 2.3: Mental health nurse of the century!

Hildegard Peplau (1909–1999) has been cited as the most influential mental health nurse of the 20th century. She was trained and began her career in the United States where she was heavily influenced by psychologist Harry Stack Sullivan's work on interpersonal therapy. During World War II she moved to England where she served in an army hospital involved in the mental health rehabilitation of soldiers. After returning to North America after the war she contributed to developing the 1946 National Mental Health Act, which involved a major reconfiguration of mental health services away from asylums towards community-based care. In 1952 Peplau published an influential book titled, *Interpersonal Relations in Nursing*. In it she described the essential skills, functions and roles of mental health nurses of her era. The book is viewed as being the first systematic, theoretical framework for the practice of modern mental health nursing. Later in her career Peplau was appointed to various influential roles with the World Health Organization, the American Nurses Association and various universities in the United States and around the world.

Read more about it: *Peplau H 1997 Peplau's theory of interpersonal relations. Nursing Science Quarterly, 10(4): 162–7*

Self-awareness

The process of working together and understanding others begins with understanding the self. 'Self' is a concept that describes the core of our personality. We use the concept of self when we want to convey our uniqueness as a human being. The self has consistent attributes that pervade the way we live in and experience the world. It is awareness of these attributes of self that can enhance the way we relate to others. A strong sense of self allows us to develop resilience in dealing with the difficulties and complexities of human communication and experience. Self-awareness is about knowing how you are going to respond in specific situations, about your values, attitudes and biases towards people and situations, and about knowing how your human needs might manifest in your work. The purpose of being self-aware is to know those things in our background and our way of relating that might affect how we relate to others. The way we view people is always subjective. The lens through which we look at the world is always our own. Although there can be no true objectivity, knowledge of the things that impinge on our subjective view of the

world allows us to identify how they influence our thinking. Nurses need to be aware of the belief systems and values that arise from their cultural, social and family backgrounds. Everyone develops biases that affect the way they view other people's behaviour. Behaviour that is understandable to one nurse might not be understandable to another. However, the self is not static but constantly evolving and sensitive to experience. We bring values, biases and beliefs to nursing and to our relationships with service users, and in turn those relationships offer the opportunity for self-development. It is through the process of self-reflection and the examination of particular experiences that nurses can learn and flourish (Fowler 2019).

Working in the mental health field requires the ability to listen to, respond to and empathise with people from a range of backgrounds. Unexamined belief systems can become obstacles to developing a therapeutic alliance. Lack of self-awareness can cause nurses to respond to a person's distress and behaviour in ways that may not be helpful. For example, it might cause nurses to use their power coercively in the belief that this is best for the service user. Lack of self-awareness can also lead to nurses being overly concerned, refusing to allow service users choice or overwhelming them with advice, in an attempt to protect them. Alternatively, nurses may avoid contact with particular service users or fail to respond to distress. This growing self-awareness needs to take place against a background of self-compassion, and to develop the ability to empathise with others requires 'the ability to be sensitive, non-judgemental and respectful to oneself' (Gustin & Wagner 2013, p. 182).

Hope and spirituality

There is still much that we do not know about recovery, healing and how people manage chronic health problems. Why do some people pull through a disease, while others do not? How is it that some people seem to cope well with even very invasive treatments, while others suffer terribly? How do some people with chronic mental illnesses function well in the community, while others are in and out of hospital? We know that factors such as personality, resilience, social support, general health and access to acceptable (to the service user) health services all play a crucial role in service user outcomes. But the importance and value of concepts such as hope and the role hope plays in the lives of service users and their families are areas of increasing interest. 'Hope' is a taken-for-granted term and, although it is used widely in the literature, it is seldom clearly defined. Hope is considered essential in handling illness and can be described as an act by which the temptation to despair is actively overcome. We know hope is a complex and multidimensional variable that has optimistic and anticipatory dimensions and involves looking ahead to the future. Hope has been linked to emotional healing and better adaptation to life stress (Carretta et al. 2014) and is a central component in recovery from mental illness (Slade et al. 2015).

In a study of qualitative literature related to hope in older people with chronic illnesses, Carretta et al. (2014, p. 1,211) identified characteristics of hope as including 'transcending possibilities' and 'positive reappraisal'. Transcending possibilities involve finding meaning through searching and connecting with others. The positive role of health professionals in maintaining hope is described as supporting hope and the search for meaning. Positive reappraisal depends on the ability to seek and find positives in the illness experience, and health professionals also have a role in supporting service users in this search. Hope has particular relevance to mental health nursing practice, and there is growing recognition of the concept of hope and its relationship to health, wellbeing and recovery from illness or traumatic life events (Duggleby et al. 2012). Closely linked with hope, Hemingway et al. (2014) describe therapeutic optimism in mental health nurses as a belief that they can make a difference and a belief that the people they work with can recover.

