Mental Health Care

An Introduction for Health Professionals in Australia

HUNGERFORD | HODGSON | CLANCY | MONISSE-REDMAN | BOSTWICK | JONES

SECOND EDITION

WILEY

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PREFACE

One in five Australians will experience a significant mental health problem at some stage in their life. There is also strong evidence that people with mental illness have an increased risk of physical comorbidities. For this reason, it is important that all health professionals in Australia, whether they work in community-based, emergency services or hospital-based settings, have an understanding of how they can help people with mental health issues.

Mental Health Care: An Introduction for Health Professionals, 2nd edition has been developed quite specifically as a resource for undergraduate students of the health professions, including nurses and midwives; allied health professionals such as counsellors, chaplains, dietitians or nutritionists, Indigenous health workers, paramedics and ambulance officers, occupational therapists, pharmacists, physiotherapists, psychologists, social workers and welfare workers; and medical officers. Set firmly within a wellness framework, the text will also be useful for health professionals already working in a health-related field, who need information to support them to assist people who are experiencing a mental health problem. This second edition has been bolstered with additional integrated coverage of child and adolescent mental health.

Our text is deliberately structured to suit curriculum planning, including 12 discrete chapters to align with a semester of learning. It also provides opportunities to explore a variety of topics using simple, jargon-free language. There is a user-friendly blend of theory and practice that enables the student to think carefully about the issues involved and develop strategies for working effectively with people, across the lifespan, from diverse cultures who are located in a variety of contexts in Australia.

Each of our chapters contains a number of pedagogical features to support health professionals in their learning. These include:

- clear and concise explanations of new or mental health specific terms, including margin and glossary definitions
- boxed features titled 'Upon Reflection' that contain statements to encourage critical thinking, accompanied by questions to encourage the student to reflect upon what they have read
- discussion of topical issues or dilemmas relating the chapter material to the 'real world' in 'The Big Picture' features
- 'In Practice' case studies or other practice-oriented examples to assist health professionals to link theory to practice
- a summary of the content to assist the health professional to consolidate their learning
- a set of review questions, discussion and debate questions, and web questions to support discussion and further exploration of content.

In combination with the chapter content, these many features provide readers with a comprehensive resource to support the development of the skills and abilities required to care for people who are experiencing mental health problems.

We are a mix of clinicians who also work in the academic context, and academics who also work as clinicians. Each has a passion for the subject area — each is keen to build the capacity of the health care workforce to support people who experience mental illness.

The publication of *Mental Health Care: An Introduction for Health Professionals, 2nd edition* represents an important and exciting step in challenging the stigma that has been traditionally associated with mental illness and meeting the needs of a new generation of health and related professionals.

Chapter 4 considers the multicultural context of Australia, including the way in which Indigenous, multicultural, rural and remote issues influence a person's mental health. In particular, we thank and acknowledge Aunty Kerrie Doyle, a Winninninni woman from Darkinjung country, for her insight and enthusiasm as a consultant and contributor to the section that describes the social and emotional wellbeing of Australia's Indigenous peoples.

We would also like to thank the contributors who have developed the invaluable instructor resources to accompany this edition.

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Finally, and on a more personal note, the authors are also grateful to those who are closest to them. In particular, Catherine expresses her appreciation to her family and friends for 'being there' for her; Donna sends her great love to Trevor, Tara, Zoe, Logan, Alicia, Nevaeh and Ryder — without whom there would be no purpose; and Michael expresses his thanks to his wife and daughter, Antoinette and Sophie, for all their love and support, and also thanks his friend and colleague Rich for making the project an awesome journey.

Catherine Hungerford
Donna Hodgson
Michael Monisse-Redman
Richard Bostwick
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Catherine Hungerford is Associate Professor of Nursing at the University of Canberra, where she teaches into undergraduate and postgraduate courses. She is also a Registered Nurse and endorsed Nurse Practitioner in the field of mental health, and remains clinically active. In addition to her wide experience in the clinical, leadership, management, education and research domains of mental health nursing, Catherine also works closely with consumers and carers and is committed to supporting the provision of person-focused, consumer-centred healthcare. Catherine's current research interests include Recovery in mental health.

DONNA HODGSON

Donna Hodgson is a credentialed Mental Health Nurse who was awarded the National Mental Health Nurse of the Year in 2009 by the Australian College of Mental Health Nurses for her outstanding contribution to the educating and mentoring of undergraduate and postgraduate nurses in the field of mental health. Donna is passionate about ensuring the connection between the theory and practice of mental health nursing. She currently participates strongly in the teaching and researching of mental health nursing students. Since commencing work in the field of mental health in 1991, Donna has worked in a variety of roles, including establishing the first nursing Clozapine coordination role under the first National Mental Health Plan in Canberra and regional NSW. She has been the Clinical Nurse Consultant of the acute adult inpatient unit in the ACT, and worked as a clinical manager in the community. Donna is the co-author of Australian longitudinal research on the neuroleptic Clozapine. Donna also has a strong focus on consumer rights, and promotion and prevention of mental illness in the community. Some of this advocacy for consumers stems from Donna's personal experience after acquiring a permanent disability following a car accident in 2000. Donna has worked for ACT Health as the Coordinator of Mental Health Nursing Education Programmes for more than ten years. She has additionally spent one year as an academic teaching Mental Health units at the University of Canberra in 2010, and maintains an adjunct position there. She is the principal of DMH Nursing.

MICHAEL MONISSE-REDMAN

Dr Michael Monisse-Redman is a registered and practising Clinical Psychologist currently working in both academic and clinical roles. He has over 20 years of clinical experience in child, adolescent and youth mental health working for both the Education and Health Departments, and more recently in tertiary and private practice settings. He currently works at Edith Cowan University (ECU) as a lecturer in mental health across both undergraduate and postgraduate units and courses in the School of

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RICHARD BOSTWICK

Originally a nurse, trained at the University of Sheffield in the United Kingdom, who emigrated 16 years ago, Richard Bostwick is currently working at Edith Cowan University as a senior lecturer in the area of Mental Health and Population Health where he has been for 3 years. He has joined the university from the mental health industry, where he spent the previous 13 years in both managerial and clinical roles. These roles have included: Lead Planning and Development Consultant in the commissioning of the Fremantle HEADSPACE site (Federal Government initiative for Youth Mental Health); Operations Manager of Royal Perth Hospital (Department of Psychiatry and Community Mental Health); Manager of South Metropolitan Emergency Mental Health Services; Clinical Director State-wide Comorbidity Services (AOD and Mental Health); Clinical Manager Peel and Rockingham, Kwinana Adult Mental Health Services; and Clinical Nurse Specialist South Metropolitan Community Mental Health Services. His clinical areas of interest lie within the treatment of clients with comorbid disorders of substance misuse and mental health, and primary mental health care. He is passionate about the mental health and wellbeing of the community as a whole and is currently completing his PhD, focused around support systems for tertiary students with psychological distress. While at Edith Cowan Richard has rolled out a program of Mental Health First Aid training with staff across all areas of the university in order to support the wellbeing of staff and students and increase the resilience within its community. He has in the last year been the recipient of the Vice Chancellor's Citation for Outstanding Contributions to Student Learning and was the 2011 winner of the Western Australian Nursing and Midwifery Award for Education.

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1

Mental health care in Australia

LEARNING OBJECTIVES

This chapter will:

- define the major terms and concepts used in the delivery of mental health care in Australia
- describe the effects of stigma on people with mental health problems
- discuss notions of ‘care’ and ‘caring’
- explain the context of care in Australia
- outline the prevalence and impact of mental illness in Australia
- describe the most common mental health issues that health professionals in Australia will encounter.

Introduction

All **health professionals** in Australia, across the full range of health care settings, will encounter people with mental health issues. This is because mental health problems account for 13 per cent of the total **burden of disease** in Australia, ranking third for **morbidity** and **mortality** after cancer and cardiovascular disease (Australian Institute of Health and Welfare [AIHW], 2012b). Mental illness is also a lead cause of the non-fatal burden of disease (Department of Health and Ageing [DoHA], 2009a). For example, one in five Australians will experience symptoms of mental illness at some stage in their lives (Australian Bureau of Statistics [ABS], 2013). Also, people with mental health problems have an increased risk of physical comorbidities (AIHW, 2012). It is therefore vital that all health professionals — including first responders, and community and hospital-based personnel — have an understanding of how to help the person with a mental illness.

health professional a person who delivers competent, appropriate and effective health care in a systematic way

burden of disease the overall impact of disease or injury on a society, including that which is beyond the immediate cost of treatment. Burden of disease incorporates individual, societal and economic costs.

morbidity the incidence of ill health or disease

mortality the incidence of death in a population

This text introduces health professionals to the specialty field of mental health, and describes how mental health services are delivered in Australia today. The information provided is intended as a resource for health professionals who work in non-mental health specialty contexts and also students of the health professions. The text gives an overview of the core skills and knowledge required by health professionals to support people who are affected by mental illness, regardless of where they live in Australia. While there are many differences between the states and territories with regard to mental health policy frameworks, legislation, practice approaches, and use of terminology, there are also enough similarities to enable health professionals nationwide to work together to improve mental health outcomes for all.

This chapter focuses specifically on the frameworks that guide the delivery of mental health services in Australia. It commences with definitions of the terms 'health professional', 'mental health', 'mental ill-health', 'mental illness' and other key terms that are often used in the field of mental health. Also considered is the power of language, together with the impact of stigma on people who are affected by mental health problems. Another important focus of the chapter is the notions of care and caring, including the context of care in Australia. This discussion sets the scene for an outline of the prevalence of mental illness in Australia and definitions of the most common mental health problems encountered by health professionals in all settings.

UPON REFLECTION

Physical, social and emotional wellbeing

The close links between mental health, physical health, and social and emotional wellbeing support the saying that 'There is no health without mental health'.

Questions

1. What are three things you already know about mental health and mental illness?
2. What are three things you would like to learn from this text about mental health and illness?
3. What are three things you would like to change in your professional practice, to foster a more comprehensive approach to delivering health care?

Definitions

Health professionals often work in **multidisciplinary teams**. The multidisciplinary team in the health context consists of a wide range of personnel, each with their own professional or regulatory standards or requirements, who work together to deliver systematic and comprehensive treatment and care to those in need (Moser, Monroe-DeVita, & Teague, 2013). This systematic and comprehensive care encompasses all aspects of personhood — for example, behavioural, biological, cultural, educational, emotional, environmental, financial, functional, mental, occupational, physical, recreational, sexual, spiritual and social. The range of disciplines or fields of health involved includes:

- ambulance officers and paramedics
- counsellors
- dietitians and nutritionists
- Indigenous health workers
- medical practitioners
- midwives
- nurses, including enrolled and registered nurses, and nurse practitioners
- occupational therapists
- pastoral workers and chaplains
- pharmacists
- physiotherapists
- psychologists
- social workers.

Each of these disciplines has an important role to play in the delivery of care that is comprehensive.

multidisciplinary team a group of health professionals from a variety of disciplines, with different skills or areas of expertise, who work together to provide systematic and comprehensive care and treatment to those in need

For example, **social workers** are committed to pursuing social justice, and enhancing the quality of life and developing the full potential of individuals, groups and communities. In view of the importance of the social determinants of health, which are discussed in more detail in chapter 4, the role of the social worker in the multidisciplinary team is essential.

social worker a health professional who intervenes to support those who are socially disadvantaged by providing psychological counselling, guidance and assistance with social services

Another important allied health worker is the **occupational therapist**, whose role is to support the person to attend to their own everyday needs and preferences (often referred to as 'functional needs and preferences') as well as participate in meaningful activities. Enabling people to be independent and self-sufficient is integral to supporting good health in our society. Occupational therapists also work with families, groups and communities, and are becoming increasingly involved in addressing the effects of social, political and environmental factors that contribute to the exclusion of people from employment and the personal, social and recreational activities in which they would like to become involved.

occupational therapist a health professional who supports and enables people to accomplish everyday tasks to achieve a maximum level of independence and safety

Other allied health workers include ambulance officers and paramedics, counsellors, dietitians or nutritionists, Indigenous health workers (see chapter 4), pastoral workers and chaplains, pharmacists and physiotherapists. Each of these health professionals play a significant role in delivering health care to people with mental health issues. These roles will vary according to the scope of practice of each profession, and can range from crisis or emergency care, to brief consultation or ongoing support. Whatever their scope of practice, all health professionals will require some understanding of what is required to help the person who is affected by symptoms of mental illness.

In the field of mental health, there are a number of health professionals with quite specific roles, and this can sometimes be confusing. For example, many people are uncertain about the difference between a **psychiatrist** and **psychologist**. A psychiatrist is a medical practitioner who has undertaken additional study and acquired a very high level of expertise in the diagnosis and treatment of mental illness. A particular focus of the care and treatment provided by a psychiatrist — like all medical practitioners — is the physical or biological aspects of a person's illness. A psychiatrist can prescribe medications and admit a person to a hospital. Some psychiatrists have also been trained to provide psychotherapy or other forms of psychological therapy.

In contrast, psychologists and clinical psychologists have been trained to provide psychological interventions or therapies for people. Psychologists and clinical psychologists cannot prescribe medication or admit a person to a hospital. It is also important to differentiate between the psychologist and clinical psychologist. Clinical psychologists hold a master's degree in clinical psychology and generally provide interventions that are more complex than psychologists. However, a shared focus of psychologists and clinical psychologists is the cognitive and behavioural aspects of a person.

The most common health professional in the field of mental health is the **nurse**. Some people are confused by the different types or levels of nursing and para-nursing roles, which include assistants in nursing, enrolled nurses, registered nurses and nurse practitioners. Each of these categories has a different educational requirement and scope of practice. Nurses who work in the field of mental health are sometimes called psychiatric nurses, but 'mental health nurse' is the preferred terminology. This is because 'psychiatric' has biomedical connotations and the nurse's scope of practice includes far more than biomedicine alone. Traditionally, nurses have provided care to people, around the clock, to help address a wide range of needs and preferences. The approach of the nurse is defined by holism, encompassing all aspects of personhood.

The term 'mental health nurse' is often used to describe the nurse, enrolled or registered, who works in a mental health related field. However, the Australian Health Practitioner Regulation Agency has no special category for 'mental health' or 'psychiatric' nurse. The Australian College of Mental Health Nurses — the national professional body for mental health nursing — administers a credential for registered nurses who hold a specialist postgraduate qualification and can demonstrate substantial and current experience in the field of mental health, as well as ongoing professional development. Credentialed mental health nurses are often leaders in public mental health services, as well as the defence health and justice health systems; and can work as autonomous practitioners in the primary health care context, providing care to people with complex symptoms of mental illness.

Just as important to the multidisciplinary team are those who are employed by community managed organisations to provide counselling, social and recreational support, housing and accommodation support, assistance to obtain employment, and opportunities for education. As explained later in this text, there are many social determinants of mental health and illness. Health professionals do not work in a vacuum. With one in five Australians experiencing symptoms of mental illness at some stage in their lives, the delivery of high quality mental health services has become an increasingly important

psychiatrist a medical practitioner who has specialised in the field of psychiatry. Psychiatrists focus largely on the biological causes of illness and prescribing medication.

psychologist a health professional whose focus is the cognitive and behavioural aspects of a person and their health. A clinical psychologist has a higher level of education and expertise in this area of health delivery than a psychologist.

nurse a health professional with a holistic and comprehensive or 'whole of person' approach to health care focus for governments and communities alike. It is important, then, for the associated health professions to work together to develop a greater understanding of mental health and illness, to enable the best possible outcomes for all concerned.

Mental health and mental illness

The term '**mental health**' has different meanings for different people in different contexts. In Australia, the field of mental health describes an area of health care that focuses on the psychological, emotional and behavioural wellbeing of the population. With the development and implementation of the National Mental Health Strategy in the early 1990s, governments across Australia at the national and state or territory levels, joined together to define mental health as

> the capacity of individuals and groups to interact with one another and their environment in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational); and to achieve individual and collective goals consistent with justice (Australian Health Ministers, 1991, p. 24).

This national definition has remained unchanged over the years.

Mental ill-health is most commonly referred to as **mental illness or disorder** in Australia. According to the Australian government, a mental illness is a health problem that significantly affects how a person feels, thinks, behaves and interacts with other people (Australian Government, 2013). Mental illness is diagnosed according to standardised criteria, such as that provided by the DSM-5 or ICD-10 (see chapter 2). One reason the term 'mental illness' is so commonly used to describe a mental health problem is because the Australian health system continues to be dominated by the **biomedical approach** to treatment and care.

A **mental health problem** also interferes with how a person thinks, feels, and behaves, but to a lesser extent than a mental illness (Australian Government, 2013). Mental health problems are more common and less severe than mental illnesses or disorders, and include the mental ill-health that can be experienced temporarily as a reaction to the stresses of life. A person with a mental health problem may develop a more severe mental illness if they are not supported effectively (Australian Government, 2013).

mental health the capacity of individuals and groups to interact with one another and their environment in ways that promote subjective wellbeing, optimal personal development, and use of their abilities to achieve individual and collective goals

mental illness or disorder the term most commonly used in health care to describe the spectrum of cognitive, emotional and behavioural conditions that interfere with social and emotional wellbeing and the lives and productivity of people

biomedical approach the Western, scientific approach to the treatment of illness or disease. The causes of illness are viewed as biological. The health professional's role is to make a diagnosis, prescribe treatment interventions and achieve measurable outcomes.

mental health problem a mental health issue that is less severe than a mental illness or disorder which, if not dealt with, can develop into a mental illness or disorder

Biomedical approaches to health care

The biomedical perspective evolved after the age of the Enlightenment, a period which began in the late seventeenth century and ended in the late eighteenth century, and was characterised by the advancement of scientific knowledge. This age saw the development of the 'rational' explanation of health and illness. Supported by the theories of the French philosopher, René Descartes, the body was viewed as a material object that could be understood only by scientific study and physical examination (Berhouma, 2013). In contrast, the mind was posited as part of a higher order, understood through introspection. As such, the body and mind were separated into two distinct entities, with illness considered as either somatic (physical) or psychic (mental) (Melnick, 2011). This philosophy paved the way for the development of an area of science now known as biomedicine.

Today, the biomedical approach to the treatment of illness is viewed by many as a paternalistic or vertical approach to health care. It involves 'expert' health professionals assessing the symptoms of a person, making a diagnosis and devising treatment based on their scientific knowledge of the disease process. In turn, the unwell person follows the directions provided by the expert health professionals to achieve a reduction in the severity of their symptoms (Deacon, 2013). There is a focus on cause (disease or condition), effect (illness or deficiency), treatment (pharmacological, surgical and rehabilitative) and outcome (cure or disability) (Caldwell, Sclafani, Swarbrick, & Piren, 2010; Weiner, 2011).

Psychiatry is the branch of biomedicine that specialises in the treatment of mental illness. A person is diagnosed by a psychiatrist according to the way in which the symptoms reported by the person fit a set of predetermined criteria (e.g. DSM-5 or ICD-10). Diagnoses range in type and degree of severity, and can include depression, anxiety, substance use disorder, psychosis, schizophrenia and dementia. Upon diagnosis, the person is prescribed medication and often advised to participate in one or more of the psychological therapies. If appropriate, electroconvulsive therapy may also be recommended. Once the person responds to this treatment regimen, they are discharged from care.

psychiatry the branch of medicine that specialises in the treatment of mental illness

The dominance of the biomedical model in the field of mental health has given rise to terminology that is likewise dominated by notions of disease or pathology. For this reason, the concepts of health and wellness often take second place to those of 'disorder', 'dysfunction', 'illness', 'deviancy' or 'abnormality'. This creates a degree of tension for health professionals who are committed to working within a framework of health and wellness, as they find themselves moving between the notions of health and illness, well-being and dysfunction. Wherever possible in this text, however, terminology is framed by the health and wellness framework. This includes the use of phrases such as 'mental health problem', rather than mental illness, with the word 'health' retained to promote notions of wellness over illness.

To further complicate matters, language used in the field of mental health is also influenced by the legislative frameworks in place across Australia. For example, 'mental illness', 'mental disorder' and 'mental dysfunction' are defined in different ways, according to the mental health legislation of each of the states and territories across Australia. To minimise the possibility of confusion for readers located in different states and territories across Australia, in this text the terms 'mental disorder' and 'mental dysfunction' are avoided.

Finally, it is also important to highlight one of the problems of using a health and wellness framework. A common misunderstanding is that the term 'mental health' now replaces, or is synonymous with, the term 'mental illness'. Frequent errors in using the term include the following.

- 'The person has mental health; she is hearing voices', rather than the more appropriate 'The person may have a mental health problem; she is hearing voices'.
- 'The consumer has been diagnosed with mental health', rather than the more appropriate 'The consumer has been diagnosed with a mental illness'.

To maintain their authenticity, health professionals are encouraged to familiarise themselves with the most appropriate and current usage of relevant terms. This is important in light of the substantial power and influence of language in our society today.

The power of language

Various philosophers have discussed how language plays a crucial role in framing, informing, developing and maintaining social relations (e.g. Fairclough, 1989; Foucault, 1961; Goffman, 1967). Language shapes or interprets the way people see the world; it is also used to define or describe personal experiences or situations. Language has the power to persuade, control and even manipulate the way people think, act and react (Váňa, 2012).

For these reasons, language must be used carefully. When working within a health and wellness framework, one of the core aims of the health professional is to inspire hope in others (Health Workforce Australia, 2011). This includes helping a person to focus on their strengths and abilities, rather than their deficiencies or disabilities. One way to inspire hope is to employ language that empowers rather than disempowers. This often requires health professionals to make the choice to use one word over another.

For example, it is generally understood that the word 'patient', in the health context, signifies a person who is being attended to by a health professional. This is because the word has a long history of association with medical practitioners and hospitals. Notions of 'patient' have also been connected with ideas of passivity (i.e. a patient is a diseased or disabled person who is being treated by an active and expert health professional). In this way, the word 'patient' sets up ideas of disempowerment, with health professionals positioning themselves as authorities and the patients taking a more subordinate role. It is this unequal relationship that has led to the development of alternative terms — including 'client', 'consumer', 'service user' or, quite simply, 'person' — to connote a person who is seeking assistance from a health professional.

In this text, the word 'person' is the preferred signifier for someone who is being cared for by a health professional. This choice was made because the word helps to normalise the process of giving and receiving help or assistance. However, the terms 'patient', 'consumer', 'service user' or 'client' are also used occasionally. This is because, in the clinical context, people who require assistance for physical or mental health issues are referred to in a variety of ways. It is important to use terms that will communicate to all health professionals, in all contexts.

Similarly, health professionals are referred to in a number of different ways throughout the text. The term 'health professional' has already been defined. Other similar terms used in this text may include 'clinician', 'health care professional', 'personnel', 'practitioner', 'staff member' or, again, 'person'. Use of a variety of names reflects the diversity in our health system. It also reflects a desire to be inclusive and avoid labels.

Indeed, health professionals are encouraged to examine the way in which language can be used to label or stereotype people. In the field of mental health, stereotyping or labelling can have quite negative consequences. It is important to acknowledge that those who experience symptoms of mental illness are people first, and their symptoms or conditions are of secondary importance. For this reason, outdated descriptors such as 'schizophrenic', 'the mentally ill', 'mentally ill person' or 'mental institution' are viewed as unhelpful, even counterproductive. Instead, health professionals are encouraged to use language such as:

- a person who is experiencing symptoms of schizophrenia
- a person with schizophrenia or living with schizophrenia

- a person who is receiving help for their mental health issue
- a mental health facility or unit.

Fostering the use of constructive language is one way health professionals can help to manage the stigma that is experienced by people with mental health issues. Stigma and its outcomes are the focus of the next section of this chapter.