The need for further research to generate knowledge and enhance understanding about suffering, hope and spirituality in relation to mental health nursing is acknowledged in the literature (Cutcliffe et al. 2015; Schrank et al. 2008). However, the emphasis on the biomedical understanding of mental illness provides barriers to such research. The biomedical model values things that can be seen, measured and quantified. Although hope and spirituality can be felt, they cannot be seen, touched or smelt and cannot always be clearly articulated and so occupy what Crawford et al. (1998, p. 214) termed 'an embarrassed silence'. However, if we recognise that spirituality underpins the meanings that people make of illness and other life events, and that hope is a variable that has some form of healing potential, then we cannot ignore the importance of spirituality and the search for meaning in practice. Indeed, Cutcliffe et al. (2015) reinforces the importance of recognising and responding to the spiritual care needs of service users and calls for nurses to develop skills in supporting service users to understand and search for meaning in their experience. The ability to maintain hope and to make meaning of the experience of illness is central to recovery, and it is important for mental health nurses to maintain hope for consumers' recovery and to support consumers in maintaining hope and finding meaning in their experiences. This leads to the question: What skills do nurses need if we are to care for the spiritual needs of consumers? The short answer is that we need to develop effective interpersonal skills. Being open to the belief systems of other people, intuitiveness, active listening, being alert to the cues that tell us the things that matter to a person, self-awareness, spiritual awareness and reflective skills are crucial in providing spiritual care (Ramezani et al. 2014).

Compassion and caring

Compassion is a concept closely associated with and underpinning caring. Compassion is linked with sensitivity

to suffering and a desire to alleviate distress (Day 2015; Gustin & Wagner 2013; Sawbridge & Hewison 2015). Gustin and Wagner (2013) suggest that compassion inspires 'the act of the conscious intention of being present in moments of another's despair' (p. 175). Compassion underpins concepts of acceptance, a non-judgemental attitude, awareness, being present and listening. To be able to provide compassionate nursing care, we need to be able to imagine what it would be like to be in the person's situation, what it would be like to experience the world as they are experiencing it and to imagine what might help.

Caring is widely considered to be central to nursing theory and practice (Hogan 2013; Schofield et al. 2013). Although the word 'caring' is simple, its use in complex healthcare situations has rendered it problematic. Following a meta-synthesis of research, Finfgeld-Connett (2008) conceptualised caring as a 'context-specific interpersonal process that is characterised by expert nursing practice, interpersonal sensitivity and intimate relationships' (p. 196). Finfgeld-Connett further elaborate on the concept to make explicit factors related to the roles of the consumer and the nurse, and to the working environment, discussing the 'recipient's need for and openness to caring, and the nurse's professional maturity and moral foundations ... [as well as] a working environment that is conducive to caring' (p. 196). Providing nursing care in mental health settings can, however, be even more complex as people with mental illnesses may not identify the need for care, or be open to caring interventions, especially in acute phases of illness. Nurse scholars have invested much time and energy in trying to explain what it is that makes nurse caring special or different from informal caring and from the caring provided by medical practitioners. There have also been many attempts to find a 'fit' between caring as a construct and the biomedically dominated and economically driven healthcare sectors within which nursing is situated. From a mental health perspective, there are even more issues to consider in relation to nurse caring. For example, there are special issues associated with caring for consumers who are compelled to accept professional care under mental health legislation.

Historically, mental health nursing was associated with custodial care and control. Godin (2000) captured the dilemma of mental health nurses when he raised questions about the *dis*-ease between the caring and coercive roles that mental health nurses assume. Godin positioned caring as 'clean' and constructed the coercive control elements of mental health nursing (a term he used for forced treatment, community orders and so on) as 'dirty' (Godin 2000, p. 1,396). While Godin's argument focused on service users and nurses in the community, many of the issues he raised (related to forced administration of medication, seclusion and detention) are still relevant to nurses in inpatient and community settings. In addition, forensic mental health units raise further challenges (Cashin et al. 2010). From the perspective of people who have been involuntarily detained for treatment, Wyder et al. (2015) found that having staff willing to listen empathically was important and that the person's involuntary legal status should not be an impediment to nurses providing compassionate care and forming therapeutic relationships. The absolute vulnerability of service users who can be detained against their will and subjected to various treatments that they may vigorously and robustly resist means that elements of the caring role, such as consumer advocacy, are critical to skilful and compassionate mental health nursing practice.

Professional boundaries

In nursing, professional boundaries are invisible yet powerful lines that mark the territory of the nurse. They define a role and allow the nurse to say: 'This is what I do. This is the purpose of my presence here.' Professional boundaries are important in all areas of health care, but in mental health nursing they have an increased importance due to the nature of the work of mental health nurses and the vulnerability of the service user population. Clear boundaries provide service users and nurses with a safe interpersonal context in which therapeutic work can take place. Over time there has been a decrease in formal divisions between staff and service users in mental health services, with the encouragement of friendliness and collaborative partnerships (Gardner 2010). However, a power imbalance is always present in clinician–consumer encounters (Henderson 2004), and there are a number of ways that boundary violations can occur. Boundary violations can involve exerting power through coercion, use of force, over-treatment or under-treatment, or inappropriate intimate relationships. Maintaining professional boundaries while being involved in therapeutic relationships is a skill that cannot be underestimated in importance. Tariman (2010) noted that social networking provided a further challenge. This medium for relationships needs to be viewed with caution when considering professional boundaries.

Mental health nurses have to be able to maintain professional boundaries while simultaneously developing close therapeutic relationships with service users based on empathy and positive connectedness. While many of the interactions and interventions of mental health nurses may appear social in nature (e.g. playing table tennis, cards or volleyball with a service user, or going for a walk or having a coffee with a service user), it is the therapeutic intent and the conscious awareness of the purpose of the relationship that put them within the professional role. It is when interventions and interactions lose their therapeutic intent and are instead primarily for the benefit of the nurse that professional boundaries are breached. Any breach of professional boundaries has the potential to cause serious harm to service users and is a violation of professional ethics.

Professional boundaries are maintained by nurses having a clear understanding of their therapeutic role, being able to reflect on therapeutic interactions and being able to document and narrate their interventions. Maintaining

professional boundaries is always the responsibility of the nurse.

Self-disclosure

Mental health nurses use self-disclosure as a way of developing therapeutic relationships with service users. Many of the relationships that nurses have with service users are long term, either by repeated admissions to hospital or by continued contact in community or primary care/private practice settings, so nurses and service users may come to know each other well. In a study of nurse–consumer relationships between community mental health nurses and service users with long-term mental illness, nurses described the use of self-disclosure: 'The nurses used their own experiences of living a life to: be seen as ordinary people; be credible; illustrate aspects of being-in-the-world; allow the service users to identify with them; and to normalise the service user's fears and difficulties' (O'Brien 2000, p. 188). Service users described the nurse as 'a friend – but different ... not like other friends' (O'Brien 2001, p. 180). Service users were able to identify that the therapeutic relationship was different even though they knew things about the nurse's life (O'Brien 2001, p. 180).

However, self-disclosure should be used consciously and carefully. The boundary issue is not whether disclosure of information occurs or does not occur. The issue is the nature of the disclosure and whether the nurse burdens the service user with their own personal problems. The decision about what to disclose to service users about your life needs to be made in advance. Self-disclosure does not include unburdening your personal problems. In the above studies, the experienced nurses were able to use their own life experiences to relate in ways that were beneficial to service users without overburdening them. These experienced clinicians also made decisions about what to share with service users according to the length of the relationship and what each service user could use productively.

Chapter summary

This chapter has introduced some of the core concepts and ideas that shape and inform mental health nursing practice and outlined the social ecological approach to practice used throughout this text. Therapeutic relationships lie at the heart of mental health nursing, and a clear understanding of professional boundaries is crucial to developing and sustaining such relationships. To be effective and therapeutic in caring for others, nurses must understand concepts such as compassion, caring, hope and spirituality.

Mental health nursing is an exciting and challenging area of nursing practice. Effective mental health nursing requires the culmination of all your skills as well as your professional and life experiences, and in return it offers a stimulating and rewarding career path. As we strive to meet the complex needs of diverse communities and to provide care within increasingly restrictive economic environments, there are many challenges before us. Developing positive personal qualities such as self-awareness and fostering productive and supportive collegial relationships will help us to meet the challenges that lie ahead.

Acknowledgement

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EXERCISES FOR CLASS ENGAGEMENT

Consider the social ecological approach to mental health nursing described in this chapter.

1. What personal characteristics (including strengths) do you bring to your nursing practice?
2. How can these be used to develop an effective partnership with consumers and their family/carers?
3. In respect to social determinants of health, which determinants do you think nurses can have an influence on? How might they do this?

CONSUMER'S STORY 2.1

Therese

You are a new nurse working in an emergency department and have been assigned Therese. You are aware of the other staff's negative feelings about this consumer. Some of the staff know her from previous presentations and see her problems as self-inflicted. However, as you take the necessary observations you ask Therese about what has happened to her.

Therese then tells her own story:

> I am 28 years old and have had lots of presentations to emergency departments. I used to cut myself often or take overdoses. However, in the past 3 years I have hardly had any presentations and no admissions to hospital. I have two children aged 4 and 2 and I am trying to get my act together for them. I do not want to lose my children. My childhood was chaotic with lots of foster care. I spent time in refuges and took drugs for a while. I do not take drugs or drink alcohol now. I have had a community mental health nurse who has been seeing me regularly for more than 3 years. Tonight I took an overdose of antidepressants that I had been prescribed. I feel ashamed because it was impulsive and stupid. I can see the staff talking about me and saying all the old things. They do not think I deserve care because I inflicted this

on myself and everyone else here is physically ill or has had an accident. I just got to the end of my tether. I had a boyfriend who moved in and I didn't like how he treated the kids so he has gone now. My community nurse is on leave. I couldn't contact anyone; I just felt so alone, empty and lost. I thought the kids would be better off without me.