Stigma

Seminal philosopher Goffman (1967) defined social stigma as the overt or covert social disapproval of the personal characteristics, beliefs, behaviours, or conditions that are believed by a society to be at odds with social or cultural norms. **Stigma** is a social reality that works to discriminate between those who are accepted as 'insiders' and those who are rejected as 'outsiders' (Webster, 2012). Stigma makes a clear distinction between 'us' as 'normal' and 'them' as 'deviant' — with the latter marginalised or ostracised accordingly.

stigma an attribute, behaviour or reputation that is perceived, constructed and/or represented by a group of people, society or culture in a negative way

There are many examples of groups that have experienced social stigma over the centuries. These include those who belong to a minority cultural group or ethnicity, have diverse sexual preferences or expressions of gender, or have a mental illness or a disability (Carman, Corboz, & Dowsett, 2012). Other examples of social difference that can lead to social marginalisation include contagious or transmittable diseases (e.g. leprosy, HIV/AIDS), a criminal conviction, an unemployed status, or an addiction to alcohol or illicit drugs (Thomas & Staiger, 2012).

There is evidence globally that some progress has been made to reduce stigma and change the ways in which people who experience symptoms of mental illness are perceived (Arboleda-Flórez & Stuart, 2012). These changes are partly due to developments in pharmacology, together with other treatment interventions that have brought about a marked improvement in outcomes for people who experience symptoms of mental illness. Another reason for changed attitudes relates to the progress made by the global human rights movement, together with evolving socio-cultural perceptions of the ways in which minority groups should be treated. More specifically, in Australia, improved community perceptions are also the result of the work that has been undertaken by primary health care organisations such as *beyondblue*, SANE Australia, and headspace (National Youth Mental Health Foundation). For example, the roles of these community managed organisations include supporting people with mental health issues to live in the community and educating the community about mental illness. Primary health care initiatives, including the work of community managed organisations, are discussed in more detail in chapter 12.

Although such progress and associated community initiatives are to be commended, there is always room for improvement. For example, Buys, Roberto, Miller, and Blieszner (2008) suggest that depression caused by physical pain or illness is more socially acceptable in Australia than depression resulting from emotional concerns. Similarly, depression is a more acceptable diagnosis than psychosis (Reavley & Jorm, 2011). Questions also remain about the community perceptions of people who experience symptoms of psychosis, especially when linked to drug or alcohol use. For example, is it more acceptable in Australia to be diagnosed with a psychosis of an unspecified origin or a drug-induced psychosis? Health professionals are wise to consider the answers to such questions and how these answers may influence their practice.

THE BIG PICTURE

Myths about mental illness

Myth: mental illness is a life sentence

Facts

- Some people will only experience one or two episodes of mental illness. For others, mental health problems occur occasionally, often with years of wellness between episodes. Others again will manage their ongoing mental ill-health with regular therapy. For a minority of those with a more severe illness, periods of acute illness may occur more regularly.
- There are many different kinds of interventions available to support people with mental health problems. Some of these interventions involve medications; others focus more on the psychological and social aspects of the person.
- The earlier a person receives help for a mental health problem, the better their outcomes.
- There is no reason why people with mental health problems cannot live full and productive lives.
- Many people experiencing mental health problems delay seeking help because they fear stigma and discrimination. Reducing stigma will encourage more people to seek help early.
- Most people with mental health problems are treated in the community by their general practitioners (GPs).

Myth: mental illnesses are all the same

Facts

- There are many different mental health problems, with different symptoms.
- A particular mental illness will have a particular set of symptoms, but not every person will experience all of these symptoms. For example, some people with schizophrenia may hear voices, but others may not.
- Simply knowing a person has a mental illness will not tell you about their own, unique experiences of that illness.
- Mental health problems are not just ‘psychological’ or ‘all in the mind’. While a mental health problem may affect a person’s thinking and emotions, it can also have physical effects such as insomnia, weight gain or loss, increase or loss of energy, chest pain and nausea.

Myth: people who are mentally ill are violent

Facts

- Research indicates that people who are receiving treatment for a mental illness are no more violent or dangerous than the general population.

➜

- People living with a mental illness are more likely to be victims of violence (especially self-harm). It has been calculated that the lifetime risk of someone with an illness such as schizophrenia seriously harming or killing another person is just 0.005 per cent, while the risk of that person harming themselves is nearly 10 per cent.
- There appears to be a weak statistical association between mental illness and violence. This seems to be concentrated in certain subgroups — for example, people not receiving treatment who have a history of violence, and those who abuse drugs or alcohol. However, the association between mental illness and violence is still weaker than the association between violence and alcohol abuse in general, or between violence and being a young male between 15 and 25 years of age.

Myth: some cultural groups are more likely than others to experience mental illness

Facts

- Anyone can develop a mental health problem; no one is immune to experiencing mental health problems.
- Many people from culturally and linguistically diverse and refugee backgrounds have experienced torture, trauma and enormous loss before coming to Australia. These experiences can cause significant psychological distress and predisposes people to developing mental health problems.
- Cultural background affects how people experience mental health problems and also how they understand and interpret their symptoms.

Source: Adapted from Hunter Institute of Mental Health (2014)

Community attitudes

One way in which people with mental health problems are stigmatised in and by the community is through their misrepresentation in the news and entertainment media as comical, subhuman, or objects of fear or ridicule (Whitley & Berry, 2013). Perhaps most concerning is the suggestion that people with a mental illness are the main perpetrators of violent crime in our community — a representation that is statistically inaccurate (Hodgins et al., 2011; Short, Thomas, Luebbers, Mullen, & Ogloff, 2013). As noted by Vendsborg, Nordentoft, and Lindhardt (2011), the major determinants of violence are socio-demographic and economic, with substance abuse the most significant indicator. Yet, people with a mental illness continue to be misrepresented as, for example, a maniac on a killing spree, a free-spirited rebel, a narcissistic parasite, or victims of mind games played by psychopaths (e.g. *Psycho, One Flew Over the Cuckoo's Nest, Silence of the Lambs, Shutter Island*). Other representations include being prone to violence, not responsible for one's actions, incapable of making even simple decisions about their lives, necessarily excluded from public office, or being locked up in a mental institution at the first appearance of symptoms (Ramchandani, 2012; TNS Research International, 2010). Certainly there are exceptions to such representations. For example, in the movie *A Beautiful Mind*, a man with a serious mental illness is sympathetically portrayed. Significantly, however, a feature of this and similar movies is that the protagonists have genius-like attributes in addition to their mental illness, thereby suggesting that mental illness is acceptable only if the person has other exceptional qualities to compensate for the mental illness.

Media representations reflect and also perpetuate community values and attitudes: the media construct the community in a particular way, and community members generally understand media representations as 'the way things are' (Couldry, 2008). This has significant ramifications for people with a mental illness. For example, mis-representations work to dehumanise, marginalise and isolate people with mental health issues. Although changes in community attitudes are evident, it would seem the fundamental problem remains — people with mental health issues continue to be stigmatised by the community.

IN PRACTICE

StigmaWatch: Keeping an eye on the media

SANE Australia (2011) is a national charity working for a better life for people affected by mental illness, through campaigning, education and research.

The charity's StigmaWatch program responds to community concern regarding media stories, advertisements and other representations that may stigmatise people with mental illness or inadvertently promote self-harm or suicide. StigmaWatch (www.sane.org/stigmawatch) also provides positive feedback to the media where they have produced accurate and responsible portrayals of mental illness and suicide.

The program relies (and follows up on) reports submitted by hundreds of 'StigmaWatchers' — those concerned about how the Australian media depict mental illness and suicide — who amongst their ranks include health workers, people with mental illness and their friends and family.

StigmaWatch reviews these reports against the Mindframe National Media Initiative's *Reporting Suicide and Mental Illness* guidelines and its own criteria. Should it find that a media story is stigmatising, inaccurate or irresponsible, StigmaWatch will raise these concerns with the media outlet or journalist responsible and encourage them to revise or withdraw the article. StigmaWatch will also provide advice relating to how to safeguard against future media coverage that may stigmatise mental illness and suicide.

Questions

1. Name two specific outcomes for people who experience mental health problems and encounter media descriptions such as 'fruitcake', 'nutter' or 'psycho'.
2. As a health professional, what are two things you can do to help destigmatise mental illness?

The impact of this stigma is considerable and includes unemployment, homelessness, breakdowns in social networks, personal distress and low self-esteem (Evans-Lacko, Henderson, Thornicroft, & McCrone, 2013). Self-stigma is also a problem, as people with mental health issues may view themselves in a negative light. This results in diminished self-esteem and self-efficacy (Thornicroft, Kobayashi, Lewis, Meagher, & Nilsson, 2012). Additionally, it may lead to people with mental health issues feeling reluctant to disclose their symptoms and to postpone seeking help.

As a means of supporting the reduction of stigmatising attitudes in our community, the Australian government has legislated to protect the rights of minority groups. When stigma is acted upon and a person is treated differently because they have a mental illness or other disability, they are experiencing discrimination. In Australia, such **discrimination** is unlawful under the *Disability Discrimination Act 1992* (DDA). According to Webber et al. (2013), discrimination against people with a mental illness is one of the biggest challenges to people receiving effective care and treatment. Health professionals are encouraged to familiarise themselves with the DDA and model the principles it upholds. This is an important means by which prevailing community attitudes can be challenged.

discrimination the unfair treatment of a person or group of people based on categories such as gender, age, class, ethnicity, culture, religion, health issue or disability

Indeed, health professionals are in a prime position to assist with the process of bringing about change. For this reason, it is important that health professionals understand the impact of social stigma on a person's level of education, employment, income, housing, community involvement and, ultimately, health. By speaking out against stigma, educating the community and advocating for the person with mental health issues, the health professional will assist in breaking down the barriers. This includes the barriers that are evident within the health professions themselves.

Attitudes of health professionals

It is important to note that negative attitudes towards people who experience symptoms of mental illness are also evident within the health professions (Byrne, Happell, Welch, & Moxham, 2013). These negative attitudes are demonstrated in a number of ways. For example, 'guilt by association' often means that health professionals who work in the field of mental health are stigmatised in the same way as mental health consumers (Verhaeghe & Bracke, 2012). One of the outcomes of this stigmatisation is the difficulty experienced nationally in recruiting health professionals to work in the field of mental health (Happell & Gaskin, 2013). Negative attitudes are also expressed by health professionals towards colleagues who work in the field through comments such as 'I could never work in mental health!', 'Everyone who works in the field of mental health gets assaulted!', 'You have to be mad to work in mental health' or 'Don't go and work in mental health; you'll lose your clinical skills!' Such comments express presumptions that are based on stereotypes rather than evidence.

Perhaps even more alarming are the attitudes of a small number of health professionals who work in the field of mental health itself. Some of the behaviours identified in health professionals when dealing with mental health consumers include:

- talking about consumers rather than to consumers
- putting down and ridiculing consumers

- failing to provide information to consumers to enable them to make informed decisions
- failing to provide appropriate or respectful services
- failing to respect the information shared with the service by family members
- perpetuating negative stereotypes (Hansson, Jormfeldt, Svedberg, & Svensson, 2013; Happell & Gaskin, 2013; Munro & Baker, 2007).

Other researchers have identified health professionals as patronising and unwilling to involve or collaborate with consumers and carers in treatment decisions (Goodwin & Happell, 2006), and as feeling threatened or challenged by notions of **empowerment** for consumers (O'Reilly, Bell, & Chen, 2012). Significantly, these findings are not confined to the Australian context. Similar attitudes and behaviours are evident in countries across the globe and encompass a range of health professionals, including medical practitioners, nurses, allied health professionals and students (Chien, Yeung, & Chan, 2012; Hansson, Jormfeldt, Svedberg, & Svensson, 2013).

empowerment the process through which people become more able to influence the people and organisations that affect their lives

In light of these attitudes and behaviours, it is important that health professionals are educated about the issues involved, especially about the notions of empowerment and disempowerment (Ryan, Baumann, & Griffiths, 2012). There are many situations in which the inequalities of power are played out by health professionals. These include:

- the removal of the personal freedom of the person with a mental health problem
- the forced administration of medication on those who are contained
- deciding which aspects of treatment and care will or will not be provided, without consulting the consumer
- making decisions about the consumer's 'best interests', without consulting the consumer
- using language and terminology that alienates or excludes the person who is experiencing symptoms of mental illness (Happell & Cutcliffe, 2009).

Situations such as these suggest the need for each and every health professional to take responsibility, self-examine, and identify their personal attitudes towards or perceptions of people with mental health problems.

Such self-reflection will include considering the individual situation of each consumer; being aware of the insidious, even seductive, nature of power; and adapting and adjusting their responses accordingly. Questions health professionals may ask themselves could include, 'How do I view people with a mental illness?' and 'How do these attitudes and perceptions impact upon my professional practice?' Answering these questions honestly will assist the health professional to become a practitioner with a much greater self-awareness.

Indeed, fostering self-awareness is necessary for all health professionals. It is only through self-awareness that health professionals can address issues that may impede their capacity to:

- build and maintain an effective therapeutic alliance or relationship
- collaborate with consumers and their carer or families
- support the development of coping strategies for people with mental health issues
- facilitate the recovery journey and best possible long-term outcomes for mental health consumers.

Acquiring this capacity will, in turn, enable the health professional to more effectively assist the many people in Australia who experience mental ill-health.

UPON REFLECTION

Reflective practice

Reflection is the examination of personal thoughts and actions. Health professionals can reflect on their practice by focusing on how they interact with their colleagues and the environment, in the context within which they work. Reflective practice is a process by which health professionals can become more self-aware, build on their strengths, work on their weaknesses and take action to make changes for the future (Somerville & Keeling, 2004; Webber & Nathan, 2010).

Questions

1. Reflection-in-action involves considering events that have occurred in the past. Identify an event in which you were involved and a person with a mental illness was stigmatised. What could you have done differently?
2. Reflection-in-action involves considering events, including your own behaviour and the behaviour of others, as they occur. What techniques could you use, as a health professional, to develop reflection-in-action?
3. Critical reflection involves uncovering our assumptions about ourselves, other people, and the workplace. What techniques could you use to critically reflect on your assumptions and attitudes towards people with a mental illness?

A focus on caring

In light of a context that is characterised by negative attitudes towards people with a mental illness, as a health professional, what does it mean to 'care'? With the many advancements that have been made in science and technology, research and evidence-based practice, is 'caring' a construct that is relevant to the delivery of health services today? These are important questions for health professionals, with the delivery of health care in Australia driven by a demand to meet **key performance indicators (KPIs)** and collect **empirical data** to inform **evidence-based practice** (Nowak, 2012; Shields, 2012). In this context, ideas of care and caring can sometimes take a back seat.

Interestingly, precise definitions of the terms 'care' and 'caring' are lacking in the health context. For example, care is both a noun and a verb — it is a feeling or attitude, such as concern; and it involves action or activity, such as attending to a person (Ranheim, Kärner, & Berterö, 2012). Care can be understood as a way of being and also a way of behaving (Leininger, 2012a). However, this difference in meaning suggests the possibility for confusion. Not only that, there is sometimes a presumption that an understanding of the notion of caring 'comes naturally' to health professionals (Alpers, Jarrell, & Wotring, 2013). For example, by virtue of choosing to work in the field of health, a health professional may be described as a caring person. However, the nature of health care in the twenty-first century means that health professionals will practise, intervene, treat, manage, assist and support, engage in therapy or provide a service (Hogan & Cleary, 2013). Efficiency and effectiveness are the name of the

key performance indicators (KPIs) a set of quantifiable measures used by health services to gauge or compare performance in meeting strategic and operational goals

empirical data data gathered from observation or experiment, most often related to values that form part of the scientific method

evidence-based practice relates to the health interventions or practices for which systematic research has provided evidence of effectiveness; also known as 'empirically supported treatment' game. So where does care and caring fit? Answers to these questions in part lie with the history of caring.

History of caring

Different disciplines have developed different knowledge bases to explain what it means to provide care. For example, health professionals who work in the field of nursing have a long tradition of providing care, developed from the work undertaken as far back as Florence Nightingale in the mid 1800s. Caring theorists Peplau (1952, 1991) and more recently Barker (2009) have built on this work, describing the craft of caring as both a science and an art — that is, it comprises a set of technical skills, but also involves personal qualities such as sensitivity and attention to detail, together with respect.

From a multidisciplinary perspective, the seminal philosopher Heidegger (1962) described 'caring' as a **universal phenomenon** that influences the way people think, feel and behave in relation to one another. In the health context, early commentators such as Ray (1981) identified four ways of thinking about 'caring':

universal phenomenon a factor, feature, event, situation or dynamic that is not confined to any particular category, group, culture or population

1. psychological care
2. practical care
3. interactional care
4. philosophical care.

In so doing, the notion of care is constructed as both a theoretical framework and an approach that is taken by health professionals to improve the levels of a person's physical and mental health, and also their ability to function on a day-to-day basis.

Morse, Bottorff, Neander, and Solberg (1991) went on to suggest five categories of caring:

1. a human trait
2. a **moral imperative**
3. an effect or outcome
4. an interpersonal interaction
5. a therapeutic intervention.

moral imperative originally defined by the philosopher Kant, who described a principle of conscience and reason that compels a person to act

This view of caring suggests much more than the demonstration of concern for a person or even attending to that person. More, it also involves knowledge, thinking, planning, implementation and evidence of effectiveness. At the same time, the categories of interpersonal interaction and therapeutic intervention suggest that caring has a very personal focus.

It is perhaps for this reason that Dyson (1996) went on to link caring to the personal qualities of knowing, patience, honesty, trust, humility, hope and courage. Watson (1988) likewise conceptualised care and caring as an interpersonal process between two people that protects, enhances and preserves human dignity, bringing about growth or change. Caring, then, is constructed as both theoretical and practical; as both procedural and personal.

Of particular importance is the difference noted by Leininger (1981) between general or generic caring and professional caring. General or **generic caring** is learned as part of a person's ongoing growth and development — by way of upbringing, family background, life experiences and so on. **Professional caring** has a more conscious and

generic caring learned as part of a person's ongoing growth and development — by way of upbringing, family background and life experiences

professional caring caring that is conscious, comprehensive, competent, context specific, and encompasses the physical, psychological, social and spiritual aspects of a person comprehensive focus, and encompasses each of the different dimensions of personhood. This view has been supported by other researchers across the years, with suggestions that feelings of concern and the act of attending to a person hold a significant place in the delivery of health services, but are unlikely to be therapeutic unless the person providing the care is competent or proficient (Barker & Reynolds, 1994; Leininger, 2012b). For health professionals, then, health care and caring involves specific knowledge and skills, as well as attitudes and action. This is because proficient care and caring has a context and purpose.

Aims of care and caring

Care and caring in the professional sense will always be influenced by the aims of its delivery, and these aims will depend upon the context. The health care context is complex and comprises many relational and environmental factors. This includes the structures and settings created by the organisation that is providing the service, the type of service delivery, the knowledge base and approach of the health professional providing the service, and also the needs and preferences of the person(s) receiving the care (Wright & Chokwe, 2012).

In turn, each of these contextual aspects is multifaceted. For example, the context of the person who is receiving care will comprise many aspects of personhood including, as mentioned earlier, the behavioural, biological, cultural, educational, emotional, environmental, financial, functional, mental, occupational, physical, recreational, sexual, spiritual and social. For this reason, health professionals must change or adapt their practice to meet the very specific needs and preferences of each person they help.

The purpose of caring

The way in which care is understood and delivered in the health context will also depend on the aim or purpose of that care. In the broad sense, the aim of all health care is to improve health outcomes (World Health Organization, 1986). More specifically, in Australia an important aim of delivering a mental health service is consumer participation. This aim is in line with national strategic direction (Commonwealth of Australia, 2005, 2009); and also with the growing influence of the consumer movement (Drake & Deegan, 2008; Adams & O'Hagan 2012).

Another purpose of care delivered to people with mental health problems is to protect or maintain the dignity of the person. Care aims to protect, enhance and preserve human dignity; and enables the survival, development, and growth of those involved (Barker & Buchanan-Barker, 2004; Dewar & Nolan, 2013; Ranheim, Kärner, & Berterö, 2012). For this reason, there is no **one-size-fits-all approach** to the delivery of care. Rather, the type of care delivered must be flexible enough to fit the person it serves.

one-size-fits-all approach
an approach or intervention that does not take into consideration diversity or difference; rather it demands that the needs and preferences of all people are met by a standardised approach or intervention

Definitions of 'care' and 'caring'

In light of the history, context and purposes of delivering health care, in this text the terms 'care' and 'caring' are understood as a collaborative process that occurs between health professionals and a person or persons to achieve mutually agreed upon objectives.

Care and caring are delivered in a systematic way by health services to support people and improve health outcomes. Care and caring is also an attitude and set of actions demonstrated by competent health professionals in the course of their work (Alpers et al., 2013; Barker, 2009; Watkins, 2009). The best **health care** and caring is consumer-centred and person-focused; that is, it is delivered according to each person's individual needs and preferences.

health care a systematic and comprehensive service that is delivered in the health context; is person-centred, collaborative, supportive; and aims to improve health outcomes

Indeed, research has identified a marked difference between the activities that consumers choose as the most important to receiving care, and those that health professionals choose as the most important (Barker & Buchanan-Barker, 2004; Leininger, 2012a). For example, consumers often report that they remember the kindness exhibited by a health professional, while health professionals tend to be more focused on providing effective clinical interventions as efficiently as possible. These differences suggest that consumers must always be given the opportunity by the health professional to express their preferences. Further, and as much as is possible within the health service framework, health professionals must work towards supporting these preferences. For this reason, care can be described as a process that is negotiated between the consumer and the health professional in a process that involves caring *with* as well as caring *for* the person (Hogan & Cleary, 2013).

In any definition of care, the related **competencies** of the health professional must also be identified. When helping the person with a mental health problem, these competencies include specific knowledge, clinical skills and communication skills to:

- engage with the person
- actively listen to the person
- build a relationship with the person.

competency a capability or standard or level of practice comprising knowledge, skills and attitudes that are measured by a set of valid and reliable items

Further, care requires health professionals to demonstrate an attitude of compassion and sensitivity, a giving of self, honesty and sincerity, and respect for human dignity (Barker, 2009; Dewar & Nolan, 2013). While these attributes are very personal, it should also be noted that, for the health professional, they do not necessarily 'come naturally' in the workplace. Rather, health professionals must develop themselves professionally so that they can provide care regardless of their reactions to a person or situation. More detailed information on how the health professional can manage their reactions and emotions in a difficult situation is provided in chapters 5 and 6.

Mental health professionals must display competency in engaging with the person, actively listening to the person and building a relationship with the person.

Finally, while there is no doubt that technology is important to the delivery of health services in Australia today, it is the health care itself that ensures the humanity of these health services. Essentially, it is in the very nature of people to care for others in need. Perhaps most profoundly, when competent care and caring is delivered and people connect to and with one another, the health outcomes will speak for themselves (Barker, 2009; Leininger, 2012b). These outcomes will include an improved social and emotional wellbeing of the people involved.

UPON REFLECTION

Care and caring

Think of a time when you were unwell, and you presented to a health professional for help and found them to be uncaring. Think of another time you were unwell and you presented to a health professional who was caring.

Questions

1. What qualities were exhibited by each of the health professionals, to leave you with the impression that one was caring and the other was not?
2. What are the qualities that you see as most important in health professionals? Consider the ethics of your profession in your answer.
3. What qualities do *you* most need to develop to become a 'caring' health professional? Why?

Caring in the health context

All health professionals can learn from the way in which mental health care has been provided over the years. In particular, there are quite profound lessons to learn from the many errors that have been made when delivering services, both past and present.

In early colonial times, people with a mental illness were locked away from the community in 'lunatic' asylums. The first 'mental asylum' in Australia was located at Castle Hill, New South Wales, from 1811 to 1825 (Evans, 2013). Prior to this, 'the insane' were housed at either Parramatta Gaol or, in some cases, Bedlam Point at Gladesville. Other asylums were established in each of the new colonies in the years that followed.

At that time, endeavours were made to provide humane treatment and there were numerous commissions and inquiries into reported abuses. Even so, overcrowding in institutions across Australia meant that a predominantly custodial approach was taken to the care of those who were 'committed'. As a result, treatment options were limited (Evans, 2013). Moreover, the focus of these treatment options available was generally physical in nature and included straitjackets and cold baths (Coleborne & Mackinnon, 2006).