If my community nurse was here, she would ask me what happened, how I was feeling. She would treat me with respect without condoning what I did. She would help me identify how I can get out of this mess I have made. We would talk about the crisis plan that is on my fridge and how I can get through the next few days keeping myself and my children safe.

Critical thinking challenge 2.1

Consider Consumer's story 2.1. What are your thoughts and feelings on reading about Therese's self-harm? How do you think this might impact your relationship and nursing practice with her?

Useful websites

Professional boundaries

Australian Nurses and Midwives Council: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx

Te Kaunihera Tapuhi o Aotearoa, Nursing Council of New Zealand – Guidelines: professional boundaries: https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx?hkey=9fc06ae7-a853-4d10-b5fe-992cd44ba3de

Recovery

National Standards for Mental Health Services – Principles of recovery oriented mental health practice: www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-i-nongov-toc~mental-pubs-i-nongov-pri

Trauma

Adults Surviving Child Abuse: http://www.asca.org.au/

Adverse Childhood Experiences (ACE) study: http://acestudy.org/ and www.cdc.gov/violenceprevention/acestudy/

Australian Institute of Health and Welfare – Closing the Gap: Trauma-informed services and trauma-specific care for Indigenous Australian children: http://www.aihw.gov.au/uploadedfiles/closingthegap/content/publications/2013/ctg-rs21.pdf

Domestic Violence Services New Zealand Help for family violence: www.police.govt.nz/advice/family-violence/help

Mental Health Coordinating Council (MHCC) – Trauma informed care and practice: http://www.mhcc.org.au/our-work/resources/

NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS): http://www.startts.org.au/

Phoenix Australia, Centre for Posttraumatic Health: www.acpmh.unimelb.edu.au/trauma/ptsd.html

References

Anthony, W.A., 1993. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychiatr. Rehabil. J. 16 (4), 11–23.

Banfield, M.A., Morse, A.R., Gulliver, A., et al., 2018. Mental health research priorities in Australia: a consumer and carer agenda. Health Res. Policy Syst. 16, 119.

Browne, G., Cashin, A., Graham, I.W., 2012. The therapeutic relationship and the mental health nurse: it is time to articulate what we do! J. Psychiatr. Ment. Health Nurs. 19 (9), 939–943.

Carretta, C.M., Ridner, S.H., Dietrich, M.S., 2014. Hope, hopelessness, and anxiety: a pilot instrument comparison study. Arch. Psychiatr. Nurs. 28, 230–234.

Cashin, A., Newman, C., Eason, M., et al., 2010. An ethnographic study of forensic nursing culture in an Australian prison hospital. J. Psychiatr. Ment. Health Nurs. 17, 39–45.

Cleary, M., Horsfall, J., O'Hara-Aarons, M., et al., 2012. Mental health nurses' perceptions of good work in an acute setting. Int. J. Ment. Health Nurs. 21 (5), 471–479.

Cleary, M., Raeburn, T., West, S., et al., 2018a. Two approaches, one goal: how mental health registered nurses' perceive their role and the role of peer support workers in facilitating consumer decision-making. Int. J. Ment. Health Nurs. 27 (4), 1212–1218.

Cleary, M., Raeburn, T., West, S., et al., 2018b. 'Walking the tightrope': the role of peer support workers in facilitating consumers' participation in decision-making. Int. J. Ment. Health Nurs. 27 (4), 1266–1272.

COAG Health Council, 2017. The Fifth National Mental Health and Suicide Prevention Plan. Retrieved from: https://apo.org.au/sites/default/files/resource-files/2017-10/apo-nid114356-1220416.pdf.

Commonwealth of Australia, 2010. National Standards for Mental Health Services. https://www1.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf.

Commonwealth of Australia, 2013. A national framework for recovery-oriented mental health services: guide for practitioners and providers. https://www1.health.gov.au/internet/main/publishing.nsf/content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf.

Crawford, P., Nolan, P., Brown, B., 1998. Ministering to madness: the narratives of people who have left religious orders to work in the caring professions. J. Adv. Nurs. 28 (1), 212–220.

Cutcliffe, J.R., Hummelvoll, J.K., Granerud, A., et al., 2015. Mental health nurses responding to suffering in the 21st century occidental world: accompanying people in their search for meaning. Arch. Psychiatr. Nurs. 29, 19–25.

Day, H., 2015. The meaning of compassion. Br. J. Nurs. 24 (6), 342–343.
Deegan, P.E., 1988. Recovery: the lived experience of rehabilitation. Psychiatr. Rehabil. J. 11 (4), 11–19.
Duggleby, W., Hicks, D., Nekolaichuk, C., et al., 2012. Hope, older adults, and chronic illness: a metasynthesis of qualitative research. J. Adv. Nurs. 68 (6), 1211–1223.
Felitti, V.J., Anda, R.F., Nordenberd, D., et al., 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am. J. Prev. Med. 14 (4), 245–258.
Finfgeld-Connett, D., 2008. Meta-synthesis of caring in nursing. J. Clin. Nurs. 17 (2), 196–204.
Fowler, J., 2019. Reflection and mental health nursing. Part one: is reflection important. BJMHN 8 (2), 68–69.
Gardner, A., 2010. Therapeutic friendliness and the development of therapeutic leverage by mental health nurses in community rehabilitation settings. Contemp. Nurse 34 (2), 140–148.
Glover, H., 2012. Recovery, Life-long learning, social inclusion and empowerment: is a new paradigm emerging? In: Ryan, P., Ramon, S., Greacen, T. (Eds.), Empowerment, Lifelong Learning and Recovery in Mental Health Towards a New Paradigm. Palgrave Macmillian, London, pp. 15–35.
Godin, P., 2000. A dirty business: caring for people who are a nuisance or a danger. J. Adv. Nurs. 32 (6), 1396–1402.
Goffman, E., 1963. Stigma: Notes on the Management of Spoiled Identity. Prentice-Hall, Englewood Cliffs.
Gordon, S., O'Brien, A.J., 2018. Co-production. Power problems and possibilities. Int. J. Ment. Health Nurs. 27 (4), 1201–1203.
Green, M., Linscott, R.J., Laurens, K.R., et al., 2018. Latent profiles of developmental schizotypy in the general population: associations with childhood trauma and familial mental illness. Schizophr. Bull. 44 (Suppl. 1), S229.
Grzanka, P.R., Brian, J.D., 2019. Clinical encounters: the social Justice question in intersectional medicine. Am. J. Bioeth. 19 (2), 22–24.
Gunasekara, I., Pentland, T., Rodgers, T., et al., 2014. What makes an excellent mental health nurse? A pragmatic inquiry initiated and conducted by people with lived experience of service use. Int. J. Ment. Health Nurs. 23, 101–109.
Gustin, L.W., Wagner, L., 2013. The butterfly effect of caring – clinical nurse teachers' understanding of self-compassion as a source of compassionate care. Scand. J. Caring Sci. 27, 175–183.
Hall, C., 2014. Bereavement theory: recent developments in our understanding of grief and bereavement. Bereave. Care 33 (1), 7–12.
Hemingway, S., Rogers, M., Elsom, S., 2014. Measuring the influence of a mental health training module on the therapeutic optimism of advanced nurse practitioner students in the United Kingdom. J. Am. Assoc. Nurse Pract. 26, 155–162.
Henderson, J., 2004. The challenge of relationship boundaries in mental health. Nurs. Manage. 11 (6), 28–31.
Hogan, K., 2013. Caring as a scripted discourse versus caring as an expression of an authentic relationship between self and other. Issues Ment. Health Nurs. 34, 375–379.
Isobel, S., Edwards, C., 2017. Using trauma informed care as a nursing model of care in an acute inpatient mental health unit: a practice development process. Int. J. Ment. Health Nurs. 26 (1), 88–94.
Jääskeläinen, E., Juola, P., Hirvonen, N., et al., 2012. A systematic review and meta-analysis of recovery in schizophrenia. Schizophr. Bull. 39 (6), 1296–1306.
Javier, J.R., Hoffman, L.R., Shah, S.I., Pediatric Policy Council, 2019. Making the case for ACEs: adverse childhood experiences, obesity, and long-term health. Pediatr. Res. 86 (4), 420–422.
Jones, T., Nurius, P., Song, C., et al., 2018. Modeling life course pathways from adverse childhood experiences to adult mental health. Child Abuse Negl. 80, 32–40.
Le Boutillier, C., Leamy, M., Bird, V.J., 2011. What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. Psychiatr. Serv. 62 (12), 1470–1476.
Leamy, M., Bird, V., Le Boutillier, C., et al., 2011. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. Br. J. Psychiatry 199 (6), 445–452.
Lees, D., Procter, N., Fassett, D., 2014. Therapeutic engagement between consumers in suicidal crisis and mental health nurses. Int. J. Ment. Health Nurs. 23 (4), 306–315.
Leete, E., 1989. How I perceive and manage my illness. Schizophr. Bull. 15 (2), 197.
Lund, C., Brooke-Sumner, C., Baingana, F., et al., 2018. Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. Lancet Psychiatry 5 (4), 357–369.
McAndrew, S., Chambers, M., Nolan, F., et al., 2014. Measuring the evidence: reviewing the literature of the measurement of therapeutic engagement in acute mental health Inpatient wards. Int. J. Ment. Health Nurs. 23, 212–220.
Mental Health Commission, 2012. Blueprint II: How Things Need to Be. Mental Health Commission, Wellington.
Muskett, C., 2014. Trauma-informed care in inpatient mental health settings: a review of the literature. Int. J. Ment. Health Nurs. 32 (1), 51–59.
O'Brien, L., 2000. Nurse-service user relationships: the experience of community psychiatric nurses. Aust. N. Z. J. Ment. Health Nurs. 9, 184–194.
O'Brien, L., 2001. The relationship between community psychiatric nurses and service users with severe and persistent mental illness: the service user experience. Aust. N. Z. J. Ment. Health Nurs. 10, 176–186.
Oral, R., Ramirez, M., Coohey, C., et al., 2016. Adverse childhood experiences and trauma informed care: the future of health care. Pediatr. Res. 79 (1–2), 227.
Peplau, H., 1997. Peplau's theory of interpersonal relations. Nurs. Sci. Q. 10 (4), 162–167.
Pilgrim, D., Rogers, A., Bentall, R., 2009. The centrality of personal relationships in the creation and amelioration