It was only after the Second World War that scientific advancement gave rise to new pharmacological interventions that enabled better outcomes for people with a mental illness (Beer, 2009). In turn, with improved knowledge and better outcomes, came changes in the way people and societies viewed mental health and mental illness. This included recognition that people with mental health issues had the right to live freely in the community; and that the previously common practice of locking people away from mainstream society, with no right of reply, was unethical.

In response, governments across the Western world began to examine the way in which health care was delivered to people with a mental illness. In Australia, the inquiries and reports that were most influential in questioning the ethics and practices of the day include the:

- Richmond Report (1983)
- Barclay Report (1988)
- Burdekin, Guilfoyle, and Hall Report (1993).

Detailed information about these reports can be found on the websites of relevant state and territory departments of health, or the University of Sydney Index of Australian Parliamentary Reports.

The implementation of recommendations made by these and similar reports and inquiries gave rise to huge changes to the way mental health care was delivered in Australia. These changes have included:

- the **deinstitutionalisation** of mental health services
- a decrease in the size and number of psychiatric hospitals
- the separation of developmental disability services from mental health services
- support for consumers to live in the community
- the development and expansion of **integrated community services** or networks, including health services, accommodation services, and other social services
- changes in funding arrangements to support the new era in mental health service delivery (Hillingdon, 2011; Loi & Hassett 2011).

The profound impact of these changes continues to be felt by many health professionals and services in all states and territories.

deinstitutionalisation the process of dismantling the asylum or mental institution network and rethinking the social position of people with a mental illness

integrated community services services located in the community that have established links and work in partnership or a coordinated way to improve outcomes for consumers

The process of deinstitutionalisation also saw the development and implementation of new mental health legislation across Australia. While there are clear differences in the way in which this legislation is enacted in each of the states and territories, the fundamental principles are the same. These include:

- protecting the human rights of people with mental health problems
- guarding the safety of people with mental health problems, and also the safety of the community
- ensuring that people with mental health problems are treated in the least restrictive environment
- promoting individual choice of lifestyle for consumers.

By upholding these principles, health professionals will effectively support the spirit of the legislation in each of the states/territories.

At this point it is also helpful to note that, in line with the development of mental health legislation, each of the states and territories have also developed legal frameworks to protect the rights of people with disabilities (Gleeson, 2010). Although this legislation was and continues to be distinct from mental health legislation, it reflects many of the same principles and ethics. The health services available for people with a mental illness and intellectual disability are outlined in chapter 12. In addition, health professionals are encouraged to seek out information on this important aspect of health service delivery, especially as people with a disability have a higher incidence of mental illness than the general population.

The advent of deinstitutionalisation also saw the development and implementation of new models of care and treatment for people with a mental illness. This included **mainstreaming**, which was introduced as a means of reducing the health inequalities and stigma experienced by people with mental health issues. Today, people who present to health services with symptoms of mental illness are no longer sent to separate campuses at 'other' locations. Instead, mental health services have been integrated into the general or mainstream system (Martens, 2010).

mainstreaming the integration of mental health services with general health services

Not only that, the traditional custodial function of those who treat or care for people with mental health issues has now been replaced by a therapeutic function.

Today, it is the role of the health professional to enable consumers to live in the community and be contributing members of that community. To do this, health professionals work with other government departments and agencies, such as Centrelink, to facilitate care that is comprehensive and integrated, and encompasses all aspects of the person's life.

UPON REFLECTION

Deinstitutionalisation

Some people suggest that deinstitutionalisation in Australia was a failure. This is because many people who had previously lived in institutions — where they were provided with food, clothes and a roof over their head — became homeless and ended up living on the streets.

Questions

1. What do you see are the benefits of deinstitutionalisation?
2. What do you see are the challenges of deinstitutionalisation?
3. As health professionals, what lessons can we learn from the experience of deinstitutionalisation in Australia?

Current policy directions

In 1991, the United Nations (UN) established the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*. This document commences with a statement upholding the fundamental freedoms and basic rights of those who experience symptoms of mental illness. The remaining 24 principles provide guidance on how these freedoms and rights are upheld. They include enabling people with mental health problems to live in the community; and also ensuring that care is readily accessible, has the least number of restrictions on the person's freedom and rights, and is appropriate for the particular needs and preferences of the person.

In January 2011, Australia was reviewed by the UN Human Rights Council for its human rights performance as part of a regular process that occurs for all member states. The Human Rights Council made over one hundred recommendations for change, including those related to mental health. These include recommendations that the Australian government:

- allocate adequate resources for mental health services and other support measures for persons with mental health problems in line with the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care
- implement the recommendations of the Australian Medical Association's 2008 report on Aboriginal and Torres Strait Islander health
- reduce the high rate of incarceration of people with mental illness
- ensure that all prisoners receive an adequate and appropriate mental health treatment when needed (Human Rights Law Centre, 2011).

The way in which Australia provides mental health care also fits within the frameworks provided by the **World Health Organization**, which recommends that all mental health policies be anchored by the four guiding principles of:

1. access
2. equity
3. effectiveness
4. efficiency (World Health Organization, 2001).

Services that are accessible allow all people to seek treatment sooner rather than later. In Australia, providing equitable and accessible services can be challenging considering the cultural and linguistic diversity of the population, and the vast distances between many rural and remote communities (Veitch et al., 2012). Even so, access and equity are two of the cornerstones of mental health service delivery in Australia today. Quality mental health services must be available to all, regardless of distance, cultural background, religion, or ability of the person to pay.

Likewise, the Australian government is committed to delivering appropriate, timely, effective and efficient mental health care that is in line with the best available, contemporary, evidence-based research (National Health and Hospital Reform Committee, 2009). Services must be comprehensive and integrated; and facilitate the timely treatment of those who are in need of help (Petrakas et al., 2011). As with access and equity, effectiveness and efficiency are core tenets that guide the delivery of all health services, including mental health services in Australia.

World Health Organization (WHO) an agency of the United Nations that is an overarching authority on international public health and coordinates international public health initiatives. Its headquarters is in Geneva, Switzerland.

Since the early 1990s, the national and state or territory governments have developed a number of mental health strategies, plans and policies to reflect UN and WHO principles and recommendations. For example, the National Mental Health Strategy provides direction to state and territory governments across Australia to enable improvement in the quality of life of people living with symptoms of mental illness. This strategy was first endorsed in April 1992 by the Australian Health Ministers' Conference (1992a, 1992b) as a framework to guide mental health reform.

According to the Department of Health website (www.health.gov.au), the National Mental Health Strategy aims to:

- promote the mental health of the Australian community
- prevent the development of mental health problems
- reduce the impact of mental health problems on individuals, families and the community
- assure the rights of people with a mental illness.

Milestones for the development of the National Mental Health Strategy are outlined in the various documents that mark the evolution of the National Mental Health Strategy. These include the:

- National Mental Health Policy (1992, 2008)
- National Mental Health Plan(s) (1992–1997, 1998–2003, 2003–2008, 2009–2014)
- National Mental Health Standards (2010)
- Mental Health: Statements of Rights and Responsibilities (1991, 2012)
- Australian health care agreements.

The National Mental Health Strategy has great significance for all health professionals across Australia. Regardless of the context in which they work, health professionals have a responsibility to be familiar with and abide by the principles and policies outlined in the strategy. An A–Z listing of mental health publications can be found at the Commonwealth Department of Health website (www.health.gov.au).

Current service frameworks

It is important that health professionals understand the frameworks within which they provide health care. Such understanding enables health professionals to see the 'big picture' of their everyday work. This section provides a brief overview of the principles that guide the delivery of health care in Australia so that health professionals can contextualise the information provided throughout this text.

Significantly, the overarching framework within which health care is delivered to people with mental health issues in Australia is the same as that which guides all health care and treatment. This framework is called the public health framework or approach.

Public health framework

The 'big picture' framework for health service delivery in Australia is called '**public health**'. This term is not to be confused with the **public health care system**, which includes Medicare and other health funding provided by the Commonwealth and state or territory governments to subsidise the cost to Australians of receiving health care. Rather, by examining the health trends in populations, communities or groups, and recommending or overseeing appropriate interventions, the public health framework in Australia aims to:

- prevent disease
- promote good health practices
- prolong life.

Public health includes epidemiology, which is the study of patterns of health and illness in populations or groups, and involves statistical analysis of data generated to provide an evidence base that shapes strategic direction (Putland, Baum, Ziersch, Arthurson, & Pomagalska, 2013). Some health professionals would know this approach as 'population health', which identifies groups of people that are particularly vulnerable to health issues because of their demographic characteristics (e.g. age or cultural background) or past experiences (e.g. exposure to trauma or abuse) (Perkins et al., 2011). For example, the statistics cited earlier, in relation to the mental health status of the Australian population, fall into the population health category, and provide a basis upon which the Australian government develops strategic direction and shapes services (e.g. DoHA, 2009a; National Health and Hospital Reform Committee, 2009). The public health framework also incorporates services such as prevention and promotion, environmental health, occupational health and safety services, and other services that enable self-determination, self-care and self-help for all communities and people. These services form an integral part of the Australian primary health care agenda.

public health framework
the overarching approach to health service delivery in Australia that focuses upon population trends, prevention of illness and promotion of health

public health care system
universal health care funded and administered by the Commonwealth and state/territory governments in Australia. This system is subsidised by these governments through Medicare and state and territory departments of health, and can be accessed by all Australian citizens or permanent residents.

Primary health care agenda

Primary health care is an integral part of the public health framework. Primary health care is currently defined by the World Health Organization (WHO) as:

> essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health

primary health care
health care that focuses on the multiple determinants of health and the need for community control over health services

> system of which it is the nucleus and of the overall social and economic development of the community (WHO, 1978).

Primary health care, then, is essential care — it is about supporting people, families and communities (Scott & Happell, 2013). It is holistic and comprehensive in approach, incorporating all aspects of what it means to be human and achieve optimal levels of health (DoHA, 2010). Primary health care focuses on health rather than illness, prevention rather than cure, and communities rather than hospitals (National Health and Hospital Reform Committee, 2009).

An important aspect of the various primary health care services in Australia is the delivery of resources and information to promote healthy lifestyles within communities, by communities, and to support communities (Primary Health Care Working Group, 2009). Other areas of focus include equity in health care; research-based methods; accessible, acceptable, affordable technology; promotion of health; prevention of illness; early intervention; and continuity of care. In short, primary health care is 'community-centric'.

primary care a subset of primary health care; it is accessible, affordable, and enables people or groups of people to participate individually and/or collectively in the planning and implementation of their health care

Primary care — a subset of primary health care — is accessible, affordable, and enables people or groups of people to participate individually and/or collectively in the planning and implementation of their health care (Primary Health Care Working Group, 2009). There has been a tendency in Australia to position 'primary care' within the biomedical model and the domain of general pracitioners located in the community. Consequently, the term is often construed as meaning 'first point of contact' in the health care system. However, primary care is much bigger than this. Indeed, all health professionals can provide primary care, regardless of setting, because this type of care enables them to:

- acknowledge diversity in the culture, values and belief systems of the person, while promoting their dignity as a person and right to self-determine
- establish collaborative partnerships with the person, together with their family or significant others, ensuring open channels of communication, and active participation in all aspects of their care
- engage therapeutically with the person, together with their family or significant others, in a way that is respectful of the person's choices, experiences and circumstances; building on the strengths of the person, enhancing the person's resilience, and promoting health and wellness
- collaboratively plan and provide a variety of health care options to the person (including the coordination of these options) and ascertain that these options are consistent with the person's mental, physical, spiritual, emotional, social, cultural, functional and other needs
- actively value the contributions of other health professionals, health services, agencies and stakeholders, ensuring the collaborative and coordinated delivery of holistic or comprehensive evidence-based health care
- pursue opportunities to participate in health promotion and illness prevention activities with and for the person — including health education and support of social inclusion and community participation (DoHA, 2010).

It is all too easy for health professionals to overlook the essential role played by primary health care services, such as prevention and promotion services, because these services tend to be 'behind the scenes' (Roberts, 2012). Similarly, health professionals who work in the very busy **secondary health care** and **tertiary health care** sectors may underrate the important and ongoing health-related work that is carried out by non-government or community managed organisations, or by small medical or allied health practices. Yet primary health care services provide an important means by which people, especially those with mental health issues, are supported to live in the community. Indeed, in Australia, primary health care services play an essential role in supporting the deinstitutionalisation of the mental health services. More information about the primary health care agenda, primary care, and the primary health care services that are delivered in Australia, is provided in chapter 12.

secondary health care health care that is generally accessed after referral by a health professional. Secondary health care is typically delivered through hospitals or other related services funded by state or territory public health services.

tertiary health care health care that is delivered by highly specialised health professionals and services, often located in larger service centres

Current service approaches

All health systems will take a particular approach to the way they deliver their services, with different approaches taken at the different levels of health care. For example, one approach may be used when providing a service to the individual and their family or carers, whereas another one will be used when supporting the health care team. Another consideration is the service approaches taken by the health service organisations that provide the infrastructure and complementary resources required to meet the demands of the political and economic environment (Merkes, Lewis, & Canaway, 2010).

In Australia, the Federal government has identified person-centred care, together with family-centred care, as the first principle for guiding the delivery of health care (National Health and Hospitals Reform Commission, 2008). This approach to care is described as being responsive to the individual differences and the preferences of the people receiving care. It involves health professionals focusing on the person as an individual in the process of planning and delivering care — including the experiences or stories of the person, together with the individual needs, preferences and aspirations of the person and their significant others (McMillan, Kampers, & Traynor, 2010; Kitwood, 1997; Rogers, 1977). Person-centred care is achieved partly by ensuring there is a wide range of services options or health care choices available. The principles for delivering person-centred care include getting to know the patient as a person, sharing power and responsibility, being accessible and flexible, and ensuring care is coordinated and integrated (Clissett, Porock, Harwood, & Gladman, 2013).

Another common approach to care is the strengths-based approach. This approach focuses on the strengths rather than deficiencies of the person, and also the community in which the person is located, with a view to building on the person's and community's abilities and developing their resilience (Campbell & Burgess, 2012; Simmons & Lehmann, 2013). The aim of the strengths-based approach is to assist the person (or community) to develop their strengths as a means of managing their own particular set of circumstances (Tedmanson & Guerin, 2011).

Significantly, however, both of these approaches have been developed by health professionals, with health professionals playing a central role — that is, it is the health professional who gets to know the patient as a person; it is the health professional who is accessible and flexible to meet the needs of the person; and it is the health professional who empowers the person. Essentially, then, this approach maintains the position of the health professional at the centre of the delivery of health services.

In contrast, consumer-centred approaches place the person or 'consumer' at the centre of the care they receive. **Consumer-centred care** is becoming an increasingly common approach taken by health services organisations located in Western countries such as Australia. The participation of consumers and carers in the planning, development and delivery of mental health services is now an expectation of Australian governments at federal and state or territory levels (Commonwealth of Australia, 2005, 2009; DoHA, 2009a). Consumer and carer participation in health service delivery is said increase adherence to and the effectiveness of treatment programs, facilitate consumer satisfaction and promote best-evidence practice (Adams & O'Hagan 2012; Corrigan et al. 2012; Hungerford & Kench, 2013).

consumer-centred care
a model of care in which the health professional 'works with' the consumer rather than 'acts upon' the patient; this includes advocating for the consumer and enabling them to become active participants in their treatment and care

Consumer-centred approaches grew out of the 'patients' rights' movement in the United States, which was part of the wider civil rights movement of the late 1960s, which advocated for the rights of women, African–Americans, homosexual people and other minority groups. This movement eventually gave rise to postmodern notions of multiple realities, including the many and varied individually constructed meanings of experiences of health and ill-health (Collier, 2010). As a consequence, there are now many and varied consumer-centred models of health care. At the heart of each of these models, however, lies the principles of consumer participation, with consumers involved with — even driving — the development of health services and the models of care utilised, as well as the individual health care received (Newman & Kulman, 2011). As noted by Deegan (1996, p. 92), an internationally renowned mental health consumer peer advocate, 'those of us who have been diagnosed are not objects to be acted upon. We are fully human subjects who can act and in acting, change our situation'. It is the consumer who will determine how they respond to the challenges of their lives, not the health professional. Consumer-centred models, then, involve an active consumer rather than a passive patient; with the health professional a co-worker in the process of delivering care.

Recovery

In the field of mental health, the notion of 'Recovery' first emerged over 30 years ago out of the consumer movement and growth in advocacy for consumer rights and autonomy (Anthony, 1993). Recovery is a consumer-centred approach to health care that is underpinned by the principles of hope, optimism, health and wellness (Corrigan et al., 2012). Recovery approaches position the consumer as the expert in their own lived experience of mental illness who collaborates or works in partnership with health professionals to make choices about the health care they receive (Slade, Adams & O'Hagan, 2012). Recovery for people with a mental illness involves a whole-of-life journey of transformation as they move from a position of disempowerment to one of self-determination and autonomy (Drake & Deegan 2008).

The Australian government is firmly committed to Recovery-oriented mental health services. This commitment is demonstrated in a number of ways, and is explicit in the government's definition of Recovery as:

> a personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually-identified essential services and resources (Commonwealth of Australia, 2009b, p. 31).

Other definitions of Recovery, or the **Recovery model**, can be found in the literature, but all are based on the tenets of hope, optimism, individual strengths and wellness. Recovery approaches are described as less about an absence of symptoms or illness and more about enabling consumers to move beyond the negative consequences of their condition. This means accepting that they may continue to experience symptoms of mental illness and to continue on towards a future framed by hope (see table 1.1). As such, Recovery is a process more than an outcome, a journey rather than a destination.

Recovery model a consumer-centred model of health care that focuses on hopes and goals for the future, optimism, and living life to the full

TABLE 1.1 Principles of Recovery

Principles of Recovery
A focus upon the concepts of: • hope, optimism, individual strengths and wellness • meaning, purpose and respect • equality, mutuality, collaboration and responsibility • community engagement • self-confidence, empowerment and agency • personal growth • individual rather than universal solutions • social inclusion and connectedness • process rather than outcome orientation.

There has been some confusion about how to integrate Recovery as a model of care into the practice of health professionals. One reason for this is the more traditional understanding of the term 'recovery' in the context of the biomedical model of treatment and its focus on 'cure'. Another reason is the challenge involved in fitting a truly consumer-centred approach into health service organisations that are dominated by the biomedical model and restricted by the demands of clinical governance (such as the publicly funded health system in Australia). It is perhaps for this reason that the Australian government has recommended that health services are 'Recovery-oriented', rather than definitively consumer-centred (Hungerford, 2014). According to Australia's *National standards for mental health services* (Commonwealth of Australia, 2010), which guide the way in which health professionals care for people with a mental illness, Recovery-oriented practice is guided by six principles:

1. the uniqueness of the individual
2. real choices
3. attitudes and rights
4. dignity and respect
5. partnership and communication
6. evaluating recovery.

The uniqueness of the individual

The health professional recognises that Recovery is 'not necessarily about cure, but rather the opportunity to live a meaningful, satisfying and purposeful life' as a valued member of the community. The health professional also accepts that the outcomes of Recovery-oriented health care are personal and unique for each person, going beyond an exclusive health focus to include an emphasis on quality of life and social inclusion.

Finally, this principle involves the health professional supporting empowerment of the person, with that person recognising that they are the centre of the care received (Commonwealth of Australia, 2010).

Real choices

The health professional supports and empowers the person to make their own choices about the way they live, promoting choices that are meaningful to or for that person. The health professional supports the person to build on their strengths and to take as much responsibility as they can for the choices they make. This includes the health professional balancing duty of care with supporting the person to take positive risks and advantage of new opportunities (Commonwealth of Australia, 2010).

Attitudes and rights

This principle promotes the health professional as someone who listens to, learns from and acts upon communications received from the person and their partners, families or friends about what is important to them. The health professional also respects each person's legal, citizenship and human rights. Finally, the health professional supports each person to 'maintain and develop meaningful social, recreational, occupational and vocational activities'; and instil hope into the person's future and ability to live meaningfully (Commonwealth of Australia, 2010).

Dignity and respect

The health professional is courteous, respectful and honest in all interactions with the consumer and their partners, families or friends. This principle also requires health professionals to be sensitive and respectful when dealing with the values, beliefs and culture of others. Finally, the principle of dignity and respect involves the health professional challenging discrimination and stigma wherever it exists, whether in their own organisation or the broader community (Commonwealth of Australia, 2010).

Partnership and communication

The health professional acknowledges that the person who experiences symptoms of mental illness is an expert on their own life; and that Recovery involves working in partnership with this person, and also their partner and family, to provide support in a way that is meaningful to them as people. In addition, health professionals value the importance of sharing relevant information; as well as the need to communicate clearly and to work in positive and realistic ways to help people to realise their hopes, goals and aspirations (Commonwealth of Australia, 2010).

Evaluating Recovery

The health professional supports the continuous evaluation of Recovery-oriented practice at all levels. This includes the health professional's support of the person and their carers, to track their own progress; and demonstration that they use the individual's experiences of care to inform quality improvement activities. This principle also involves the reporting of key outcomes of Recovery that include (but are not limited to) 'housing, employment, education, and social and family relationships' in addition to health and wellbeing (Commonwealth of Australia, 2010).

When the care that is delivered to people with mental health problems is framed by these six principles — together with the support provided to partners, family members and friends — there is every chance that Recovery will be achieved. As noted by Deegan (1996), health professionals cannot force Recovery to happen, but rather they must work to create an environment in which the Recovery process is nurtured. This aspiration is important in view of the large number of people in Australia who experience symptoms of mental illness and are in need of health care that is accessible, equitable, effective and efficient.

IN PRACTICE

Recovery-in-practice

Despite widespread support for the implementation of Recovery approaches into clinical mental health services worldwide, many commentators have noted the lack of connection between Recovery-in-policy and Recovery-in-practice (Slade, Amering & Oades, 2008; Newman & Kulman, 2011). Some commentators say this is because health professionals are confused about the meaning of the term (Collier, 2010; Barker & Buchanan-Barker, 2011). On the one hand, consumer-centred Recovery is characterised by humanistic notions of health, wellness and consumer empowerment; on the other hand, more traditional, biomedical understandings of recovery are framed by notions of disease and cure. Others again have argued that confusion between the terms has dissipated over the last few years, and now point to deeper, structural factors that challenge the effective implementation of consumer-centred Recovery into clinical services, including legislative requirements and the demands of risk management (Smith-Merry, Freeman & Sturdy, 2011; Hungerford & Kench, 2013).

Questions

1. What do you think needs to happen for Recovery approaches to delivering health care to work?
2. What are three things you can you do to support the implementation of Recovery-oriented services?

The prevalence of mental illness in Australia

As noted earlier in the chapter, mental illness is one of the leading contributors to the non-fatal burden of disease and injury in Australia. It is associated with increased exposure to health risk factors, greater rates of disability, poorer physical health and higher rates of death from many causes (including suicide). It is of great concern, then, that approximately 45 per cent of Australians aged between 16 and 85 will experience a mental illness at some point in their lives, and one in five Australian adults will experience a mental illness in any given year (Australian Bureau of Statistics, 2013).

Figure 1.1 outlines the prevalence rates of anxiety, mood and substance use disorders across the lifespan in Australia. In particular, there are concerning trends for those aged 25–54 years, who are most likely to be raising families and working.