of mental health problems: the current interdisciplinary case. Health (London) 13, 235–254.
Raeburn, T., Liston, C., Hickmott, J., et al., 2018. Life of Martha Entwistle: Australia's first convict mental health nurse. Int. J. Ment. Health Nurs. 27 (1), 455–463.
Raeburn, T., Schmied, V., Hungerford, C., et al., 2017. Autonomy support and recovery practice at a psychosocial clubhouse. Perspect. Psychiatr. Care 53 (3), 175–182.
Ramezani, M., Ahmadi, F., Mohammadi, E., et al., 2014. Spiritual care in nursing: a concept analysis. Int. Nurs. Rev. 61, 211–219. doi:10.1111/inr.12099.
Reid, R., Escott, P., Isobel, S., 2018. Collaboration as a process and an outcome: consumer experiences of collaborating with nurses in care planning in an acute inpatient mental health unit. Int. J. Ment. Health Nurs. 27 (4), 1204–1211.
Sawbridge, Y., Hewison, A., 2015. Compassion costs nothing – the elephant in the room? Pract. Nurs. 26 (4), 194–197.
Schofield, R., Allan, M., Jewiss, T., et al., 2013. Knowing self and caring through service learning. Int. J. Nurs. Educ. Scholarsh. 10 (1), 267–274.
Schrank, B., Stanghellini, G., Slade, M., 2008. Hope in psychiatry: a review of the literature. Acta Psychiatr. Scand. 118, 421–433.
Slade, M., Bird, V., Clarke, E., et al., 2015. Supporting recovery in patients with psychosis through care by community-based adult mental health teams (REFOCUS): a multisite, cluster, randomised, controlled trial. Lancet Psychiatry 2 (6), 503–514.
Slade, M., Leamy, M., Bacon, F., et al., 2012. International differences in understanding recovery: systematic review. Epidemiol. Psychiatr. Sci. 21 (4), 353–364.
Smith, S., Macduff, C., 2017. A thematic analysis of the experience of UK mental health nurses who have trained in Solution Focused Brief Therapy. J. Psychiatr. Ment. Health Nurs. 24 (2–3), 105–113.
Spittlehouse, J.K., Boden, J.M., Horwood, L.J., 2019. Sexual orientation and mental health over the life course in a birth cohort. Psychol. Med. 1–8. doi:10.1017/S0033291719001284.
Stewart, D., Burrow, H., Duckworth, A., et al., 2015. Thematic analysis of psychiatric patients' perceptions of nursing staff. Int. J. Ment. Health Nurs. 24 (1), 82–90.
Sweeney, A., Filson, B., Kennedy, A., et al., 2018. A paradigm shift: relationships in trauma-informed mental health services. BJPsych Adv. 24 (5), 319–333.
Tariman, J.D., 2010. Where to draw the line: professional boundaries in social networking. ONS Connect 25 (2), 10–13.
Turolla, A., Venneri, A., Farina, D., et al., 2018. Rehabilitation induced neural plasticity after acquired brain injury. Neural Plast. 2018.
Ungar, M., 2011. The social ecology of resilience: addressing contextual and cultural ambiguity of a nascent construct. Am. J. Orthopsychiatry 81 (1), 1–17.
van Weeghel, J., van Zelst, C., Boertien, D., et al., 2019. Conceptualizations, assessments, and implications of personal recovery in mental illness: a scoping review of systematic reviews and meta-analyses. Psychiatr. Rehabil. J. 42 (2), 169–181.
Voss, P., Thomas, M.E., Cisneros-Franco, J.M., et al., 2017. Dynamic brains and the changing rules of neuroplasticity: implications for learning and recovery. Front. Psychol. 8, 1657.
Warner, R., 2010. Does the scientific evidence support the recovery model? Psychiatrist 34 (1), 3–5.
Wheeler, K., 2011. A relationship-based model for psychiatric nursing. Perspect. Psychiatr. Care 47 (3), 151–159.
World Health Organisation (WHO), 2018. Social determinants of health. Retrieved from: http://www.who.int/social_determinants/sdh_definition/en/.
Wyder, M., Bland, R., Blythe, A., et al., 2015. Therapeutic relationships and involuntary treatment orders: service users' interactions with health-care professionals on the ward. Int. J. Ment. Health Nurs. 24 (2), 181–189.
Wyder, M., Ehrlich, C., Crompton, D., et al., 2017. Nurses experiences of delivering care in acute inpatient mental health settings: a narrative synthesis of the literature. Int. J. Ment. Health Nurs. 26 (6), 527–540.
Zugai, J.S., Stein-Parbury, J., Roche, M., 2015. Therapeutic alliance in mental health nursing: an evolutionary concept analysis. Issues Ment. Health Nurs. 36 (4), 249–257.

CHAPTER 3

The spectrum of mental health and illness

Toby Raeburn, Peta Marks and Kim Foster

KEY POINTS

- In the course of their work, nurses frequently encounter people experiencing mental health challenges.
- Nurses need to appreciate the spectrum of mental health and illness, including stress and emotional upset, crisis, mental distress, mental disorder and mental illness, and respond according to the person's needs.
- Nurses need mental health nursing skills in every clinical setting to support the mental and emotional wellbeing of the people they work with. This will enable them to provide a platform for developing therapeutic relationships.
- Most people who experience episodes of mental ill health will experience recovery.

KEY TERMS

- Bereavement
- Coping strategies
- Crisis
- Emotions
- Grief
- Loss
- Mental disorder
- Mental health
- Mental health problems
- Stress

LEARNING OUTCOMES

The material in this chapter will assist you to:

- understand the spectrum of mental health and illness that people may experience during their lives
- distinguish between stress, crisis, loss and bereavement
- identify the various types of crisis
- describe how to take a strengths focus in practice.

Introduction

It doesn't matter where a person is from, what language they speak or how much money they have, mental health is crucial to everybody's quality of life. Research has shown that mental health affects not only individuals and families but also the social and economic fabric of whole communities, states and nations (Grech & Raeburn 2019; Maron et al. 2019).

Mental health and illness are not static states. Rather, all people experience a spectrum of mental health and illness including a wide variety of complex states that are constantly variable and open to change. In the same way that any physically healthy person may become sick or a physically sick person may become well, there is always the opportunity for a person who is mentally healthy to develop mental ill-health or for a person who is experiencing mental illness to recover and regain mental health. People can move along the spectrum of mental health and illness (see Fig. 3.1) and remain in various states for shorter or longer periods. Understanding the spectrum of mental health and illness is therefore crucial if nurses are to effectively assist the people to whom they deliver care. Mental health cannot be separated from the concept of overall health, which is defined in the constitution of the World Health Organization as:

> A state of complete, physical, mental and social well-being and not merely the absence of disease or injury.
> (World Health Organization 1947)

Unfortunately, mental health is often underemphasised by nurses and other health professionals, who often focus more on assessing people for mental illness than assisting them towards recovery. This may be compared to a football team that becomes focused on defence, forgetting to invest in training that supports them to score goals. Such services inevitably end up in an ongoing cycle of assessment, diagnosis, treatment and discharge, resulting in poor outcomes for patients and families, with high rates of relapse (Rosenberg & Hickie 2019). As discussed in Chapter 2, in this book we promote a 'social ecological' understanding of mental health nursing practice that views mental health as existing within a multifaceted environment of social, environmental, psychological and biological influences. Using this conceptualisation, mental health and illness can be described as existing on a spectrum ranging from mental health to illness. The spectrum of mental health is heterogeneous, meaning everyone experiences it differently, and it is important to acknowledge that there are a wide variety of words and concepts used to explain various stages of the spectrum. The following sections synthesise several major concepts in mental health and illness.

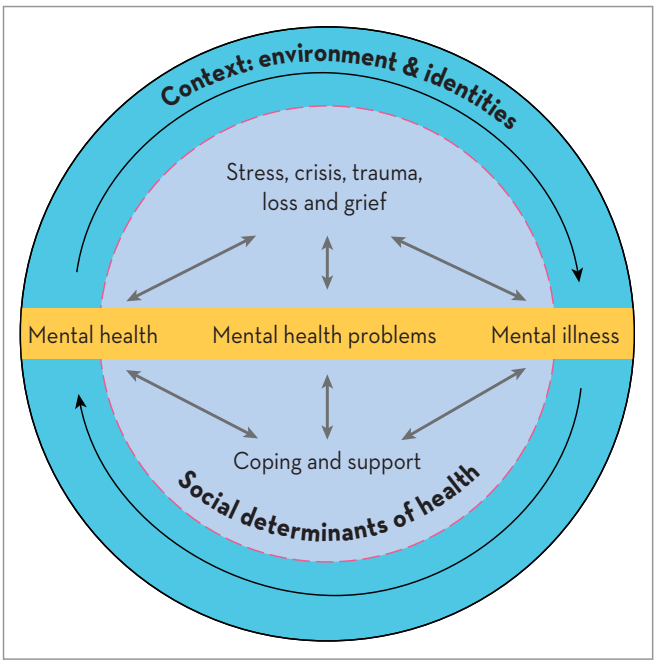

Figure 3.1
The spectrum of mental health and illness

Mental health

Mental health is a phenomenon that includes the common social and emotional experiences shared by all human beings on a daily basis. In spite of this, descriptions of mental health have differed throughout history and continue to vary in the modern era due to factors such as language, culture and the influence of particular interest groups. For example, in 2009 the Australian Government emphasised the importance of mental health to maintaining a productive and harmonious society:

> Good mental health is a crucial aspect of good general health, and underpins a productive and inclusive society.
> (Commonwealth of Australia 2009, p. 10)

Perhaps the most widely accepted modern description of mental health is the one promoted by the World Health Organization:

> Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.
> (World Health Organization 2013, p. 38)

It is important to recognise that a mentally healthy life is not an all-perfect, all-positive life. Most societies accept a wide range of diversity, and most human beings living a mentally healthy life present a wide range of personal and social characteristics. A person who is living a mentally healthy life may present a variety of personal characteristics and social circumstances. Personal characteristics exhibited by people who are mentally healthy may mean that they appear to be: accepting or angry, hopeful or hateful, active or anxious, humble or humourless, joyful or jealous, brave or bullying, successful or sad, compassionate or conniving, flexible or fanatical, trusting or intolerable, or wise or not. Similarly, the social circumstances of people who are

mentally healthy also vary tremendously. People who are single or married, gay or straight, employed or unemployed, wealthy or poor, connected or disconnected, introverted or extroverted, or with or without family and friends can live mentally healthy lives. Mental health helps a person to live a life that is satisfying to them and the community they live in. It does not matter how this is achieved or what the person's life looks like – this is of no consequence at all – as long the person and the community they live in believe that their life is satisfying.

Mental health nurses are well placed to assist individuals and communities to improve modifiable environmental, relational, psychological and physical determinants that can affect a person's mental health. Nurses can work clinically to enhance people's mental health using practices such as mental health assessment, psychotherapy, promotion of physical health care, social advocacy and promotion of ethical medication management. At the public health level nurses may work to influence the development of service models and advocate for fairer social factors that impact on mental health such as affordable housing schemes, access to education, income equality, employment and access to community resources.

In describing aspects of the spectrum of mental health, parts of consumer advocate Jarrad Hickmott's mental health journey are used for illustrative purposes. The first part of Jarrad's story is in the box below.

Jarrad's story: mental health

It seems that when things are going well and we are experiencing what is referred to as 'mental health' we tend to kind of take it for granted and don't really think much about it. Blessed with a happy childhood in a safe and loving family home, I performed well at primary school. In my final year of primary I was school captain, debating team captain, school sports representative, involved in and achieving all that I could.

Stress

Regular experiences of stress are a normal part of life. Stressors can include life events such as exams, a relationship breakdown or running late for an important appointment. A person's response to these stressors is referred to as the 'stress response', where 'stress' involves the effects of something that might threaten a person's physical and psychological homeostasis, or constant state of being (Selye 1956). Emotional distress can occur in relation to personal and social difficulties created through a range of life stressors, a crisis, trauma, loss or bereavement. For the most part, a person presenting in mental distress needs empathy, understanding and emotional support, rather than a diagnosis, treatment and medication (Middleton & Shaw 2000). Every individual responds to stressors differently, depending on factors including their appraisal of the stressor, and their existing coping strategies. Research informs us that life stress can generally be divided into four broad groups:

1. **Environment**: When human beings live in environments overwhelmed by circumstances such as unemployment, poverty, homelessness, violence, war or natural disasters such as bushfires or floods, they are more likely to experience levels of distress.
2. **Relationships:** Our family, community, living environment and culture can affect us as well. Any of these factors may in one way or another affect mental health.
3. **Psychology:** The attitudes we bring to circumstances we face, our thinking skills, our personality and the way we cope with stress can have a huge impact on whether or not we experience mental health.
4. **Physical health:** Many illnesses such as depression, bipolar disorder, schizophrenia and alcoholism can affect biochemicals that keep our body running smoothly. Vulnerability to such problems can sometimes run in families. Just as some families are predisposed to diabetes or high blood pressure, so too other families may be predisposed to mental health vulnerability.

Stress may be acute or chronic. It is different from crisis, which is an acute state where the person's usual coping strategies and ability to manage a situation has been overwhelmed.

Historical anecdote 3.1: Ancient ideas about mental health

Ancient Greek philosopher Aristotle (384–322 BC) theorised that good mental health was connected to the pursuit of happiness. He proposed two broad ways to experience happiness. The first was to cultivate good character through principled living such as caring for the poor or homeless; he referred to this as 'eudemonic' happiness. The second was seeking pleasure through wealth or sex; he referred to this as 'hedonic' happiness. Aristotle suggested that eudemonic happiness was more valuable than hedonic happiness because hedonic interests like power, wealth and sexual pleasure were generally associated with feelings that failed to last. According to Aristotle, parental guidance, good education and a moderate level of wealth were all required for people to be able to pursue eudemonic happiness, and he argued that providing the social platform for such opportunities was the role of government.

Read more about it: *Ryan RM, Huta V, Deci EL 2008 Living well: a self-determination theory. Anecdote on eudemonia. Journal of Happiness Studies 9(1):139–70*