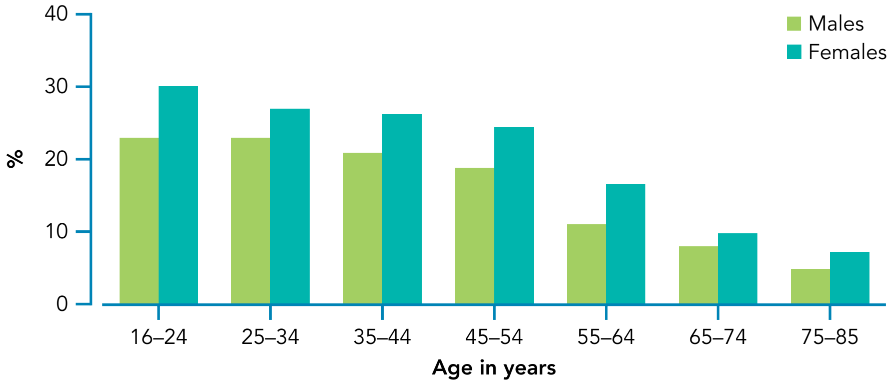

FIGURE 1.1 Prevalence rates of selected mental illness by age group

Source: ABS (2012)

These statistics suggest the widespread — even endemic — nature of mental illness across Australia. The statistics are even more concerning when considered in light of the effect of mental health problems on a person's ability to interact successfully with their family, friends, colleagues and the broader community. People with mental health problems often find it more difficult to relate to others or maintain functional relationships. Further, mental illness has a financial cost. For example, the annual loss to the Australian economy due to mental health problems has been estimated at $20 billion, including losses in productivity and labour force participation (AIHW, 2012b). Additionally, mental health problems were identified as the leading cause of the loss of healthy years of life due to disability (Franke, Paton, & Gassner, 2010).

The prevalence of mental illness across Australia is an important motivating factor for health professionals to learn about the issues involved and integrate mental health care into their everyday practice. This importance is underscored by the fact that many people who are currently seeing health professionals for a physical health problem may also have mental health issues that have not been identified.

Indeed, there has been an increase in the number of people in Australia with physical illnesses or injuries who also have a mental health problem. For example, there has been an increase in the range and volume of people with mental health issues within the hospital context (Ahire, Sheridan, Regbetz, Stacey, & Scott, 2013). Many people will also develop mental health issues in the course of their stay in a hospital or once they have been discharged to the community. Perhaps of most concern, however, is the finding of an Australian study that suggests although 15–20 per cent of people with a chronic physical illness experience depression, anxiety or other psychological distress, 75 per cent of these people receive no mental health treatment or interventions for these conditions (Kelly & Turner, 2009). This indicates that many health professionals are either not identifying mental health issues in the person with a chronic illness or they are unable to provide the care required (Lawrence, Hancock, & Kisely, 2013).

Prevalence of suicide in Australia

Suicide and other self-harming behaviours are discussed in detail in chapter 8. In this section, the prevalence of suicide in Australia is briefly reviewed as a means of introducing this very significant issue and establishing a platform for further reading.

On average, over 2300 people die each year in Australia from suicide. Over three-quarters of these deaths are males, with suicide as the tenth leading cause of death for males in Australia (ABS, 2011a).

The Australian Bureau of Statistics (2011b) goes on to note that, while suicide accounts for a relatively small proportion (1.5%) of all deaths in Australia, it accounts for a greater proportion of deaths from all causes within specific age groups. For example, in 2011, over one-quarter (27.8%) of all male deaths aged 15–24 years were due to suicide (ABS, 2011b). Similarly for females, suicide deaths comprise a higher proportion of total deaths in younger age groups compared with older age groups. In short, young people are less likely to die from a disease or medical condition, which means the proportion of young people who die from suicide is higher. Also of concern is the rate of suicide in males aged 85 years and over, with this group having the highest suicide rate of all groups.

More generally, it is also important to note the following.

- There are more deaths by suicide each year in Australia than by motor vehicle accidents.
- People with a previous history of attempted suicide are at greatest risk of suicide.
- Mental illnesses such as major depression, psychotic illnesses and eating disorders are associated with an increased risk of suicide, especially after discharge from hospital, and when a treatment regimen changes or has been reduced.
- People with alcohol and drug abuse problems have a higher risk of dying by suicide than the general population (Hunter Institute of Mental Health, 2014).

It is also important to consider the suicide rate of Australia's Indigenous peoples, which is much higher than that of non-Indigenous Australians. For example, young Aboriginal and Torres Strait Islander males (15–19 years) are 4.4 times more likely to die by suicide than are other young Australian males. Similarly, young Aboriginal and Torres Strait Islander females (15–19 years) are 5.9 times more likely to die by suicide than are other young females (ABS, 2011b; Hunter Institute of Mental Health, 2014).

There is much that can be done by health professionals to reduce the rates of suicide in Australia for Indigenous and non-Indigenous groups. Preventative measures include early identification of risk factors, and these are discussed in more detail in chapters 2, 4 and 6. Also important is building on a person's protective factors so that they can develop resilience to cope with stress and minimise risk of harm. Such protective factors will include the involvement or participation of families, friends and relevant support services; community connectedness; enabling the development of resilience, and hope.

Issues for young people

Adolescence is a time of great physical, emotional and social change. This brings with it new challenges — and associated stress. The way a young person reacts to stress will affect their ability to cope with life. It is important that young people are supported to develop personal coping skills and also become aware of the potential for stress to affect them (McGorry, Bates, & Birchwood, 2013). Stress can be positive because it can motivate people and groups into action (see chapter 5). Stress can also have a negative impact on a person, especially young people who are already feeling insecure, confused or anxious. This, in turn, can give rise to a range of mental health issues for the young person.

It is perhaps of no surprise, then, that one in four young Australians aged 16–24 years have a mental health problem (ABS, 2013). Anxiety disorders were the most common, affecting 15 per cent of young people. Substance use disorders are the next most common mental health problem experienced by young people (13%), with the harmful use of alcohol the most common substance use disorder (9%). Post-traumatic stress disorder is the most commonly experienced anxiety disorder (8%). Following this, around 6 per cent of young people have an affective disorder, with bipolar affective disorder (3%) and depression (3%) the most common types (ABS, 2013).

The Australian Bureau of Statistics (2010) also identified that almost one-third of young women experience a mental health problem, compared to around one-quarter of young men. Young women were more likely to have anxiety or affective disorders; young men were more likely to have a substance use disorder. In addition, young people with a mental health problem are more than five times more likely than those without a mental health problem to use illicit drugs or misuse legal drugs, twice as likely to be current smokers, and around 1.5 times more likely to drink alcohol at least weekly (ABS, 2013).

While the prevalence of mental illness is relatively high in young people, they also have a relatively low use of mental health services (Carlson, McClellan, McGaw, Walter, Bennett, & Walter, 2013). One reason for this is that the current mental health system is not adequately resourced to deal with young people who have mild-to-moderate mental health issues (headspace, 2011). As a consequence, young people may have difficulty finding a service that can meet their needs or preferences. This is of concern as it means the young people are not receiving the support or health care they need.

According to the Australian Bureau of Statistics (2010), less than a quarter of young people with a mental health problem use mental health services. General practitioners are the service most frequently accessed by young people with a mental disorder (15%), followed by psychologists (10%). Young people with a substance use disorder are the least likely to use mental health services (Zimmermann, Lubman, & Cox, 2012).

Of young people who did not access mental health services, most (85%) felt that they did not need any type of assistance (ABS, 2010).

It is a concern for all health professionals that young people with mental health problems are not seeking or receiving help. Whether this situation is the result of stigma, lack of awareness, or uncertainty of where to go, it is important that health professionals work together to ensure they know what services are available and how these services can be accessed, and advise the young people and their families accordingly. Young people who experience mental health problems are more likely to experience issues with their physical wellbeing and educational, psychological and social development (Eather, Morgan, & Lubans, 2011). In contrast, when the early signs of mental health issues are identified and addressed, outcomes for the young person are improved. More information about the early intervention strategies currently used to help young people with mental health problems, together with the services that are available for young people in Australia, are discussed in chapter 12.

UPON REFLECTION

Young people and suicide

Suicide accounts for 17.8 per cent of deaths in the 15–19 year age group, and 24.6 per cent of all deaths in the 20–24 year age group (headspace, 2011).

Questions

1. Identify at least three reasons why young people in Australia would consider suicide as an option.
2. As a health professional, what can you do to help address the high rates of suicide in young people in Australia?
3. As a health professional, what can you do to encourage young people to seek help for a mental health issue?

Common mental health issues

The most common mental health issues in Australia are anxiety disorders, including generalised anxiety disorder, post-traumatic stress disorder, social phobia, panic disorder and obsessive–compulsive disorder (14.4%) (AIHW, 2013). Affective or mood disorders, such as depression or bipolar disorder, are the next most common issue (6.2%); with substance use disorder next in line (5.1%), in particular, alcohol use disorder (2.9%). Other mental health conditions that health professionals may face in the emergency context include suicide attempts and self-harming behaviours, and challenging behaviours due to psychosis or a mania. Health professionals who work in the hospital context or in a general practice may also interact with those who exhibit psychologically based physical symptoms, often called **somatisation**.

somatisation the experience of a person who feels, reports, or is preoccupied with physical symptoms that have no biological cause and/or are disproportionate to any actual physical disturbance

Statistics such as these suggest one reason why the National Mental Health Strategy prioritises an improved understanding of mental health issues by all health professionals, not just mental health professionals, and also communities. This prioritisation includes community education and the delivery of mental health education to front-line workers in health, emergency, welfare and associated sectors, ensuring coordination between these services (Green, Hunt, & Stain, 2012).

At the same time, these statistics present a challenge to health professionals who are committed to providing comprehensive care. Of particular concern are the potential consequences for people when mental health issues go unrecognised. As noted in figure 1.2, these consequences can include a decrease in quality of life for the person and reduced health outcomes. It is essential, then, that health professionals recognise the signs and symptoms of mental illness and that they also have knowledge that will enable them to provide the most appropriate referral for or treatment and care to the person exhibiting these symptoms.

Consequences of unrecognised mental health issues

- Decrease in the quality of life of the person and possibly their relatives/carers
- Physical recovery impeded
- Unnecessary physical investigations undertaken in a search of 'answers' to symptoms that have no physical cause
- Increase in cost for health service providers
- A longer period off work and related financial problems
- Social isolation
- Early treatment not implemented, leading to an increase in symptoms of mental illness
- Higher risk of suicide

FIGURE 1.2 Potential consequences of mental health issues going unrecognised

Source: Elder, Evans, and Nizette (2013)

A list of the mental health issues that health professionals are more likely to encounter in a health context is provided in table 1.2 (overleaf), together with a brief description of the way in which the person who is experiencing these issues may present, and the recommended intervention. The information in this table has been drawn from the diagnostic manuals DSM-5, ICD-10 and also evidence-based clinical practice guidelines produced by organisations and institutions such as the Australia and New Zealand Academy for Eating Disorders (2011); Australian Centre for Posttraumatic Mental Health; Kaplan & Sadock (2009); National Institute for Health and Clinical Excellence (NICE) (2013), the Royal Australian and New Zealand College of Psychiatrists (2013); and the Royal Australian College of General Practitioners (2013). For health professionals working in the wider health context, the conditions outlined in table 1.2 (overleaf) may be experienced by the person as a **comorbid** disorder. This term describes people with mental health issues who have also developed physical conditions that require medical or other interventions; or people with physical conditions who develop a mental health problem. More comprehensive descriptions of these conditions are provided in later chapters, including those with the greatest burden of disease — for example, bipolar disorder and schizophrenia (chapter 9), and substance use disorders (chapter 10).

comorbid relating to a disease, disorder or condition that occurs at the same time as another unrelated disease, disorder or condition

TABLE 1.2 Summary of the more common mental health issues

Mental health issue	Typical presentation	Recommended intervention
Acute stress reaction (ASR), also called acute stress disorder (ASD) (see also chapter 5)		
A transient psychological condition that develops in response to a traumatic event. It is not necessary for the person to have been physically involved in a trauma to experience this reaction. Traumatic events include any experience of perceived threat to life or physical safety of the person or others around them that arouse feelings of intense fear, helplessness or horror.	Usually begins within minutes of the event and disappears after hours or days. Symptoms can be severe and distressing for the person, and may include (i) initial state of 'daze' or other dissociative symptoms such as emotional detachment or an apparently inward focus that reduces attention to and awareness of the person's surroundings; (ii) memory loss — especially for the traumatic event ('dissociative amnesia'), and depersonalisation (a perceived loss of contact with reality, feeling unreal); (iii) altered levels of consciousness, agitation or overactivity, withdrawal, anxiety symptoms (e.g. sweating, increased heart rate or flushing). People with an ASR may also present to health professionals with problems ranging from psychosocial issues like anger and relationship problems to health issues such as chronic tiredness, gastrointestinal upset and headaches.	The condition is usually self-limiting, with most people recovering using their own internal resources. Health professionals can assist by treating the symptoms (e.g. if a person is shivering, provide them with a blanket). Health professionals also need to provide verbal reassurance and normalise the experience for the person and their partner or family. This includes providing explanations and information about the event, and social support if necessary. Structured psychological interventions such as debriefing should not be offered routinely. After two weeks, a person for whom ASR persists can be offered a comprehensive clinical assessment with trauma-focused cognitive behavioural therapy (CBT) including exposure and/or cognitive techniques.
Adjustment disorder (see also chapter 5)		
A maladaptive emotional or behavioural reaction to an identifiable stressful life event or life change. The reaction generally occurs from one to three months after the initial stressor and tends to resolve within six months.	Associated symptoms fall on a continuum, from mild depression and/or anxiety, to traumatic stress, distress, and up to suicidality. Impaired social or occupational functioning can occur, from withdrawal to an ability to cope. The reaction generally resolves when the identified stressor(s) abates.	Interventions include psychosocial support that focuses on (i) reassurance, (ii) arousal reduction, (iii) addressing the cause of individual's stress or conflict and (iv) skills training.

Mental health issue	Typical presentation	Recommended intervention
Anxiety (see also chapter 7)		
Characterised by feelings of tension, worried thoughts and physical changes (including increased blood pressure). There may be recurring intrusive thoughts or concerns, avoidant behaviours and physical symptoms such as increased blood pressure, sweating, trembling, dizziness or rapid heartbeat. Six anxiety disorder subtypes are recognised: (i) panic, (ii) generalised anxiety, (iii) social anxiety, (iv) specific phobias, (v) obsessive-compulsive and (vi) post-traumatic stress.	Subjective symptoms include feelings that range from apprehension, discomfort and dread, up to the fearful impression of impending doom and panic. Objective symptoms include palpitations, chest pain, diarrhoea, headache, nausea, urinary frequency, increased respiration and muscle spasm.	Interventions include (i) psychological therapies such as cognitive behavioural therapies and anxiety management techniques, and (ii) pharmacotherapy such as benzodiazepines and antidepressant medications. A combination of medication and psychological therapies is also helpful.
Bipolar affective disorder (including manic/hypomanic and depressive phases)		
A mood or 'affective' disorder that cycles between mania and depression. For most people, bipolar is a recurring, disabling illness. People have difficulties in maintaining stable relationships and employment, and account for 12 per cent of all Australian suicides annually. The major ongoing Recovery issue is non-adherence to pharmacological treatment. This may be associated with the stigma attached to the disorder and associated difficulties with self-concept and self-esteem.	Lifetime misdiagnosis is not uncommon, with symptoms frequently ascribed to schizophrenia or personality disorder. Mania and hypomania (mania of a lesser intensity) are characterised by episodes of (i) impaired insight and judgement with (ii) chaotic behaviour that can include irritability, aggression, disinhibition, (iii) disorganised cognition (e.g. grandiosity, tangentiality) and (iv) psychosis (e.g. delusions, hallucinations). For depressive symptoms, see the separate entry for depression.	Initially (i) ensure safety from harm to self or others; (ii) exclude underlying organic conditions (e.g. substance-induced mania, delirium); (iii) treat physical complications (e.g. dehydration). The main long-term treatments are (i) pharmacological (e.g. mood stabilisers); (ii) psychosocial support to help manage the symptoms; (iii) psychoeducation, suicide prevention and family therapy to manage the condition; and (iv) support groups are also helpful. Psychological treatments can also be used alongside pharmacological treatment and psychological treatments to identify and manage stress, prodromes and symptoms, and to prevent relapse or recurrence through monitoring and challenging negative assumptions and thoughts.
Deliberate self-harm (DSH) (see also chapter 8)		
An acute, deliberate, non-fatal act (e.g. self-cutting, self-burning, self-poisoning with drug misuse) that may or may not include suicidal intent. Associated with psychiatric disorders such as depression, substance use and anxiety disorders and personality disorders. Vulnerability to DSH may persist long term for some people.	Self-injury includes a wide variety of behaviours: self-mutilation (e.g. cutting, burning), jumping from heights, attempted hanging and deliberate car crashes. Self-poisoning refers to an overdose of medications or the ingestion of other substances. Self-mutilation usually refers to self-harm where there is non-suicidal intent at the time of the injury.	Initially, (i) ensure safety from further self-harm and (ii) refer to the mental health specialist team. Long term, (iii) cognitive behavioural therapy and problem-oriented approaches (especially dialectical behaviour therapy (DBT), address underlying mental disorders, and aim to reduce distress and enhance coping skills.

(continued)

TABLE 1.2 *(continued)*

Mental health issue	Typical presentation	Recommended intervention
Delirium (see also chapter 11)		
Delirium is a medical emergency: if left untreated, it can result in death. It is generally reversible when the underlying cause is treated. Delirium can be difficult to detect and is often undiagnosed, particularly in older people with comorbid dementia, although it also occurs and remains undiagnosed in up to 20 per cent of younger hospitalised people. Delirium is also called acute brain syndrome, acute confusional state or acute organic psychosis. It is generally caused by an underlying illness, or metabolic or chemical disturbance. However, it can also be caused by stress.	There are three main signs: (i) acute or swift onset and fluctuating course over hours to days, which tends to be worse at night ('Sundown syndrome'); (ii) inattention or erratic/disorganised thinking and behaviour (e.g. confusion, disorientation, paranoia, hallucinations, memory impairment); and (iii) altered level of consciousness — from comatose (unable to be aroused), to lethargic (drowsy), to hyper-aroused (agitated) to a mixed presentation. Clinicians look for problems encapsulated by 'the 5 Ps': • Pus — an infected lesion that has previously gone undetected • Pills — including misuse, adverse reactions and drug interactions for over the counter drugs, illicit drugs and alcohol as well as prescribed medications • Pain — particularly in people whose ability to communicate has been compromised • Pee — urinary tract infections often go undetected, particularly in older people who have become dehydrated • Poo — constipation or diarrhoea (gastrointestinal problems) (DBMAS-RADAR, 2009).	The underlying cause of the delirium should be treated. Psychosocial support and reassurance is given to reduce any distress. In extreme cases, where the person is at risk of further harm, psychotropic medication can be used.

Mental health issue	Typical presentation	Recommended intervention
Dementia (see also chapter 11)		
A cluster of symptoms that provide a label for a range of specific behavioural, psychological, physical and social deficits. The incidence increases dramatically with age but tends to be rare in the under-55 age group. The most common form of dementia is Alzheimer's disease, which accounts for 50–70 per cent of all cases. The onset is insidious and irreversible. The disease progresses gradually but continuously and survival is approximately 8–11 years from the time of onset of symptoms.	Symptoms include: (i) slow cognitive decline exhibited through slowly increasing functional deficits such as memory loss, confusion, language disturbance, an increasing inability to self care, and often depression and anxiety; (ii) 'challenging behaviours' or behavioural and psychological symptoms of dementia, including wandering, pacing, hoarding, verbal and physical aggression, screaming, repetitive vocalisations, delusions and hallucinations, sexual disinhibition and faecal smearing. Typically dementia ends in permanent dependence in all aspects of care and, ultimately, death.	Interventions include: (i) person-centred approaches where health professionals respond to the immediate needs and preferences of the person and their carer; (ii) pharmacological treatments (e.g. anticholinesterases).
Depression (see also chapter 7)		
Diagnosed when a person's mood is consistently depressed or they lose interest and pleasure for at least two weeks. Also accompanied by four or more other symptoms from those listed in the middle column. Physical illnesses such as cancer, respiratory and cardiovascular disease, diabetes, stroke and neurological conditions increase the risk of depression. Similarly, depression following a cerebral vascular accident, myocardial infarction or prolonged physical illness is associated with increased mortality.	Symptoms include (i) feelings of worthlessness or guilt, (ii) impaired concentration, (iii) loss of energy/fatigue, (iv) suicidal thoughts, (v) appetite/weight change, (vi) altered sleep pattern, (vii) tearfulness, (viii) depressive body posture, (ix) agitation, (x) social withdrawal, and (xi) inability to be 'cheered up'. Symptoms of depression can be difficult to identify in physically ill people as they are often the same as symptoms of physical illness and associated treatments such as medication, chemotherapy, radiotherapy (e.g. changes in sleep and appetite). It is therefore important to focus on further assessment of the psychological symptoms.	Treatment includes (i) medication (antidepressants); (ii) psychological therapies (e.g. cognitive behavioural therapy or interpersonal therapy); (iii) social support and physical care if required; (iv) or a combination of (i), (ii) and (iii).

(continued)

TABLE 1.2 *(continued)*

Mental health issue	Typical presentation	Recommended intervention
Eating disorders (anorexia nervosa, bulimia nervosa) (see also chapter 8)		
Eating disorders are a potentially life threatening biologically based mental disorders with variable causes and a high rate of relapse that require specialist, multidisciplinary care. Fifteen per cent of Australian women will develop an eating disorder over their lifetime and the incidence is rising, with a major risk factor being negative 'body image', which is the primary concern of those aged 12 to 24 years. Among this age group: 29.3 per cent binge eat, 13.6 per cent purge and 20 per cent are dieting or fasting (Australian Institute of Health and Welfare, 2007). Around 0.5 per cent of those with an eating disorder will go on to develop anorexia nervosa. The prognosis for people with eating disorders varies widely — 50 per cent of people with anorexia nervosa never fully recover and overall mortality is 5 per cent.	*Anorexia nervosa:* Deliberate weight loss and a refusal to eat. Hyperactivity is common. About 50 per cent of consumers also use unhealthy purging and vomiting behaviours to lose weight. A common symptom is a preoccupation with body shape and size, including delusions (e.g. seeing self as fat even when severely underweight). Depression and obsessions are often found in people with an eating disorder, particularly in those with anorexia nervosa. A range of medical complications can be experienced from both conditions. These can affect all of the body systems but amenorrhoea, osteoporosis and hypometabolic symptoms are common in people with anorexia nervosa. *Bulimia nervosa:* Consumers episodically binge on food (repeatedly over-eat to an extreme degree) and then take extreme measures such as making themselves vomit, taking laxatives or starving themselves. Low self-esteem, impulsivity, problems with intimacy and dependency, and difficulty managing anger are common in people with bulimia nervosa. Common medical conditions for those with bulimia nervosa including gastrointestinal problems and electrolyte imbalances.	All eating disorders require complex, specialist multifactorial and multidisciplinary care across a range of settings including medical support, psychiatry, psychology, mental health nursing, dietetics and social work. It may be necessary to have a specialised mental health professional with the person continuously in the clinical environment if they are assessed as being at a high risk of continued self-harming behaviours.

Mental health issue	Typical presentation	Recommended intervention
Hypochondria		
Hypochondria is also known as hypochondriasis, and is a type of somatoform disorder. It involves the person experiencing an overwhelming, persistent fear of having a serious illness based on misinterpreting physical sensations as signs of physical illness. These anxiety-based beliefs are not addressed by positive results from physical examinations and tests, and, over time, tend to interfere with psychosocial functioning.	Repeated presentations with intense anxiety related to variable reported symptoms that may or may not correspond with an identifiable physiological response.	Supervised, 'real life' exposure with response prevention and cognitive behavioural therapy are the interventions most likely to be successful.
Panic (see also chapter 7)		
Panic is an intense form of anxiety. When a person experiences a panic attack, the intense symptoms develop abruptly and tend to peak within ten minutes (Stuart, 2008). A panic disorder occurs when the person experiences recurrent and unexpected panic attacks and at least one of the attacks has been followed by at least one month of either persistent concern about having additional attacks, worry about the implications of the attack or its consequences, and/or a significant change in behaviour related to the attacks.	The symptoms are as those for anxiety, but possibly intensified.	Aim of interventions is (i) control and cessation of panic attacks, (ii) control and cessation of fear-driven avoidance and (iii) reduction in vulnerability to relapse. Both psychological and pharmacological treatments can achieve the first two goals but there is no evidence that drugs are able to reduce vulnerability. Cognitive behavioural therapy can help the person develop the skills to deal with panic attacks and reduce the probability of relapse.
Post-traumatic stress disorder (PTSD)		
Classified as an anxiety disorder, occurring as a delayed psychological response (i.e. after 4 weeks) after an individual has been exposed to an extreme traumatic stressor involving actual or threatened death or serious injury, or a threat to the physical integrity of self or others. The individual will have experienced intense fear, helplessness or horror. Most people exposed to a traumatic event will adapt over time. For the 5 per cent of people who develop PTSD after experiencing a traumatic event, psychosocial functioning can be seriously impaired.	Main signs and symptoms are evident for more than a month after the event and include (i) reliving the trauma — such as through nightmares and intrusive memories, with associated physical reactions as for anxiety and panic; (ii) hypervigilance including trouble sleeping, irritability, difficulty concentrating, hyperarousal; and (iii) avoidance of reminders of the trauma including people, places and activities, and also feelings of unreality or emotional numbness (up to and including dissociation).	Preferred interventions are (i) psychological intervention, including trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprocessing with supervised, 'real life' exposure. Pharmacological interventions not generally regarded as a first-line intervention although anti-depressants can usefully support psychotherapy. Immediately post-trauma, psychological first aid should comprise mental health assessment and monitoring, and the provision of information and emotional support to those seeking help.

(continued)

TABLE 1.2 *(continued)*

Mental health issue	Typical presentation	Recommended intervention
Psychosis		
The causes of psychosis are not completely understood. About three in every hundred people will experience a psychotic episode at some point in their lives. Psychosis is generally understood to be the result of organic brain dysfunction. A person experiencing psychosis has a reduced ability to distinguish what is real. Psychosis is also associated with a number of organic conditions including delirium, dementia and the use of alcohol or other drugs. Diagnoses may include schizophrenia, schizoaffective disorder, bipolar affective disorder, depression and neurological syndromes.	The most common symptoms are (i) confused thinking — where thoughts are disorganised or nonsensical; (ii) delusions — false beliefs not shared with others of the same cultural background; (iii) hallucinations — visual, auditory (the most common), olfactory, tactile or taste sensations or representations that are not objectively real.	Interventions are pharmacological and psychosocial: (i) antipsychotic medication; (ii) stress reduction, including a reduced-stimulus environment; (iii) support and reassurance; and (iv) lifestyle management.
Somatisation		
The development of physical symptoms in response to psychosocial distress. There are three aspects: (i) physical symptoms with no pathophysiological cause; (ii) the person believes they are physically ill; and (iii) they seek the help of health professionals (usually GPs). In Western societies, somatisation is more common than depression and anxiety in general medical practice. It is found in around 20 per cent of people who seek the help of a GP — and often people discovered to be depressed or anxious will present first with somatic symptoms. Women are twice as likely to present with somatic complaints than men.	It is important to note that people who somatise are not feigning symptoms. The most common somatic complaints are (i) throat problems, (ii) pregnancy, (iii) chest pain and (iv) anxiety. Other common somatic problems are (v) hypertension, (vi) depression and (vii) oesophageal problems.	As for anyone in distress, supportive reassurance is helpful. Long-term interventions are psychological, including cognitive behavioural therapies, interpersonal psychotherapies and the technique of reattribution, where people are encouraged to move away from somatic concerns to consider their emotional issues.

Sources: Adapted from Abramowitz, Olatunji & Deacon (2007), Australia & New Zealand Academy for Eating Disorders (2009), Bisson & Sakhuja (2006), Boyce, Carter, Penrose-Wall, Wilhelm & Goldney (2003), Charles, Fahridin, & Britt (2008), Clarke, Piterman, Byrne & Austin (2008), DBMAS-RADAR (2009), Elder, Evans, & Nizette, (2013). Harris, Nagy, & Vardaxis (2006), Hay, Bacaltchuk, Stefano & Kashyap (2009), Kaplan & Sadock (2009), Klump, Bulik, Kaye, Treasure & Tyson (2009), Marshall & Tibbs (2006), Mayou, Gill, Thompson, Hicks, Volmink, & Neil (2000), Royal Australian College of General Practitioners (2013), Royal Australian and New Zealand College of Psychiatrists (2013), Starcevic (2006)

While the list of common mental health issues in table 1.2 provides health professionals with a convenient means of categorising the experiences of a person, it is important to reiterate that knowledge about a diagnosis, signs and symptoms and treatments does not of itself lead to better outcomes for the person. As noted in previous sections of this chapter, what is most important is the quality of the care and caring the person receives. High quality care and caring is only ever achieved through high quality relationships between the person affected by mental health problems and the health professionals. Indeed, the therapeutic relationship has been identified as the most effective means of bringing about positive change in the health outcomes of people with a mental illness (Barker, 2009; Browne, Cashin, & Graham, 2012; Royal Australian and New Zealand College of Psychiatrists, 2013; Theodoridou, Schlatter, Ajdacic, Rössler, & Jäger, 2012). Quality therapeutic relationships assist with problem solving, medication compliance and improving quality of life (Dziopa & Ahern, 2009a, 2009b). They also promote positive personal growth and development, and increased levels of personal functioning and coping. The therapeutic relationship is explored at length in chapter 2 of this text.

SUMMARY

This chapter provided an overview of the provision of mental health services in Australia. It defined key terms, such as 'mental health' and 'mental illness', and explained the need for health professionals to be careful about the way they use language in the mental health context. This explanation led to a discussion about the effects of stigma upon people with mental health issues. There was a particular focus on care and caring in the chapter, including ways and means health professionals can foster a caring approach to helping people. Current policy directions and services frameworks and approaches — including a discussion of the place of mental health Recovery — were also examined. This was followed by an explanation of the prevalence of mental illness in Australia, with a focus on suicide and mental health issues for young people. Finally, the chapter outlined the most common mental health issues that health professionals who work across a range of health settings will encounter.

Review questions

1 Define 'mental health and 'mental illness'.
2 What is stigma?
3 What role does the media play in perpetuating stigma?
4 What does it mean to 'discriminate'?
5 Define 'care' as both a noun and a verb.
6 Name the four guiding principles recommended by the World Health Organization (WHO) for all mental health policies.
7 What are the differences between primary health care and primary care?
8 What are the differences between person-centred and consumer-centred approaches?

9 Identify the main principles of Recovery approaches to mental health service provision.

10 What is the prevalence of mental illness in Australia?

11 Identify and describe four mental health problems a health professionally will commonly encounter, regardless of setting.

Discussion and debate

1 Consider the following scenario.

Li Wei is studying nursing at university. He is excited and also very proud that he will be graduating at the end of the year. He has a keen interest in working in the mental health field and tells his friend Carol that he is applying to do his graduate year in that field. But Carol is very concerned about this decision. She tells Li Wei that he would be far more sensible to do his graduate year in a mainstream health context and consolidate his clinical skills before making his decision. Carol has heard that nurses who work in mental health are not 'real' nurses and does not want to see Li Wei making a decision that could place his whole new career in jeopardy.

(a) In what way does Carol's advice reflect attitudes that stigmatise the field of mental health?

(b) How are the skills used by health professionals who work in the field of mental health different to those used by health professionals in other contexts?

2 'I am not a trained mental health specialist, so I should not have to deal with people with a mental illness.'

This attitude is evident in many health professionals. Discuss the statement, in light of the prevalence rates of mental illness in Australia. Ensure you consider the notion of comorbidity in your discussion.

3 Why is it important for health professionals to understand current policy directions and service frameworks?

4 Discuss the policy-practice and research-practice divide in the health context, with a particular focus on Recovery. How can health professionals help to bridge the divide between research, policy and practice?

5 How does knowing the most common mental health problems, the signs and symptoms of these problems, and the main interventions, help health professionals in their caring role?

Project activity

The Australian government has directed publicly-funded health services in all states and territories to implement Recovery-oriented services. Little information, however, has been provided on how health professionals are to operationalise Recovery at the clinical front-line.

Research the mental health policies in the state or territory in which you live. Use the keywords 'Recovery' and 'mental health service' and the relevant state/territory in your online searches.

1. What information has been made available for health professionals about Recovery-oriented services and how they work?
2. What information has been made available for consumers and carers about Recovery-oriented services and how they work?
3. Based on the available online information, describe your role as a health professional working within a Recovery framework. What would be the benefits of this role, for health professionals, consumers and carers? What would be the challenges of this role, for health professionals, consumers and carers?

Websites

'Actively promoting the mental health and well-being of infants, children, adolescents and their families/carers', AICAFMHA aims to represent all professions working with infants, children and adolescents and their families in the area of mental health, as well as consumers and carers, and to formulate principles of best practice, promote research, gather data, disseminate information to agencies and professionals, and advise government and non-government bodies: www.aicafmha.net.au

The Australian Government Department of Health oversees the provision of mental health care across Australia. It provides information about the National Mental Health Strategy, National Mental Health Plans, and primary health care in Australia: www.health.gov.au

The Australian government's *Mindframe* National Media Initiative in Australia has a companion website. The sections of this website have been created to provide access to accurate information about suicide and mental illness and the portrayal of these issues in the news media and on stage and screen in Australia: www.mindframe-media.info

The Australian Institute of Health and Welfare provides information about mental health and a range of services offered. This includes the site, 'Mental health services in Australia', which provides a picture of the national response of the health and welfare service system to the mental health care needs of Australians: http://mhsa.aihw.gov.au/home/

Centre for Primary Health Care and Equity (CPHCE) is part of the Faculty of Medicine and is associated with the School of Public Health and Community Medicine at the University of New South Wales. CPHCE is committed to intervention research that impacts on policy and practice. The long-term vision of the centre is to improve the community's health and wellbeing through a focus on improved primary health care services and development of policies and strategies that address health inequalities: www.cphce.unsw.edu.au

Community Mental Health Australia (CMHA) is a coalition of the eight state and territory peak community mental health organisations, established to provide leadership and direction promoting the benefits of community mental health and recovery services across Australia: www.cmha.org.au

The United Nations is an international organisation that works to develop friendly relations among nations and promote social progress and human rights. It provides guidance on how people with mental illness can expect to be treated in the health care system through its Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care: www.un.org

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2

Assessment in the mental health context

LEARNING OBJECTIVES

This chapter will:

- explore the essential components of a comprehensive mental health assessment
- describe the importance of reflection, relationship, recording and reporting when conducting a mental health assessment
- explain the major mental health assessment tools, including the mental state examination (MSE), the clinical risk assessment and the suicide risk assessment
- outline the place of diagnostic manuals such as the ICD-10 and DSM-5 in the specialty field of mental health
- clarify the risk and protective factors for young people developing mental health problems
- highlight the importance of age-appropriate communication when assessing a young person with mental health issues.

Introduction

The focus of this chapter is the comprehensive mental health assessment of adults and young people. The chapter commences by introducing a framework to guide the comprehensive mental health assessment: Reflection, Relationship, Recording, Reporting. This includes a discussion of the reasons why health professionals must reflect on their personal values and professional practice before conducting an assessment. An explanation is also provided of the importance of establishing and developing a therapeutic relationship with the person who is affected by mental illness. Following this, consideration is given to the ways in which effective documentation and follow-up by health professionals can enable people with mental health problems to achieve better health outcomes.

The comprehensive mental health assessment is then described at length, including the main assessment tools utilised by mental health professionals: the mental state examination, the clinical risk assessment, and the suicide risk assessment. Consideration is then given to the place of diagnostic frameworks such as the ICD-10 and DSM-5.

The final section provides clarity with regard to the different approaches that can be taken when assessing young people with mental health issues. It provides an explanation of variations in the way a young person may present to a health professional, and the need to obtain collaborative information from the young person's parents, other family members, teachers and friends.

Mental health assessment of adults

Health professionals spend much of their time assessing people. Traditionally, formal **assessment** has allowed the health professional to identify or diagnose a person's problem or condition, gauge the extent to which the person is affected, and determine the best course of action. In recent times, however, the process of assessment has become more collaborative. Health professionals now use assessment as an important means of connecting and communicating with the person who is seeking help; and working together with this person to select the best available options to address the problems identified (Stein-Parbury, 2009; Wright, Sparks & O'Hair, 2013).

assessment a comprehensive evaluation of the health needs and preferences of a person

This process is no different in the field of mental health. Certainly, the **mental health assessment** provides a means by which the health professional can gauge the mental health of a person. This includes determining what it is that the person is experiencing and how these experiences are affecting them. At the same time, conducting a comprehensive mental health assessment also provides health professionals with an opportunity to engage with the person who has come to them for help, and commence the process of building a therapeutic relationship.

mental health assessment a comprehensive assessment of a person's social, emotional, relational, behavioural, cognitive and functional wellbeing

There are many reasons why all health professionals need to be familiar with the process of undertaking a comprehensive mental health assessment. First, such familiarity enhances communication between health professionals — for example, health professionals may at times be required to interpret the clinical records written by a mental health specialist. Second, knowledge of the 'hows' and 'whats' of the mental health assessment will support health professionals to describe the process to consumers and help allay their fears, concerns or anxieties. Third, there may be times when there are no mental health specialists available to conduct the mental health assessment. Consequently, it will be the responsibility of the non-specialist health professional to work with the person who presents with mental health problems and determine the most appropriate way forward.

Approaches to assessment

There is no 'one-size-fits-all' approach for health professionals to conduct health assessments. This is because each context and person is different. In addition, although a comprehensive mental health assessment has a particular focus — that is, to gauge the level of a person's mental health — it is nevertheless important to consider all aspects of a person's being. These aspects will include the person's behavioural, biological, cultural, educational, emotional, environmental, financial, functional, mental, occupational, physical, recreational, sexual, spiritual and social needs and preferences, as described in chapter 1. One way in which the many different aspects of a person's being can be incorporated into an assessment is by health professionals taking a biopsychosocial approach.

The term 'biopsychosocial' is generally credited to the work of the American psychiatrist George Engel (1977), who developed the biopsychosocial model as an alternative to the biomedical approach. As noted in chapter 1, while the biomedical model dominates the provision of health services in contemporary Australia, its focus is limited to the biological aspects of illness and disease (Calwell, Sclafani, Swarbrick, & Piren, 2010). In contrast, the **biopsychosocial approach** considers the *bio*logical, *psycho*logical and *social* dimensions of a person's experience, and use of this term provides a shorthand means of encapsulating the many different aspects of **personhood** (Sadigh, 2013; Smith, Fortin, Dwamena & Frankel, 2013).

biopsychosocial approach an approach to health care provision that addresses the full range of a person's health needs and preferences

personhood the state or condition of being a person; defined by one's individuality and aspects such as family background, culture, ethnicity, systems of beliefs, occupational and recreational activities, and sexuality

UPON REFLECTION

Health assessment types

Health professionals undertake many different types of health assessments. These include falls assessments, functional assessments, health impact assessments, online health assessments, preventive health assessments, medical assessments, mental health assessments, nursing assessments, nutrition assessments, physical health assessments, risk assessments and wellness screenings — to name just a few. For this reason, it is important that health professionals understand why it is necessary to take a systemic or structural approach to identifying the issues or experiences, signs or symptoms of the person.

Questions

1. What do these diverse health assessments have in common?
2. What differentiates these health assessments?
3. How would you define the term 'assessment'?

IN PRACTICE

A biopsychosocial tool

A useful way to conduct a biopsychosocial assessment is to obtain information from the person about their past and present, and then look to the future and what the person would like to achieve (Barker, 2009; Buckner, Heimberg, Ecker, & Vinci, 2013; McKay, McDonald, Lie, & McGowan, 2013; Ross, 2000; Sadigh, 2013). The information collected can be organised with and by the consumer using the following table.

For example, Graham is a 55-year-old male who was recently diagnosed with depression and commenced on antidepressant medication. To support Graham's Recovery journey, the health professional sat down with Graham to discuss his past, present and future needs and goals from the physical or biological, mental health or psychological, and social or cultural points of view.

During the conversation, the health professional discovers that Graham has had an ongoing history of a 'bad back'. Graham did not report this to the general practitioner (GP) who diagnosed his depression, since Graham didn't see it as important but rather 'just a part of getting old'. Graham also told the health professional that he had no previous history of mental illness and wasn't sure what had triggered his depression — however, he went on to say, he was recently retrenched from his job as a horticulturalist. This had occurred soon after Graham's boss told him that the business had slowed down. But Graham wondered if it was really the result of his bad back, which had been troubling him more and more with each passing year.

The health professional encouraged Graham to write down these details, under the headings 'biological/physical', 'mental health' and 'social needs and goals'.

With this history in mind, the health professional then explored Graham's current situation and found that the back pain that Graham experienced often kept him awake at night. Graham also reports that the antidepressant medication 'was doing nothing', so Graham thought it might be better if he just stopped taking it. However, his wife and adult children, who are very supportive, have told him not to — and this is the only reason he continues to take it.

The health professional reminded Graham that it was also important that he recognise his strengths, including a supportive family, as this would help him on his Recovery journey on into the future.

The health professional then asked Graham to think about his future. At first, Graham was unable to see any hope for re-employment because working outdoors is his only skill. However, he said he was keen to feel 'normal' again, get off his medication, and find more employment. He also agreed that he was interested in finding out if there was anything that could be done for his bad back.

The health professional asked Graham to list these goals under the same three headings. Writing down these goals will help Graham to see that there is hope for the future — and give him something to work towards.

		Needs and goals		
		Biological/ Physical	Psychological/ Mental health related	Social/Family/ Cultural
Timeframe	Past			
	Present			
	Future			

Sources: Barkley, (2009); Buckner, Heimberg, Ecker, & Vinci, (2013); McKay et al., (2012); Ross, (2000); Sadigh, (2013)

Questions

1 Complete this table using your own experiences of health. How useful was this exercise? Why?
2 How do you think looking at the past and present, across the three different domains, could help the person you are assessing?
3 How do you think looking to the future, across the three different domains, could help the person you are assessing?

Proponents of the biopsychosocial approach to delivering health care also promote the idea that the many different aspects of a person are linked (Buckner, et al., 2013; Mammen & Faulkner, 2013; McKay et al., 2013). For example, a physical illness that has no obvious or overt mental health component will nevertheless affect the person's levels of psychological stress (Williams & Manias, 2013). Similarly, there is a strong link between depression and a variety of physical illnesses including stroke, coronary heart disease, diabetes, cancer, chronic pain, dementia, Parkinson's disease and hypertension (Happell, Platania-Phung & Scott, 2013; Matheson, Smith, Moineddin, Dunn, & Glazier, 2013). It is unwise, then, to assess a single aspect of personhood in isolation from the other aspects of being. Instead, utilising biopsychosocial approaches when conducting an assessment, to incorporate all aspects of the person, will produce the best possible health outcomes for people who experience symptoms of mental illness (Buckner et al., 2013; McKay et al., 2013).

The next section describes four steps to enabling health professionals to undertake a biopsychosocial assessment:

1 **R**eflection
2 **R**elationship
3 **R**ecording
4 **R**eporting.

These 'four Rs' of assessment provide a useful structure or guide for health professionals in the assessment of people with mental health problems; and enable the best possible outcomes for these people.

Reflection

The first step in undertaking an assessment is reflection. There is a need for all health professionals to be self-aware; and to realistically assess or evaluate their performance as practitioners, including their skills in assessment (Van Sant & Patterson, 2013). Self-awareness and ongoing reflective practice enables health professionals to consider how they communicate as well as the different ways that they can develop their practice (Cleary, Horsfall, & Hunt, 2013; Nairn, Chambers, Thompson, McGarry, & Chambers, 2012).

Self-reflection

As Socrates once suggested, self-examination and self-knowledge are the beginning of knowledge and wisdom. More recently, Roeser and Peck (2009) suggest that self-knowledge involves the conscious cultivation of personal growth, learning, ethical development and caring for others. Van Sant & Patterson (2013) support this view, arguing that a crucial aspect of achieving professional and personal growth is self-reflection. Such self-reflection must include consideration of personal values (Byrne, Happell, Welch, & Moxham, 2013). For example, health professionals may be called on to assess a person with a forensic history, a perpetrator of child sexual abuse, an alleged terrorist, someone who is homeless, or a person who belongs to a religious minority that is viewed suspiciously by mainstream Australian society. The personal values of the health professional will inevitably influence their reactions to people who have values that are different to their own.

Questions health professionals may ask themselves in this process of self-reflection could include the following.

- What are my own beliefs and values about mental illness?
- What are my feelings about people with a mental illness?
- What assumptions or preconceptions do I bring to my encounters with the person who is affected by symptoms of mental illness?

Questions health professionals may ask themselves about the individuals they are helping could include the following.

- Does the individual irritate, offend, confront, intimidate or frighten me? If so, why?
- Is the individual's way of life outside of my experience? If so, how does this affect me?
- How have I tried to understand how or why this person is different?

Answers to such questions will help health professionals to understand their own beliefs and values, as well as the ways in which these beliefs and values may affect their attitudes and behaviours towards different individuals.

Indeed, until health professionals critically examine and reflect on their own values and attitudes, effective engagement with others will be difficult (O'Reilly, Bell, & Chen, 2012). This is because each health professional's personal reactions to others will act as a barrier to meaningful interaction. It is only when health professionals are aware of what is behind or driving their reactions to people or events, that they will be able to manage those reactions. Chapter 5 contains more detailed information about the importance of self-awareness for health professionals.

Practice reflection

Many health professionals find that reflecting on their practice can be difficult. For example, some health professionals may be perfectionists and consequently judge themselves quite severely (Christman, 2012). They may feel as though they can never be good enough, they can never get it right, and they still have much more to learn. Other health professionals may have an inflated view of their work, perceive that their practice is of a very high standard, and be satisfied that there is nothing they can do to improve when, in reality, their work is quite limited in scope. Both points of view lack insight.

One way in which health professionals can support themselves to reflect realistically on their practice is to find a mentor — that is, a senior colleague who they respect and trust; and who has the knowledge, skills and abilities to support the process of reflection through constructive questioning (Murdoch-Eaton & Sandars, 2013; Tremblay, Richard, Brousselle, & Beaudet, 2013). Health professionals will find professional relationships of this nature to be of immense value as they progress through their careers (Karpa & Chernomas, 2013; Ward, 2011).

An important aspect of practice reflection involves the health professional considering the extent of their knowledge of the assessment process. For example, many health professionals assume that assessment is a linear process with a beginning, middle and end. In contrast, it may take some time to complete a comprehensive mental health assessment, and require several meetings wherein the consumer will talk about their feelings and experiences, at their own pace and in their own way. However, when the process of assessment falls outside of the regulated routines of the health system or the kind of service ordinarily delivered, the consumer may be viewed by some health professionals as 'a problem' (Dobransky, 2009).

This kind of situation can also be defined in terms of compliance and the consumer's apparent willingness to take the advice or direction of the health professional (Koekkoek et al., 2010). For example, if the consumer is not able or ready to answer the questions asked by the health professional, they risk being labelled 'difficult' or 'challenging'. In contrast, health professionals who have critically examined their own values, attitudes and ways of being and doing — within the context of their personal lives as well as the health system — will be more able to adapt and respond to the individual needs and preferences of the consumer.

As part of reflecting on their practice, health professionals are also encouraged to consider the way they approach their day-to-day work (Taylor, 2013). For example, many health professionals are task-oriented and quite enjoy filling their day with a range of activities to keep them busy. They find it difficult to spend long periods of time sitting with a person and asking them a range of questions that require detailed answers. Health professionals who are task-oriented should contemplate how they can overcome their own personal preferences to meet the needs of the consumer.

Some health professionals may also find it difficult to sit with people who are experiencing psychological or inner distress (Geldard & Geldard, 2012). In response to their own feelings of discomfort, or their own need to provide solutions, these health professionals may find themselves resorting to the widely used but ill-informed practice of giving empty assurances, such as 'don't worry, everything is going to be just fine'. Generally, such assurances are unhelpful. First, they can sound insincere. Second, they are often unfounded — there are rarely 'quick fixes' for any health condition. Instead, health professionals are advised not to make promises or assurances about things over which they have no real control. Finally, it is important that health professionals recognise that they will always bring with them to the workplace the many concerns and frustrations of living commonly experienced by all people (Howatson-Jones, 2011). To presume that the personal life of a health professional will not influence the way in which they practise, would be to deny that health professional's personhood. For example, all health professionals maintain personal relationships with spouses or partners, children or parents, friends or family; pay bills; deal with health issues, and so on. There is an expectation that health professionals will manage their personal stresses when they are at work and provide effective, appropriate and competent care regardless of their personal circumstances (Wald & Reis, 2010). However, this is an unrealistic expectation — there will be times when individual health professionals are overwhelmed by the challenges involved in providing health care to others.

IN PRACTICE

The context of an assessment

It is important that health professionals reflect on the context in which an assessment takes place. This context may be a setting or location, such as a hospital, a person's home or the community. The context of an assessment could also be an emergency situation.

Other contextual factors that will influence the way a mental health assessment is conducted include the person's family background, culture, age, gender, education level, context, past experiences with health services, day-to-day life and here-and-now experiences.

Questions the health professional may reflect on, prior to or during the conduct of an assessment, may include the following.

- Where is the consumer right now?
- What is happening for the consumer right now?
- What additional stressors does the consumer have in their life beside the current illness?
- Is the person feeling tired, in pain, nauseous, distracted or worried?

The context of an assessment will always influence the process of assessment — including the way in which the health professional and person engages, communicates and relates. It is recommended that health professionals consider how the context of the consumer will influence an assessment, and adapt their approach accordingly.

Questions

1 In what ways could an emergency situation or busy emergency department in a hospital affect the way in which a mental health assessment is undertaken?
2 What steps could you take, as a health professional, to help engage with or support the person with mental health needs in an emergency context?

Context

As well as reflecting on their professional practice, health professionals must also take time to consider the context of the assessments they conduct. Such contexts are many and varied, and will inevitably influence the way in which an assessment is conducted (Davison, Hauck, Martyr, & Rock, 2013). For example, some assessments will be conducted in the comfort of a health professional's room or office, where privacy is not an issue; other assessments will be undertaken in a hospital ward, an emergency setting, or the person's own home where there are many distractions. Health professionals must consider how they can help the person to feel more comfortable in the location in which they are situated. For example, there may be a need to relocate the person to a place that is quiet or has more privacy. Contexts also involve people — and people are complex beings. Each individual will have their own particular reactions or responses — physical and emotional — to an event or experience of illness (Sykes & Javidnia, 2013). In addition, while some people will feel quite comfortable answering a health professional's questions, others will not. For example, the person may be distressed, in pain, frightened, upset, angry, intimidated, intoxicated with drugs or alcohol, or even feeling culturally offended by the questions being asked. Health professionals are advised to consider how such factors may affect the person they are assessing, including the information the person may or may not be willing to share, and determine how they can support the person through the process.

Relationship

The process of assessment involves at least two people: the person who is being assessed and the person undertaking the assessment. There will be times when more than two people are involved — for example, spouses or partners, families, friends, and other health professionals. Ultimately, however, one health professional will take carriage of the assessment process; and this health professional will work together with the person who is seeking help towards a common goal (Geldard & Geldard, 2012).

There are many different ways in which a health professional and consumer can relate. Sometimes, particularly in emergency situations, the interactions that occur will be brief and involve the health professional asking simple questions that require 'yes' or 'no' answers. At other times, health professionals will ask questions that are quite personal and require detailed answers. Whatever the situation, the quality of the answers received from a person will depend upon the strength of the engagement between the person and the health professional (Cahill, Paley, & Hardy, 2013). In turn, the strength of this engagement will depend upon the way in which the health professional relates to the person.

Person-centred care

Person-centred care is an approach to delivering health care that involves health professionals focusing, first and foremost, on the person they are helping (Clissett, Porock, Harwood, & Gladman, 2013; Kitwood, 1997; Marshall & Tibbs, 2006; Olsson, Jakobsson, Ung, Swedberg, & Ekman, 2013; Rogers, 1951, 1961, 1980). This focus will include taking into account the person's quite unique experiences or stories, aspirations and goals, alongside their physical and mental health needs and preferences. Health professionals who provide person-centred care will be committed to supporting

person-centred care an approach to health care that involves the health professionals being responsive to the individual differences, needs and preferences of the person who is receiving the care the person to achieve their full potential — behavioural, biological, cultural, educational, emotional, environmental, financial, functional, mental, occupational, physical, recreational, sexual, spiritual and social — across the span of their lifetime (Steenbergen, van der Steen, Smith, Bright, & Kaaijk, 2013).

When taking a person-centred approach, the health professional will work to empower consumers to make their own decisions about the health care they receive (Campbell & Burgess, 2012; Simmons & Lehmann, 2013). This means the consumer will be an active participant in the assessment process. Too often, health professionals do not stop to listen to what the person is actually saying; instead, they jump in with a range of presumptions, identify the problems based on these presumptions, and set about to fix the problems accordingly. This can leave the person who is seeking help out of the equation altogether!

Approaches that centre on the health professional as the expert who holds all the answers can be useful in some circumstances — for example, emergency situations. However, such professional centred approaches are by no means effective in the long term. This is because people are complex beings who have many different and interconnected needs (Wright, & Hacking, 2013).

The person-centred approach helps to address these many different needs by:

1. valuing the individual for their intrinsic worth and promoting their rights and wellbeing
2. treating each person as a unique individual who has their own particular life experiences, history, culture and background
3. engaging the individual according to their needs, preferences and abilities
4. understanding the social nature of what it means to be human and providing for this as a means of promoting health and wellbeing (Brooker, 2004; Campbell & Burgess, 2012; Steenbergen, et al, 2013; Simmons & Lehmann, 2013).

At the heart of person-centred care is the person, their relationships and communities. For this reason, person-centred care also involves the consumer's spouse or partner, family, friends, and the place in which they live. The best possible outcomes will be achieved for the person when they are supported not only by health professionals, but also by their families and social networks (Browne, Cashin, & Graham, 2012).

IN PRACTICE

The positive effects of social inclusion

Many people have good support systems around them and feel socially included — however, many others do not (Doyle, 2012). Supportive communities have a huge impact on people's daily lives and influence their safety and wellbeing. Being included in a community is fundamental to good health and building a better life.

Social exclusion is a process that deprives individuals, families, groups and communities of the resources they require to participate as equals in a society. Social exclusion is often the result of poverty and low income, with factors such as discrimination, low educational attainment and race also contributing (Pierson, 2010).

The Clubhouse Model of Psychosocial Rehabilitation provides a means by which people with chronic and severe mental illness can become a part of a supportive community. Clubhouses provide members with opportunities to build long-term relationships and support them to obtain employment, education and housing. There are a number of Clubhouses across Australia, with these models of health-care providing an important means of assisting members on the Recovery journey (Raeburn, Halcomb, Walter, & Cleary, 2013).

Questions

1 Identify how being included in a community leads to good health and a better life.

2 How can health professionals support the person who is experiencing symptoms of mental illness to stay connected with their families, significant others or communities? Similarly, how can health professionals work with families, significant others or communities to stay connected with the person who is experiencing symptoms of mental illness?

Unconditional positive regard

Particularly important to the therapeutic relationship is the notion of **unconditional positive regard** or acceptance (Morrison & Bennett, 2009; Gelderd & Geldard, 2012). This term was originally coined by Carl Rogers (1951, 1961, 1980), who is regarded as the father of the person-centred approach. Unconditional positive regard is an attitude that health professionals must demonstrate in the course of their work. This is particularly important when helping the person with a mental illness, who will most likely have experienced discriminatory or stigmatising attitudes in the past. People who are shown unconditional positive regard are more likely to feel accepted and, in turn, feel more able to accept themselves (Falb & Pargament, 2012). This leads to personal growth and, by association, better health outcomes. By showing unconditional positive regard, the health professional enables the person to accept themselves; and fosters a trusting relationship between the person and the health professional.

unconditional positive regard the positive and accepting attitude that is demonstrated by the health professional towards the person they are helping, regardless of who that person is or what they say or do

Of course, there will be times when a health professional feels distressed by the behaviour or attitudes of others. As already noted, health professionals are people too, and will feel stressed or distressed on occasion. This is why it is important that health professionals develop the skills and also resilience to manage other people's stress reactions (Geldard & Geldard, 2012). More information about how to manage difficult behaviours and challenging situations is provided in chapters 5 and 6.

Therapeutic relationships

Not all relationships are therapeutic. The **therapeutic relationship** is distinct from other relationships in that it enables change through therapeutic interactions. The process of

therapeutic relationship the relationship between the health professional and person that enables change in or for the person undertaking an assessment provides the opportunity for health professionals to lay the foundations for establishing a therapeutic relationship with the consumer. This is important because the therapeutic relationship has been identified as *the* most powerful tool or intervention to bring about positive change in the mental health outcomes of people (Barker, 2009; Geldard & Geldard, 2012; McAndrew, Chambers, Nolan, Thomas & Watts, 2013; Stein-Parbury, 2009).

Such positive change is achieved through personal growth and development, and also increased levels of personal functioning and coping, which can be achieved by those who experience quality therapeutic relationships (Browne, Cashin, Graham, 2012; Norcross, 2011). For example, effective therapeutic relationships support the consumer to adhere to the health interventions they are receiving; to problem-solve more effectively, and also to experience improvements in their quality of life (Dziopa & Ahern, 2009a; McCabe et al., 2012; Sylvia et al., 2013). Indeed, the opportunity and potential for change achieved by the therapeutic relationship is so great that even proponents of the biomedical model promote its centrality in the health context (Bostwick, 2013; Djurkov & Sertsou, 2012; Royal Australian and New Zealand College of Psychiatrists, 2003, 2004a, 2004b, 2004c, 2005).

Some health professionals prefer to use the term **therapeutic alliance** when describing the relationship between a health professional and the person who is seeking assistance (Goldfried, 2013; Sylvia et al., 2013). Notions of the therapeutic alliance were first generated in the psychoanalytic context and connote an active and mutual collaboration between the health professional and consumer as they work together towards a common goal. In many ways, the notion of a therapeutic alliance is more consistent with consumer-centred models of care and person-focused approaches. This is because the therapeutic alliance highlights the concepts of mutuality and collaboration (Bressi Nath, Alexander, & Solomon, 2012; Hasson-Ohayon, Roe, Kravetz, Levy-Frank, & Meir, 2011). In this text, however, the term 'therapeutic relationship' is used in preference to the therapeutic alliance. This is because 'therapeutic relationship' is the term which seems to be most commonly used by all of the disciplines across the contexts of health care.

therapeutic alliance the mutual and active collaboration established between a health professional and consumer to bring about change and healing

A number of different models or frameworks have been developed over the years to assist the health professional to develop effective therapeutic relationships, including:

- modelling and role modelling (Erickson, 2006; Erickson, Tomlin, & Swain, 1983, 2005)
- Newman's theory of health as expanding consciousness (Newman, 1995)
- Orem's self-care agency approach (Orem, 1991)
- Peplau's interpersonal relations theory (Peplau, 1952, 1991)
- Roy's adaptation model (Roy, 2009).

Other approaches include those that highlight the continuity of the relationship and ecological factors that influence the relationship, as well as the functional abilities of the person, human interactions, culture, personally meaningful recovery, social justice, and the person's strengths (e.g. Basavanthappa, 2007; Burge et al., 2011; Cameron & Keenan, 2010; Chouliara, Karatzias, & Gullone, 2013; Finn & Jacobson, 2003; Lum, 2007; Saleebey, 2006). Health professionals are encouraged to extend their reading beyond the scope of this text and explore at least one of these approaches in detail.

For the purposes of this chapter, the nature of the therapeutic relationship is described more simply through the nine constructs posited by Dziopa and Ahern (2009b). These constructs are:

1. understanding and empathy
2. individuality
3. providing support
4. being there/being available
5. demonstrating respect
6. demonstrating clear boundaries
7. demonstrating self-awareness
8. being 'genuine'
9. promoting equality.

Each of these nine facets is multifaceted and interconnected. For example, all therapeutic encounters must begin with the self-awareness of the health professional. This self-awareness fosters the capacity of the health professional to be understanding and **empathic**, characteristics that are essential to establishing rapport with the person (Falb & Paragment, 2012). Moreover, when health professionals make themselves available or follow-up on a person's concerns or questions, the person is more likely to feel supported or validated.

empathy a human quality demonstrated by a person that shows they are able to identify with the thought, feelings or experiences of another person

Other connections are also evident between the nine constructs identified by Dziopa and Ahern (2009b) as necessary for establishing and developing a therapeutic relationship. For example, the first of the nine constructs is understanding, which gives rise to respect. Respect is not an attitude that can be feigned; rather, it requires qualities such as openness, honesty, and being genuine or authentic (Wright & Hacking, 2012). In turn, it is respect, together with clear boundaries, that allows a person to feel safe in a relationship. This gives rise to an equality between the health professional and person as they work together, in an active collaboration, towards a common goal (Danzl, Etter, Andreatta, & Kitzman, 2012). While there may well be an inequality of power and authority in some health contexts, however, it is respect that enables an equality of sameness, as each person in the relationship recognises commonalities or shared experiences in the other.

As with all relationships, the nine constructs that frame the therapeutic relationship do not simply occur spontaneously. Rather, health professionals must work to establish them. This suggestion may leave many health professionals wondering just where to start. The following points provide some practical tips for health professionals on how to work at building and maintaining a therapeutic relationship.

- The process of engaging with a person should commence with an **introduction** from the health professional to the consumer and also to family members or friends who are accompanying them. This introduction should include the health professional's name, the disciplinary area to which they belong (e.g. medicine, nursing, occupational therapy, paramedicine, psychology, social work) and also the type of information they require (Warren, 2013). The health professional should also explain to the consumer and their family members that the information they share will be treated confidentially.
- **Showing kindness** will always hold the health professional in good stead (Castellano, 2012). It can be difficult to be kind in some health contexts, especially for health professionals who are working in highly stressful and very busy environments.

Moreover, some consumers may appear dishevelled, use illicit drugs, and tell stories that seem bizarre or even horrifying. Others may behave in ways that are inappropriate — for example, some consumers may present to an emergency department over and over, make unreasonable demands — and health professionals will feel their patience being stretched to the limit. Showing kindness in such circumstances is not easy, but it will reap benefits for both consumers and health professionals in the long term (Shaltout, Tooze, Rosenberger, & Kemper, 2012).

- **Clarifying expectations** is important in any relationship, including the therapeutic relationship (Gega, Smith, & Reynolds, 2013; Heins, Knoop, & Bleijenberg, 2013; Lambert & Cattani, 2012). Prior to undertaking an assessment, it is important to identify exactly what it is that the consumer is seeking from the health professional or health system. Most people who present to a health professional, or who are taken to a health professional for assessment, are unwell — and many will be hoping for a 'quick fix' solution (Christiaens & Bracke, 2013). There may be cases when such solutions can be provided — for example, if someone is experiencing a panic attack, assistance can be provided in the short term to assist them to overcome the experience (with longer-term therapy used to help manage future panic attacks). However, most mental health problems have complex causes that require help and support over a long period of time. This must be explained to the person.

  Health professionals may have expectations of their own—for example, they may expect that those who present to them for assistance will respect them and cooperate with them. When this doesn't occur, health professionals often feel frustrated. Such feelings can challenge the assessment process; these must be addressed to enable the health professional to effectively meet the needs of the person.
- **Consumer empowerment** can be facilitated through the acknowledgement of the power inequalities that define and constrain health professionals' relationships with the people they are assessing. In particular, people with mental health issues, by the very nature of seeking assistance, are placing themselves in a disempowered position (Tambuyzer & van Audenhove, 2013). For example, many people with mental health problems will feel embarrassed about or shamed by what is happening to them, due to the stigma attached to mental illness. Effective health professionals will be aware of the dynamics involved, and work hard to overcome the barriers or challenges involved (Michaels & Corrigan, 2013).

  Of course, there may be times when it is necessary for health professionals to undertake a very quick assessment and make decisions accordingly — especially in a high acuity or emergency situation. Even so, to ensure the consumer is not completely disempowered, health professionals should provide the consumer with as much choice as possible, according to the circumstances. This could include inviting the person's significant others to attend the interview; asking the person if they would like a drink or something to eat; asking permission to take notes while conducting the assessment; and generally showing courtesy and consideration to the consumer and their partners, families or friends. Another way to empower a consumer during an assessment is to provide the person with information that will help them to make decisions about their health needs (Tambuyzer & van Audenhove, 2013).
- **Involving partners, family members or friends** in the process of assessment requires far more than extending an invitation (van Draanen et al., 2013). For example,

many people don't understand what it means to participate in making health-related decisions (Marland, McNay, Fleming, & McCaig, 2011). Health professionals are responsible for explaining the process to all involved and actively facilitating their participation (Jones, Corrigan, James, Parker, & Larson, 2013). This will include inviting the person and their significant others to comment or ask questions, or giving them time to think about what is happening to them.

THE BIG PICTURE

The therapeutic relationship 'online'

In our contemporary technological age, the internet is being increasingly utilised to deliver health services, including mental health services. E-therapy involves health professionals providing mental health services via email, video conferencing, virtual reality and chat technologies, or any combination thereof.

The advent of e-therapy, however, has given rise to concerns about whether it is possible to develop an effective therapeutic relationship online. Some people prefer the anonymity that comes with e-therapy — for example, they can share their problems without identifying themselves to the therapist or telling family or friends that they have sought help for a mental health problem. However, other people may find it far more difficult to develop an effective therapeutic relationship when the health professional is not physically present.

In Australia, e-therapy is offered by organisations such the Butterfly Foundation (for eating disorder support), MensLine Australia (for relationship problem support), and Turning Point Drug and Alcohol Centre (for addiction support), as well as a growing number of private providers who deliver personal, relationship and family counselling services. There is also a focus on engaging with young people online, with a number of organisations such as headspace and Kids HelpLine offering a range of services to help and support people with mental health problems through the internet.

In a systematic review of 840 studies related to e-therapy (Sucala, Schnur, Constantino, Miller, Brackman, & Montgomery, 2012), it was found that only 11 of these studies examined the therapeutic relationship. Results of the systematic review did not allow for firm conclusions to be made; however, there is some suggestion that e-therapy is as effective as face-to-face therapy with regard to establishing a therapeutic alliance. Sucala and colleagues concluded, however, that more research is required to examine the role therapeutic relationship in online environments.

Using effective therapeutic communication

The most important factor in establishing, developing and maintaining effective therapeutic relationships is communication (Plawecki & Amrhein, 2010; Robinson, Hills, & Kelly, 2011). This may seem 'obvious' to some people; however, the clear link between poor communication and complaints against health professionals and health services suggests that developing strategies to improve communication is an area of practice that requires ongoing improvement (Birkeland, Christensen, Damsbo, & Kragstrup, 2013; Gilbert, 2012; Truskett, 2012). One way in which effective therapeutic relationships can be developed and maintained is through **therapeutic communication**, which involves using a range of techniques to engage with the person. Some of the benefits of using therapeutic communication effectively are outlined in figure 2.1.

therapeutic communication the communication techniques utilised by a health professional to engage with a person, build and maintain a relationship and enable the person to achieve personal change

Therapeutic communication
- Effective therapeutic communication enables the health professional to 'connect' with the consumer and recognise what is happening for them at that moment in time.
- Listening to and validating the person's concerns, even when those concerns cannot be immediately resolved, leads to significant reductions in anxiety and decreases in the person's feelings of helplessness.
- Effective therapeutic communication encourages consumers to share essential information. This can help the health professional to identify risks for the consumer and take steps to reduce those risks.
- Effective therapeutic communication can bring about better health outcomes for consumers and carer.
- Effective therapeutic communication can increase the quality of a health professionals' working life.

FIGURE 2.1 Benefits of using effective therapeutic communication

Sources: Barker (2009); Geldard & Geldard (2012); Green (2010)

Table 2.1 outlines a range of techniques that can be used to support health professionals to develop effective skills in therapeutic communication. These techniques can be used when undertaking a mental health assessment; and would also be useful for other one-to-one interactions with the person — for example, when providing physical care. At the same time, it is important to note that the use of particular techniques does not automatically guarantee engagement, a relationship or even therapeutic change. There are many factors involved in human relationships. For this reason, the strategies outlined in table 2.1 are only a guide for health professionals who seek to refine their practice.

TABLE 2.1 Therapeutic communication

Intervention by the health professional	Rationale and/or strategy
Preparation	
Arranges a quiet, private environment wherever possible	Promotes confidentiality and minimises interruptions Turns off mobile phone
Seeks agreement from all involved in relation to the agenda, whether formal or informal	Keeps the communication focused
Informs the person how long the health professional has available for the interview	Paces the interaction according to the time available Guards against the consumer commencing a discussion about very distressing issues just as the time is about to run out

Intervention by the health professional	Rationale and/or strategy
Non-verbal	
Actively listens	In addition to the verbal active listening skills required, this involves nodding and leaning forward towards the person Avoids crossing arms or legs, keeps a relaxed, open posture to convey interest Makes eye contact, as appropriate
Looks for non-verbal cues	Observes and reads the body language (including facial expressions) of other person Identifies incongruencies between what the person is saying verbally and what their body language is saying — for example, the person says everything is 'fine' but their body language suggests they are depressed
Uses or tolerates short silences	Enables those at the meeting to reflect on what has been said and what it means
Maintains appropriate body language and posture	Ensures physical congruence with what is said — for example, if a person verbally expressed great distress, lean towards them to express empathy
Empathises with or recognises what the other person is feeling	Validates the other person's position Uses minimal responses, reflects content and feeling, expresses empathy Responds in a way that indicates an understanding of the person's emotions and perspectives, whether stated or not
Demonstrates a genuine attitude	Demonstrates congruence to the situation — for example, responds with empathy if the person is sharing information that is distressing Does not keep checking mobile phone or watch or clock Is not defensive, but is accepting of other people's points of view
Verbal	
Actively listens	Verbally summarises the context of the person's story, including key words Verbally acknowledges and affirms the feelings the person is expressing Frequently checks with the person that they understand what the person is saying
Uses simple language with as little jargon as possible	Regularly checks with the person that they understand what the health professional is asking
Uses open questions to encourage elaboration Allows the person to direct the interaction	Uses questions such as 'What do you think is happening?' or 'How do you feel about what is happening?'
Clarifies information that is unclear	Uses sentences such as 'I'm not sure what you mean. Please tell me some more about what is happening to you.'
Re-states, where appropriate	Uses questions such as 'So you're saying that you find that difficult?'

(continued)

TABLE 2.1 *(continued)*

Intervention by the health professional	Rationale and/or strategy
Verbal (continued)	
Engages with the person's agenda, works to align themselves with the person	Finds out what the person wants and why (e.g. the needs and preferences of the person)
Sets clear boundaries	Clarifies with the person what is acceptable behaviour in the given context
Knows how to close down the interview appropriately, especially when feeling out of their depth or unsure how to respond	Uses sentences such as 'I can see this is distressing for you and I think it best that we pause at this time. It's not that I'm ignoring you, but my colleague, who is more experienced in this area, will talk some more with you about it.'
Summarises	Towards the end of the discussion, goes over the key points, and checks whether or not the person needs further information or would like to discuss anything in more detail
Confronts appropriately	Uses statements such as 'I feel uncomfortable when you start shouting at me. Also, it doesn't help me understand how to help you. Please tell me about your most pressing issue.'
Problem solves	Uses statements such as 'I can see this is very distressing for you... but I'm wondering what might help or has helped you in similar situations?'
After the interview or discussion	
Uses diagrams where appropriate	Demonstrates flexibility and willingness to illustrate difficult technical concepts or anatomical information if the person has difficulty understanding
Uses visual aids where appropriate	Demonstrates flexibility and willingness to consider people who prefer diagrams to written information, who are dyslexic or have problems reading, or who are from culturally and linguistically diverse backgrounds
Uses interpreters when required	Understands that it is essential for anyone for whom English is their second language or who has a hearing disability when important communications are planned
Provides other sources of information (e.g. the internet, self-help organisations and leaflets)	Utilises a variety of sources, including a written record of the key points of the discussion or an audio recording. Leaflets from self-help or community organisations can also be made available, as well as website addresses and anything else that may help the person
Documents, in detail, what has been discussed	Understands that these can be used as part of the feedback to the rest of the multidisciplinary team

Sources: Barker (2009); Geldard & Geldard (2012); Green (2010)

Recording

The third step to conducting an assessment involves recording or documenting the information that has been collected (Sands et al., 2013; Tuffaha et al., 2012). This step is important because it provides a structure for the information that has been collected, thereby organising or supporting the way it is communicated to others (Cleary et al., 2012). Prior to commencing the processes of recording or documenting the assessment, health professionals are advised to stop a moment to reconsider the following.

- What was the primary focus of this assessment?
- What information did I collect that may not be relevant to the presenting problem?
- What information will help to improve the health outcomes of the person?
- As I document the findings of the assessment, how can I acknowledge this person as an individual with a history and a social context, who is not reducible to a set of symptoms?

Considering the answers to these questions is especially important when assessing people with mental health issues, who sometimes relate stories that may seem unusual or bizarre to the health professional. Curiosity about the personal lives of others is a very human attribute; however, it is not the role of the health professional to have their curiosity relieved. Rather, the information gathered must have a specific purpose — the person's health and wellness.

Health services across Australia will have different ways of recording clinical information. In general, however, the following is a guide.

- The information must be succinct, legible, and also include the date, time, place and the people who are present at the meeting.
- The information must be factual. It is important that health professionals refrain from writing statements that are judgemental or value-laden when referring to the person's physical appearance, behaviour or lifestyle.
- The health professional must be easy to understand. This means that the health professional should avoid the use of jargon or words that label or stigmatise. In the field of mental health, jargon terms are common, with some health professionals bandying them around with little understanding of what they mean. For example, descriptions such as 'the person is manic and grandiose' are to be avoided. Instead, the health professional needs to describe the behaviour of the person — for example, 'the person is talking very quickly, very loudly, cannot sit still, and is claiming to be the ruler of the world'.

If a health professional goes on to document recommendations based on their assessment, it is vital that these recommendations are first discussed with the consumer (Rainforth & Laurenson, 2013). Ongoing consumer participation in decision making about treatment choices is consistent with Australia's National Mental Health Strategy (see chapter 1). The recommendations made by the health professional must then be specific and clearly documented so that all members of the multidisciplinary team can understand. Such clarity allows for continuity in the way in which health care is provided.

Finally, clear and factual documentation will also allow health professionals to measure the person's progress over time (Bell et al., 2013). Questions that could be answered as part of the ongoing process of documenting the consumer's progress, over time, may include the following.

- Has the person's symptoms changed?
- Is there improvement in how they are feeling?
- Has there been a de-compensation in their mental state?

Without the relevant records, these questions cannot be answered and outcomes cannot be identified.

Reporting

Many health professionals make the mistake of documenting the findings of an assessment and presuming that 'someone will do something' about it — that is, someone *else* will follow up on the required actions. However, unless the health professional reports the findings to colleagues or those responsible for the overall care of the person, almost always no follow up will occur (Manea, Dalla Pozza, Mola, & Facchin, 2011). All health professionals, then, must ensure that they report the findings of an assessment to support the best possible outcomes for consumers.

Another reason why the non-reporting of findings of an assessment is poor clinical practice relates to the frustration it can cause the consumers. For example, when findings are not reported, other health professionals may presume an assessment has not been conducted — and the consumer is subjected to the same questions, all over again. In the field of health, such **duplication** is a common source of complaint to health service managers by consumers and family members alike (Rosenberg & Rosen, 2012; Krilich & Marshall, 2013).

duplication similar or identical health services that are provided to or imposed on people with no added benefit for the consumer and reduced efficiency for the health organisation

The power of an assessment will always be radically reduced if it is not reported in a timely way to relevant health professionals, with suitable actions developed (di Martino et al., 2011). Reporting enables timely decision-making and development of the most appropriate interventions — at the right time, in the right place, by the right people, with the right services delivered at the right level, in a consistent and coordinated way (McGrath, 2009). Indeed, it is only when findings of an assessment are reported and the appropriate action facilitated that the assessment process is complete (Poh, Parasuram, & Kannusamy, 2013). For this reason, each health professional must make it their personal responsibility to report the findings of an assessment, including a comprehensive mental health assessment, to senior colleagues (e.g. a team leader, mental health professional or medical officer).

UPON REFLECTION

The ethics of not reporting

There are many reasons why health professionals don't report important information about a consumer, carer or even their own practice. Some of these reasons include busyness; forgetfulness; laziness; a lack of understanding of the need and necessity to report; the presumption that others will automatically know to read the clinical notes; a fear of repercussion; and a culture of non-reporting. Many health professionals are also unaware of the ethical implications of not reporting.

Questions

1. Consider the ethical guidelines of your profession. Where does reporting — or not reporting — fit within these ethical guidelines?
2. What do you see as the main challenges in relation to the non-reporting of important information in the health context?
3. How can you, as a health professional, encourage others to report findings of an assessment or other important information related to a consumer, carer or professional practice?

Assessment tools

It is important to reiterate that mental health assessments are not conducted in isolation (Coombs, Curtis, & Crookes, 2013). Rather, they are a part of an assessment that considers all aspects of the person. Likewise, mental health assessments do not occur at one particular point in time. Rather, they are an active, collaborative and continuous process, and undertaken on a regular basis with a view to measuring change and progress. Indeed, mental health assessments, like all assessments, should occur each time a health professional has contact with the person.

The tools that are used by health professionals to conduct a mental health assessment are not purely diagnostic, but rather:

- support health professionals to gather information in a systematic and structured way
- facilitate the consistency and objectivity of the assessment — similar processes enable different health professionals to undertake the same assessment on different people at different times
- facilitate decisions about the most appropriate health care options for the individual consumer (Coombs, Curtis, & Crookes, 2011; Rainforth & Laurenson, 2013).

The most common assessment tools or frameworks used in the field of mental health are the mental state examination (MSE), the clinical risk assessment, and the suicide risk assessment.

- The **mental state examination (MSE)** is a core component of the comprehensive mental health assessment of a person. Using observation and information obtained from talking to the person, health professionals employ this tool to help them describe the person's appearance, attitude, behaviour, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgement. The MSE is described in more detail in the section 'Mental state examination' later in this chapter.
- The **clinical risk assessment** is undertaken to gauge the level of clinical risk of a person across a number of different dimensions (Wu, Chang, Hayes, Broadbent, Hotopf, & Stewart, 2012). These dimensions include issues such as suicidality, self-harm, aggression, substance abuse, inappropriate sexual behaviour, adherence to medication, absconding from a health service location, delusions/hallucinations, medical conditions and prohibited items. Clinical risk assessment can also include the risk of falls in older people with mental illness (Langdon, Johnson, Carroll, & Antonio, 2013). Once identified, the overall level of these clinical risks are evaluated; and steps are taken by health professionals to minimise this level of risk (Szmukler & Rose, 2013).

  Sometimes the clinical risk is to the health professional, rather than the person who is being assessed — for example, in situations where the consumer has a high risk of aggression. The clinical risk for health professionals may also lie with external factors — for example, health professionals may visit consumers at homes where there are unknown animals. The clinical risk assessment is described in more detail in chapter 8.
- The **suicide risk assessment** is undertaken to gauge the suicide risk of a person. The dimensions measured are wide, and most often include the mental state of the person, past suicide attempts or suicidal thoughts, levels of impulsiveness, use of substances, age, gender, ethnicity, marital status, medical history, corroborative history, strengths and supports (coping and connectedness) (Homaifar, Bahraini, Silverman, & Brenner, 2012; Simon, 2011). This assessment tool is also described in

mental state examination (MSE) a systematic and structured way of observing and describing a person's current levels of mental health

clinical risk assessment the formal process by which health professionals gauge or estimate risk for a person in relation to factors such as self-harm, self-neglect, violence or aggression, vulnerability, poor adherence to treatment and homelessness

suicide risk assessment the formal process by which a health professional gauges or estimates a person's short-term, medium-term and long-term risk for suicide more detail in chapter 8. At this point, it is important to note that suicide risk assessment, like all risk assessments, gauges risk at a particular moment in time only, and a person's suicide risk may change quite quickly (Woods, 2013).

The tools used to conduct a mental health assessment should not be confused with those used to conduct **psychometric assessment**, which are commonly used by psychologists. Psychometric tests measure a person's cognitive ability or personality and behaviours in a measured and structured way (Squires et al., 2013). These tests are quite specific to the field of psychology and also relatively narrow in their focus. For example, psychometric tests largely fall into two domains in the MSE — behaviour and cognition.

psychometric assessment an assessment that focuses on the educational and psychological measurement of knowledge, abilities, attitudes and personality traits

In some states and territories, health departments provide their own mental health assessments or frameworks. For example, in New South Wales, the Mental Health Outcomes and Assessment Tools (MH-OAT) were implemented well over a decade ago to standardise the way in which mental health assessments and reviews are undertaken and documented across the state; and they support measurement of the effectiveness or outcomes of the health care provided (NSW Health, 2013). All health professionals employed by the public mental health services are trained to use the tools provided and complete the MH-OAT documentation in a consistent manner. MH-OAT includes assessment tools for triage, assessment (including the MSE; substance use; physical examination; family, social and developmental history), review, care planning, discharge planning, and also outcomes measures such as the Health of the Nation Outcomes Scales (HoNOS) and Kessler 10 (K10) (Kightley, Einfeld, & Hancock, 2010).

The comprehensive mental health assessment

When a person first presents with symptoms of mental illness, the health professional may undertake a brief assessment in the first instance, to gauge the most appropriate course of action (Coombs, Crookes, & Curtis, 2013). The focus of the shorter assessment would be to identify:

- the presenting issue or problem (i.e. why they sought help at this time)
- how long the person has been experiencing these symptoms
- how the symptoms are impacting on the person, as reported by the person and observed by family, friends and the health professional
- the urgency of a follow-up by a mental health specialist.

The information generated by this shorter assessment may then be used by health professionals to support referral to specialists, such as the mental health consultation liaison team, mental health nurse, psychologist or psychiatrist (Jelinek, Weiland, Mackinlay, Gerdtz, & Hill, 2013).

In contrast, a comprehensive mental health assessment is much broader in focus and incorporates different aspects of the person and the presenting problem. This is because mental health problems will often have quite complex predisposing factors or causes (Shah, Mizrahi, & McKenzie, 2011). Indeed, the factors or causes contributing to a person developing a mental illness are known to be **multifactorial** — that is, they are dependent on a number of factors.

multifactorial the term used to describe a state that involves, depends or is controlled by a number of elements or factors

Physical assessment

First and foremost, it is important that health professionals ascertain whether there is a physical cause for the consumer's presenting problem, or a physical health condition that has exacerbated the mental illness (Collins, Tranter, & Irvine, 2012; Frasch et al., 2012; Happell, Platania-Phung, & Scott, 2013; Wand, 2013). Many physical illnesses — such as chronic pain, kidney disease or diabetes — can cause or have been connected to anxiety or depression (Hemingway, Trotter, Stephenson, & Holdich, 2013). Likewise, some physical conditions — for example, Alzheimer's disease, Parkinson's disease, brain tumours and even hypoglycaemia — have been linked to psychosis (e.g. Murray, Kumar, Demichele-Sweet, & Sweet, 2013; Sawada & Oeda, 2013). While an MSE can be useful in such cases, it will not identify the root cause or provide an effective means of treating the illness. For this reason, all people who present with a mental health problem must be given a full physical health assessment at the outset.

Similarly, a person who is intoxicated or withdrawing from alcohol or drugs may experience symptoms of mental illness. For this reason, health professionals must wait until the person is no longer intoxicated or withdrawing from alcohol or drugs, before conducting the comprehensive mental health assessment. If the assessment is conducted too soon, it will most likely be inaccurate.

IN PRACTICE

Physical illness in people with a mental illness

Peter is a 30-year-old man with a diagnosis of schizoaffective disorder who is being treated with olanzapine 10 mg twice daily. Peter's pharmacological therapy helps him to manage his mental illness quite well — he lives independently and has a part-time job packing shelves at the local supermarket. Prior to commencing on olanzapine, Peter's condition was not well managed and he spent much of his time in an acute mental health facility as psychiatrists tried him on a number of different medications, without success. Peter is happy the olanzapine seems to have stabilised his moods and reduced his hallucinations.

One of the more concerning side effects of olanzapine is increased appetite. Since he was prescribed this medication, Peter's weight ballooned from 83 kg to 135 kg in 6 months. Peter consumes takeaway food such as pizza and deep fried chicken every day — he says he has tried to cut down but he can't control his appetite. Also, he enjoys eating fast food and says it is one of his few pleasures in life.

Peter recently developed type 2 diabetes and the general practitioner has advised him to lose weight 'or else'. Peter shrugs off this 'threat' and says the general practitioner clearly doesn't understand what it is like to have a severe mental illness.

Questions

1 What are Peter's major health problems?
2 How are each of these health problems linked?
3 How would you help Peter to lose weight?

Triggers

A comprehensive mental health assessment will also involve asking a consumer or carer to describe the circumstance(s), situation(s) or event(s) that triggered or prompted them to seek help from a health professional (Suchy, 2011). Such triggers can often provide an indication of what is happening for the person; and suggest a way forward for the health professional to identify options for managing the situation (Bell, 2012). For example, a person who has quite recently experienced or observed a traumatic event may experience an acute stress reaction. By treating the symptoms, the acute stress reaction will almost always resolve itself. Another example is the person who experiences hallucinations as a direct result of smoking cannabis. This person may be treated with an antipsychotic medication and advised not to smoke cannabis again. Alternatively, a person may have a long history of mental illness and be well aware of the particular situations or events that trigger an episode of illness — in this case, the health professional is advised to note this in the clinical records to inform other health professionals.

Biographical history

Obtaining biographical details is also a necessary part of a mental health assessment (Thomas & Chan, 2012). Such details will include information about different aspects of the person's life, such as:

- early childhood
- education
- relationships to parents, siblings and other family members
- school and work records
- perceptions of experiences as a child and adolescent
- family history of mental health issues
- past and present behaviours related to alcohol and drug use
- past and present functional, occupational and recreational activities
- past and present financial situation
- lifestyle and social situation
- spiritual beliefs
- sexual issues
- onset and course of past mental health issues
- onset and course of current issues of concern.

Every person is a product of their background, as well as their past and present experiences and lifestyles (McQuaid et al., 2012; Roberts & Bernard, 2012; Stanley & Laugharne, 2013). The different ways in which people perceive and manage what is happening to them in the 'here and now' will invariably stem from what has occurred in the past. Knowing and understanding how past events and significant experiences have shaped a person, can help them to make positive changes that will generate better outcomes on into the future (Soberg, Finset, Roise, & Bautz-Holter, 2012; Wand, 2013).

Collaborative history

In addition to talking to the person who is seeking help, health professionals are advised to speak to partners, family members and also friends to obtain a more in-depth understanding of the person and their circumstances (Ai, Rollman, & Berger, 2010;

Cleary et al. 2012). As noted by Morrison and Bennett (2009), people do not become unwell in a vacuum. Rather, their experience exists within their immediate personal context and also their larger social and cultural networks. Obtaining information from the people who are a part of these networks can be an important means by which health professionals develop understanding the person's experience and presenting issues.

A person experiencing symptoms of mental illness may also feel some distress or, as part of their symptoms, find it difficult to organise their thoughts. Obtaining a collaborative — and also corroborative — history can help to clear up confusion about a situation that may be adding to be person's distress.

In an emergency situation, it is often not possible for health professionals to ask permission from the person before obtaining information from friends and family. Ordinarily however, it is important that health professionals keep the person informed each step of the way. Maintaining clear and transparent channels of communication is an important part engaging with the person and building a trusting relationship.

Mental state examination

Perhaps the most commonly used assessment tool in the field of mental health is the mental state examination (MSE) (Barling, 2013). Some people may refer to the MSE as the mental stat*us* examination, but this the term more commonly used in the United States rather than Australia. The MSE forms part of the mental health assessment and focuses on the mental state of the person at a particular moment in time. Through observation and an interview, the health professional assesses the following aspects of the person.

- *Appearance, behaviour and attitude*. This domain considers, firstly, the appearance of the person (e.g. the grooming, hygiene, hair and condition of the nails); and secondly, the behaviour of the person (e.g. slow, restless, tremors, inappropriate or bizarre behaviour). The attitude of the person to the situation and those around them is also described (e.g. hostile, withdrawn or seductive).
- *Mood and affect*. This domain considers the subjective and objective perceptions of the person's feelings. 'Mood' is measured and described by the person (e.g. happy, euphoric, sad, fearful, hopeless, helpless, hurt, lonely or worthless). 'Affect', on the other hand, is measured or observed by the health professional (e.g. the expression they observe on the person's face or the posture of the person's body). To illustrate, a person's facial expression may be reactive (e.g. their face expresses emotion) or restricted (e.g. they are showing no emotion on their faces). Their facial expression may also be inappropriate or incongruent with their stated feelings (e.g. they report that they feel sad but the expression on their face is bright and reactive).
- *Speech*. There are different aspects of a person's speech that can provide a significant indication of their mental state. The rate of the person's speech may be slow, sporadic, monotonous, rapid or pressured. The volume of their speech may be soft or loud. The quantity of information provided by the person may be restricted or voluminous. Speech can also be spontaneous or reserved.
- *Thought process or form*. Thinking is most often expressed through speech, which explains why this domain is closely connected to the domain of 'speech'. Thinking can also be expressed in writing, artwork or other creative activities, so health

professionals will consider a range of communications when assessing this domain. A particular focus of this domain is the form taken by a person's thoughts — for example, a person's thinking may be hesitant, blocked or vague, and this could be reflected in the way they speak. The person may also experience a flight of ideas — that is, ideas that are not sequential or linked but instead 'fly' from concept to concept with little apparent connection or continuity. Sometimes, the words used by the person may create confusion — for example, the person may invent new words or use common words in a 'word salad' that no-one but the consumer can understand.
- *Thought content*. This domain describes delusions or false beliefs that are based on a misinterpretation of reality. Thought content includes suicidal thoughts, plans or intent. The health professional also needs to assess obsessive or compulsive thoughts.
- *Perception*. This domain relates to the senses — seeing, hearing, smelling, tasting and touching. Altered perceptions (where a person may see, hear or smell things that no-one else sees, hears or smells) are called hallucinations. Other perceptual disturbances include derealisation (where the person feels that their surroundings are not real), depersonalisation (where the person feels a loss of contact with their own personal reality), or heightened/dulled perception.
- *Sensorium and cognition*. This domain describes a person's level of consciousness (e.g. drowsiness, delirium, clouding of consciousness). The health professional will also consider the memory of the person (immediate, recent or remote) and orientation of the person to time, place and person. Another important consideration is concentration; the health professional may test this by asking the person to subtract a series of 7s from 100 (i.e. 100, 93, 86, 79 etc.). Finally, the health professional may consider the person's capacity for abstract thinking.
- *Insight and judgement*. This domain refers to the person's understanding or awareness of their experiences and how these experiences are impacting upon their life and the lives of those around them.

The framework provided by the MSE enables the health profession to consider, in turn, each aspect of the person's mental state and, in the process, assess the person's levels of mental health.

Process of assessment

Many health professionals are challenged by the idea of conducting a comprehensive mental health assessment and the questions they should ask to obtain the information required. Table 2.2 provides some of the more common questions or aspects of the assessment that can be used by the health professional when conducting of a comprehensive mental health assessment. The questions listed in this table provide a guide to support health professionals through the process of the assessment.

In addition to familiarity with the various assessments tools, in particular the MSE, it is also important that health professionals have some understanding of the diagnostic manuals used in the field of mental health. Many mental health professionals will use these manuals to support their assessments or to identify the significance of the symptoms described by a person and the most appropriate options for health care. These diagnostic manuals are described in the next section.

TABLE 2.2 Common questions to consider when undertaking an assessment of the person's mental health

Factors to consider before assessment	Has a physical cause or illness for the presenting problem(s) been ruled out? Has drug and/or alcohol intoxication, or withdrawal, been ruled out as a cause? Is the person physically well enough (e.g. not sedated, intoxicated, traumatised, vomiting or in pain) to interview? Does the person have a known history of mental illness? If so, is it possible to access a collaborative or corroborative history?
History of presenting issue or event that prompted the assessment at this time	What recent event(s) precipitated or triggered this presentation or made the health professional think an assessment was necessary now? Does the person pose an immediate risk (i.e. within the next few minutes or hours), with specific plans to self-harm or perpetrate aggression/violence towards others? Allow the person to tell their 'story' and place the experience of their illness or accident in context.
Biographical history	What is the personal, family, social and cultural history of the person? How is the person placed financially? What does the person do for recreation? Is the person employed? Are they in a relationship? Is this relationship functional?
Past mental health history	Does the person have a history of self-harm, suicidal ideation or perpetrating aggressive/violent acts towards others? If so, what are the details? Does the person have a history of mental illness or mental health problems? If so, what are the details? Does the person have a history of using or abusing alcohol or drugs? If so, what kind of alcohol or drugs have they abused?
Appearance and behaviour	How does the person look in terms of body build, posture, gait, obvious marks (e.g. tattoos)? Is the person clean shaven and well groomed? What are they wearing? Is the person dishevelled and unkempt? Is there eye contact, any unusual body movements, mannerisms or behaviours such as tics or posturing? Is the person agitated or restless? Are their movements fast, slow, jerky, other? Is the person obviously distressed, markedly anxious or highly aroused? Is the person quiet and withdrawn? Is the person behaving inappropriately to the situation? How attentive and engaged is the person with the assessment process? How does the person respond to and interact with the health professional? What degree of cooperation is there with the health professional? Is there any suggestion or does it appear likely that the person may try to abscond?
Speech	How much does the person talk? Is it fast or slow, loud or soft, disjointed, vague or lacking any meaningful content? Do they respond slowly or quickly? Is the speech 'pressured' (i.e. a rush of words that is difficult to stop)? Is the person skipping from one subject to another?
Mood and affect	How does the person describe their mood? How does the health professional see the person's mood? What is the expression on their face? How do they interact? How congruent are these descriptions? The descriptions can be different — for example, the person may say that their mood is 'fine' or 'okay' (subjective) but the health professional may observe in the interview that the person's mood is 'low' 'depressed' or 'high' (objective).

(continued)

TABLE 2.2 *(continued)*

Thought form and thought content	Does the person express their thoughts in a manner that is confusing, illogical or incoherent? Do the person's thoughts seem to be racing or are they very slow? Does their conversation go around in circles and never get to the point? Do ideas tumble out without any link between them? Does the person use words or sentences that don't make sense? Do they use words they have made up? What are the themes emerging from the person's thoughts? Does the person experience negative, obsessive or unwanted, intrusive thoughts? Does the person have delusions? If so, what are they? It is recommended that the health professional write down what the person says rather than use psychiatric jargon to describe their thoughts — for example, 'grandiose', 'paranoid'. It is also important to explore the details of delusions with questions such as, 'How certain are you that you are being followed?', 'How certain are you that other people can read your mind?' or 'What do you intend to do to stop the world from ending?' Does the person have any unusual beliefs about their experience of mental ill-health or injury that are not congruent with the information given or with the situation?
Perceptions	Does the person hear voices, or strange or unusual sounds? If so, what do the voices say? Are they male or female, or inside or outside of the head? When does the person hear them? Do the voices talk to the person directly? Do they tell the person what to do? Does the person see unusual things? Smell unusual odours? Feel things crawling across their skin or inside their body? Does the person feel controlled or influenced by external forces?
Judgement/ insight	Does the person think they are unwell? Do they think they need to be helped or treated? Are they aware others think they are unwell? What does the person think about their illness, treatment and prognosis?
Cognition	Is the person oriented to time and place? Are they aware of their surroundings? Can the person focus and shift attention appropriately? Does the person have the capacity to consent; that is, can the person understand and retain information, and then make balanced judgements based on an evaluation of their options? What is the person's level of concentration? What is the person's ability to make decision or choices, think critically or abstractly?
Risk	Is the person at risk of: suicide? self-harm? aggression and/or violence to others? Are there particular risks associated with the person's mental state and physical illness (e.g. hopelessness, prompting non-adherence with treatment)? Is the person at risk of self-neglect? How immediate is the risk? What would be the likely impact of any actions if the person were to act upon their ideas?
Collaborative formulation	What is the health professional's understanding of the issues the person has described? Does the consumer and/or carer share this understanding? What is the level of risk? Does the consumer and/or carer share this understanding? Is immediate action required? If so, does the consumer and/or carer share this understanding? Is a referral to the mental health consultation liaison team advisable? If so, does the consumer and/or carer share this understanding? How urgent is the referral? Does the consumer and/or carer understand the urgency?

UPON REFLECTION

Mental health assessments and corroborative information

As part of conducting a comprehensive mental health assessment on a person, health professionals should speak to spouses or partners, carers, family members, friends or other service providers of the person, to ask them to corroborate or add to the person's story. This is necessary because there will be times when the person's description of the situation or circumstances will be quite different to the stories told by significant others.

Questions

1 What are the possible explanations for differences between the perceptions of the person and their significant others?

2 How could you, as a health professional, manage these discrepancies?

Diagnostic manuals

There is a tendency in all humans to categorise the world around them. For example, we assign categories or types to activities, food, books, music, vehicles — even numbers. Categories are also evident in the health context, with classification or diagnostic systems forming an integral part of the biomedical model of treatment. These systems provide a common, 'shorthand' language by which people can communicate on a topic. In the field of health, classification systems — including diagnostic manuals — are developed through a process of international scientific consensus on the research evidence related to disease and disorder (Giannangelo, 2010). Classification systems also provide a means of identifying patterns in the signs and symptoms of an illness or disease, diagnosing the problem, and recommending options for health care, based on the best research evidence.

Diagnostic systems are beneficial in that they:

- provide a means of consistently classifying health conditions, which is required for the coding of morbidity and mortality — that is, different types of diseases or conditions and related health problems, and also causes of death. (This is necessary to help health service managers and also governments to develop policy and determine where resources are best placed.)
- assist with the study of or research into a condition, disease or associated trends by providing consistent definitions of a health-related diseases or conditions
- are a necessary part of the administrative and legal documentation required by health authorities
- enable health professionals to measure the outcomes of the treatments used and, as such, enable examination of standards or quality of care.

Some health professionals regard classification systems as unhelpful because they tend to reduce personal experience to simplistic diagnostic labels. In time, these labels can lead to the person being stigmatised. Labels can also undermine person-centred care (Whitley, 2012). Despite this disadvantage, however, it is important for health professionals to be familiar with the most commonly used classification systems. Such awareness will assist the health professional to communicate with colleagues and governing bodies, and access research evidence to support practice development.

At this point in time, the main diagnostic manuals used in the specialty field of mental health are the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10) and the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5). However, these diagnostic manuals are by no means the only way of identifying a disease or other health problem. Indeed, different cultures have developed alternative classification systems as a means of expressing their own quite distinctive view of health and illness (Jain, 2013).

ICD-10

The **ICD-10** was endorsed by the World Health Organization as the standard diagnostic tool for epidemiology, health management and the clinical management of people with diseases or other health conditions. The ICD-11, the eleventh revision of this diagnostic manual, will be published in 2015 (Della Mea, Vuattolo, Celik, & Ustun, 2013). The ICD-10 is not specific to psychiatry or mental illness. Rather, it codes all diseases and other health problems; and describes signs and symptoms, abnormal findings and complaints, as well as the social circumstances and external causes of injury and disease. The ICD-10 is used by health systems to aid decision-making related to reimbursement and resource allocation, in countries worldwide. It is also used to monitor the incidence and prevalence of diseases and other health problems.

ICD-10 the *International Statistical Classification of Diseases and Related Health Problems* manual, tenth edition, was developed by the World Health Organization. The ICD-10 encompasses all diseases and related health problems and is not specific to psychiatry or mental illness.

The ICD-10V (F00-F99), which is the chapter of the ICD-10 related to mental health behavioural disorders, is used to diagnose mental health problems in preference to the DSM-5 in many states and territories across Australia. In addition, the ICD-10 is used extensively by national government organisations such as the Australian Institute of Health and Welfare. One reason for this preferential use is the status of the ICD-10 as the only classification manual endorsed by the World Health Organization. Also, the ICD-10 sets standards that are consistent across all diseases and health conditions, not just mental health conditions, on the international stage. Another important consideration is that the ICD-10 is available free of charge through the World Health Organization website (www.who.int/classifications/icd).

DSM-5

The **DSM-5** is published by the American Psychiatric Association (APA, 2013). The main focus of the DSM-5 is abnormal psychology, mental disorder or mental illness. The first edition (DSM-I) was published in 1952. There have been five updates since its original publication, with each describing the diagnostic categories of mental health conditions consistent with societal views at the time of publication (Rey, 2010). The most recent version, the DSM-5, was published in 2013.

DSM-5 the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, published by the American Psychiatric Association; its focus is psychiatry or abnormal psychology

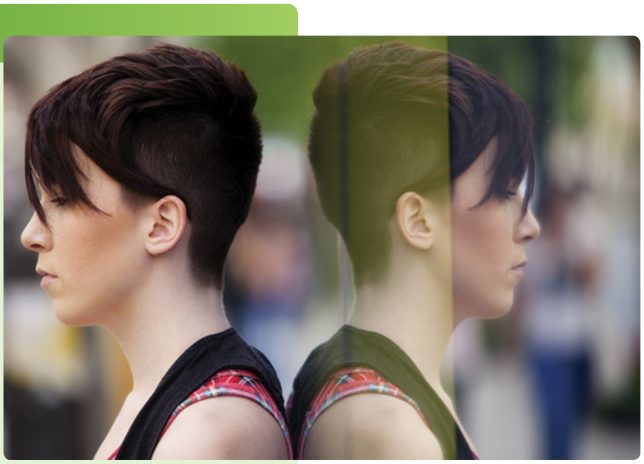
A significant feature of the DSM 5 is the discarding of the multi-axial system of diagnosis for mental health conditions used in previous editions, with which many health professionals were familiar (Jones, 2012). The previous multi-axial system allowed health professionals to differentiate between symptoms of mental illness, including psychiatric symptoms, those related to developmental delay, personality disorder, and mental retardation; symptoms associated with physical diseases or general medical conditions; symptoms related to psychological or social stress; and factors related to the functioning or disability of the person. This multi-axial system was reduced to remove the artificial distinction between medical conditions and mental health problems (Gurova, 2013). There are now only three separate axes:

- *Axis I* — all medical conditions, including physical conditions, psychiatric disorders, personality disorders and mental retardation
- *Axis II* — psychological or social stress factors affecting the person, including situations that date back to childhood, up to the present day
- *Axis III* — the global functioning or level of disability of the person.

Also important to the DSM-5 is the continuum of severity that health professionals use to rate a person's condition. Authors of the DSM-5 argue that this continuum will enable a better correlation between the experience of the person and the treatment options available.

Finally, the third section of DSM-5 provides a range of self-assessment tools that can be used by health professionals; together with a list of categories of mental disorder, identified in the manual, that are in need of further research.

THE BIG PICTURE



Mental illness or psychological pain?

The development and eventual publication of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders,* the DSM-5, has given rise to much criticism (Kraemer, 2013; Flaskerud, 2012; Rapley, 2012; Sachdev, 2013; Watters, 2013; Zimmerman, 2012). First, many mental health problems are culturally and historically constructed (Cheon & Chiao, 2012; Isaac, 2013) — for example, 'hysteria' in women was often diagnosed by medical practitioners in the late nineteenth century, whereas in the early twenty-first century this disorder is rarely diagnosed. Likewise, homosexuality was once identified as a mental disorder, but is now accepted by most Western cultures as one of the many expressions of human sexuality. In the early twenty-first century, eating disorders and 'cutting' as a form of self-harm are of considerable concern in many Western countries. In setting itself up as one of the gold standards for diagnosing mental health problems, however, the DSM-5 has more or less ignored the cues that are provided by a particular society or culture, in time, to express inner, psychological or emotional distress.

In the United States, the DSM-5 determines which mental disorders will attract health insurance reimbursement; consequently, the manual is in high demand (Flaskerud, 2012). In the same way, the disorders contained in the DSM-5 have

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attracted focused marketing by the multinational pharmaceutical companies. For example, people who were previously viewed as 'shy' can now be diagnosed with a 'social phobia' and medicated accordingly. Similarly, 'disruptive mood dysregulation disorder' now labels temper tantrums in children as abnormal, with children medicated accordingly.

Also of concern is the fact that many of the disorders described in the DSM-5 have been identified through a process of discussion and consensus-building in relation to the clusters of clinical symptoms, rather than against empirical or scientific findings (Samuel, Lynam, Widiger, & Ball, 2012). While researchers have made some inroads to identifying the genetic and biomedical causes of mental illness, there is still some way to go.

Health professionals are advised to think carefully about the growing trend to label common reactions to stressful situations. On the one hand, it is important to acknowledge that many people experience symptoms of mental illness that are distressing and debilitating. Making a diagnosis, however, is less important than supporting the person who seeks help for mental health problems by connecting with them personally, building strong and effective therapeutic relationships, and providing them with the most appropriate treatment options available.

Young people and mental health assessment

As noted in chapter 1, one in four young Australians experience symptoms of mental illness (ABS, 2013). The most common diagnosis is anxiety disorder, affecting 15 per cent of this population. Substance use disorders, in particular the misuse of alcohol, are the next most common (13%). Around 6 per cent of young people are diagnosed with an affective disorder, including bipolar affective disorder (3%) and depression (3%) (ABS, 2013).

This section describes the processes involved in providing young people with comprehensive, age-appropriate mental health assessments. These assessments are almost always undertaken with a view to developing and implementing **early intervention** strategies, to enable young people to manage the diverse stressors they experience in their lives, including change (McGorry, Bates, & Birchwood, 2013). Young people in Australia today are faced with many challenges; and supporting them to face these challenges, build the resilience, and live fulfilling lives across the lifespan, is important to the practice of all health professionals.

early intervention strategies that target individuals who are displaying the early signs and symptoms of a health issue

Young people presenting for assessment

What is perhaps most important to note when a young person presents for assessment (or is brought in by a parent, family member or friend for assessment) is that young people experience the symptoms of mental illness quite differently to adults. For example, depression can be diagnosed in an adult if the person has been feeling sad, down or miserable for more than two weeks; takes no pleasure in the activities they usually find pleasurable; and has at least three signs and symptoms across the emotional, behavioural, cognitive and physical categories (American Psychiatric Association, 2013). Depression experienced by young people, however, is less clear-cut and may include a prolonged sad mood, or a loss of interest or withdrawal from normal activities such as playing or sport; uncharacteristic behaviours such as stealing or bullying; tiredness, particularly in the afternoons; sleep disturbances; and bed wetting (Black Dog Institute, 2013). Likewise, young people will react to stress differently to adults, with these reactions dependent on their age and stage of development (see chapter 5). Health professionals must understand these differences and respond appropriately.

Another important factor to consider when assessing young people for mental health problems is the way in which they express emotional or behavioural symptoms. For example, a young person who is tired may become agitated, loud, angry and disruptive — and not think of resting or lying down. Such differences can make it difficult for the parent and also the health professional to gauge what is happening for the young person, especially if the young person is unable to articulate exactly what it is they are feeling.

The behavioural and emotional symptoms experienced or expressed by the young person can also be a consequence of life's events or experiences, rather than mental illness. In short, these behaviours and emotions are not of themselves a mental health problem (McGorry & Goldstone, 2011). However, they can be an early indicator that mental health problems may occur at a later stage in their life (Fitzpatrick et al. 2012).

Behavioural or emotional symptoms that are unusual may be triggered by events or experiences such as childhood sexual or other abuse, bullying at school, or physical health problems. For this reason, all young people with behavioural or emotional problems must be assessed by a specialist mental health professional. At the same time, it is recommended that each and every health professional is familiar with the processes involved in assessing a young person, so they can provide the young person and their families with information on what to expect; and to support them as required (Wilson, Cruickshank, & Lea, 2012).

UPON REFLECTION

Ethical considerations when assessing young people

There are many differences in the way mental health problems are currently assessed and diagnosed across the globe. These variations may reflect cultural differences, social differences, family differences or educational expectations. The variations may also result from differences in the diagnostic systems that different countries use — for example, at this point in time, the diagnostic criteria for many mental health disorders in the DSM-5 differ from those in the ICD-10.

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With regard to young people, some commentators argue that children and adolescents have a wide range of temperaments and ways of adjusting to their social worlds — and that this variation is normal. Labelling such variation as a disorder or mental illness does little more than stigmatise the child. Others question that if a young person and their family are suffering because of challenging behaviours or emotions, and this suffering can be alleviated by a diagnosis and treatment, then why withhold that diagnosis and treatment?

Questions

1. What is your view on the ethics of conducting a mental health assessment on a young person, with a view to providing a diagnostic label?
2. Who do you think should differentiate between the functional and dysfunctional emotions or behaviours in young people? Parents? Teachers? Social workers? Medical practitioners? Psychologists? The young person? Explain your reasons.

Assessment frameworks for young people

The assessment framework used by mental health professionals when assessing a young person with possible mental health problems is similar to the framework used to assess adults, described earlier on in this chapter. This includes delivering person-centred care and practising unconditional positive regard to establish and develop a therapeutic relationship — in this instance, a therapeutic relationship with the young person. It is also important to explore the presenting problem and biographical history of the young person; and conduct an MSE, clinical risk assessment and suicide risk assessment.

The main differences between the assessment frameworks used for adults and children lie with the adaptations made to meet the needs and preferences of young people and their families. Such adaptations are necessary because the mental health and wellbeing of young people is greatly influenced by family members, peer groups, and social or community factors (Wahlin & Deane, 2012). It is important, then, to include family members or significant others in the process of the assessment. Other adaptations may include the way in which the assessment is undertaken. For example, the young person may communicate through play or electronic media. If this is the case, then health professionals are advised to likewise use play or electronic media to facilitate communication with the young person (Reid et al., 2013).

As with the assessment of adults who are experiencing symptoms of mental illness, there are also a number of screening tools or questionnaires available for use by mental health professionals, to enable comparison of the young person's thoughts, feelings or behaviours to other people the same age. However, these tools are most often employed by psychologists and enable diagnosis of a particular disorder rather than assessment of the young person's levels of mental health. Indeed, the comprehensive mental health assessment has a much broader focus than the psychological screening tools alone, which should never be used as substitutes for a more thorough and personal examination.

Health professionals conducting the assessment must focus on the young person's past and present experiences, and also explore the young person's stages of development. Such information can be gathered from a range of sources, including the young person and their parents, other family members, staff at child care centres, teachers, school counsellors, general practitioners and paediatricians.

Because young people often find it difficult to articulate exactly what is happening to them or how they are feeling, observation is an integral aspect of the assessment, with mental health professionals identifying how the young person relates or reacts to other people and new situations. The young person or their parent(s) may also be asked to keep a record of behaviours over a period of time to help the mental health professional — as well as the young person and/or their parent(s) — to gain a more accurate picture of what is occurring in the home or school environments.

Risk and protective factors

Central to the mental health assessment of a young person is the identification of the risk and protective factors in his or her life. **Risk factors** are those that increase the likelihood of a person or group of people developing a disorder; and **protective factors** are those that reduce the likelihood of a person or group developing a disorder (see chapter 12).

In a recent longitudinal study of risk and protective factors for Australian children developing a mental illness, it was found that:

- harsh discipline is a predictor of behavioural symptoms
- poorer physical health, maternal emotional distress, harsh discipline, and over-involved/protective parenting (in the younger children only) is a predictor of emotional symptoms (Bayer, Ukoumunne, Lucas, Wake, Scalzo, & Nicholson, 2011).

Other risk factors that have been identified as important predictors of mental illness in young people include poor attachment to parent(s), parental mental illness, family conflict, domestic violence or family breakdown, bullying at school, peer pressure, and abuse or maltreatment (Hepworth & McGowan, 2013).

Research studies have also identified the protective factors that guard against a young person developing mental illness include:

- secure relationships and a good attachment between the young person and their family, other adults, and peers
- positive expectations of self and hopefulness for the future
- a sense of independence and autonomy
- effective therapeutic communication skills
- good problem-solving skills
- well-developed social skills
- the capacity to self-regulate behaviours and emotions
- a warm and supportive environment at home
- a supportive environment in childcare or school
- a sense of security through consistency with firm limits and boundaries
- opportunities for participation in a range of activities (Goldenson, 2011; Wilson, 2014).

risk factors factors that increase the likelihood that an individual or group of people will develop a condition or illness; they are measured in terms of consequence and likelihood

protective factors factors that decrease the likelihood that an individual or group of people will develop a condition or illness; they are measured in terms of consequence and likelihood

Figure 2.2 provides a guide for the different aspects of the young person's social and emotional life, examined by the mental health professional to obtain this information.

FIGURE 2.2 Questions to consider when assessing young people

When exploring the experiences of young people to identify possible mental health issues, the specialist mental health professional will consider the following areas of interest.

Presenting problem

- What has happened, or is happening in the here-and-now, to lead to the young person and/or their family to seek help?
- Is there a particular situation or circumstance that triggers the situation or condition? If so, what is this situation or condition?

Home life

- What is the young person's attitude towards and relationship with each member of their immediate family?
- Has the young person been placed away from home or lived away from home at any time? If so, where, when, for how long, and what is the young person's understanding of the reason for this? What was the young person's reaction to this experience?

School life

- Does the young person have learning difficulties? If so, what are they? How does the young person manage these difficulties?
- What is the young person's attitude to school, schoolwork, games, teachers and peers?

Play life

- How does the young person play? What is the content of the play? To what extent is play symbolic? To what extent is the play constructive or destructive?
- Does the young person have a fantasy life? If so, what does it entail? The mental health professional may also ask the young person to make three magic wishes or name their three most desired companions on an uninhabited island. The mental health professional may also ask the young person to describe what is the best and worst thing that could happen to them. Answers to these scenarios can often provide a great deal of information about the inner life of the person.
- Is the young person able to concentrate on their play or are they easily distracted?

Personal life

- What are the young person's interests? What are their strengths?
- Does the young person experience any particular worries or relationship difficulties?
- What is the young person's self-image? This self-image is sometimes determined from what the young person says or does, the fantasy ideas or goals expressed, and the young person's estimation of what others think of them.

Sleep

- What are the patterns of sleeping of the young person?
- Does the young person experience nightmares? If so, what is the content of these nightmares?
- Does the young person sleepwalk or sleep-talk?

Behaviours

- Are there signs of premature sexual activity?
- Is the young person anxious or depressed? Does the young person self-harm or attempt suicide?
- Is the young person feeling anxious, vulnerable or powerless?
- Is there evidence the young person is using alcohol and other drugs?
- Is there evidence the young person is using other challenging behaviours—for example, acting-out, aggression or violence, or self-destructive or reckless behaviours?
- Is there evidence of an eating disorder?

Stages of development

- Where does the young person reach each of the developmental stages?

Sources: Adapted from Hunter Institute of Mental Health and Community Services & Health Industry Skills Council (2012); Royal Australian and New Zealand College of Psychiatrists (2010)

Physical examinations are another important aspect of the mental health assessment of a young person. One reason for this is that there may be an underlying physical or biological reason for the experiences of the young person. Health professionals must consider the many different causes of physical symptoms such as headaches and pain. At the same time, a physical examination can also identify abuse, neglect or maltreatment, which are risk factors for mental illness. All health professionals, then, must look for the signs of abuse, neglect or maltreatment when undertaking the physical assessment. When undertaking a comprehensive mental health assessment of a young person, the health professional must also consider the the following physical factors, which may signify the young person's abuse, neglect or maltreatment:

- failure to thrive
- weight, height or both less than the fifth percentile for age
- signs of head injuries, a torn lip or unexplained dental injury
- bilateral black eyes with history of single blow or fall
- traumatic hair loss
- retinal haemorrhage
- skin injuries
- bruises or burns in the shape of an object or an immersion injury
- bite marks
- bruises of various colours (in various stages of healing)
- injuries to soft-tissues areas that are normally protected (thighs, groin, stomach or upper arms)
- injuries of the gastrointestinal or genitourinary tract
- bone injuries — for example, unexplained or unusual fractures (National Collaborating Centre for Women's and Children's Health, 2009).

Communicating with young people

A young person is far less likely to attend second and subsequent appointments with a health professional if they do not like the health professional on the first visit (Wilson, 2014). For this reason, health professionals must develop the acumen required to connect with or relate to a young person with health problems — particularly one with mental health problems (Cummings et al., 2013; McCann, Lubman & Clark, 2012). Perhaps the most important component of the skills required is the use of age-appropriate communication.

To exemplify, the methods of communicating with very young children are quite different to those that are used when communicating to children in their middle childhood, and different again to teenagers and young adults. All health professionals are encouraged to familiarise themselves with the developmental stages of young people to gain an awareness of differences in the way in which they express themselves. For example, it may be necessary to observe very young children as they play, or communicate with them through their play, rather than asking them questions they do not understand or for which they lack the vocabulary to answer.

Indeed, and as with young people who experience physical illness, young people with mental health problems will often find it difficult to describe exactly what it is they are experiencing. This suggests the importance of health professionals engaging with them, to access their perspectives, understand what is happening for them, and work towards meeting their needs. Consequently, all health professionals must consider how best to connect and communicate with the young person.

Figure 2.3 provides some strategies that will assist health professionals to connect with and communicate with young people. As with all strategies, following these suggestions will not guarantee success; however, with practice and reflection, health professionals will develop the skills required to support them in their work, including helping young people with mental health problems.

FIGURE 2.3 Communication strategies and young people

- Arrange a time and place that fits in with their world, rather than expecting the young person to feel comfortable with attending unfamiliar interview rooms or clinical environments.
- Communicate with the young person on their terms. This could include using sandboxes, doll houses, crayons, clay or cyber environments. Be creative!
- Listen more than you speak. This principle must guide the way health professionals work with all people, young and old. However, it is especially important for young people. If the health professional does most of the talking, the young person may feel irritated, intimidated or overwhelmed, and they may decide that it is easier to simply agree with the health professional, rather than share what they are really thinking.
- Respect who they are and their quite distinctive views. Don’t speak ‘down’ or condescendingly to a young person, or tease them about the way they look or dress or speak. The best therapeutic relationships are authenticity — young people will be able to sense if a health professional is not genuine or not interested. Young people will not share how they are feeling or their private thoughts with someone they do not trust.
- Take time. Do not expect to get an assessment completed in one session.

- Don't make presumptions. Some health professionals will presume that because they experienced a particular emotion, thought or behaviour as a child; because their own children experienced these emotions, thoughts or behaviours, all young people will have the same experiences. There is no 'one-size-fits-all' with children — they are individuals who have their own ways of dealing with their own experiences.
- Avoid telling the young person what they should or shouldn't be thinking or feeling, or how they should be behaving. While the young person may (or may not) listen politely, it is unlikely that they will follow the directions given to them by someone they hardly know.
- Don't assume that the parent's or family's story about the young person's thoughts, feelings or behaviours, is the same as the young person's. Health professionals must always ensure that they give the young person the time, space and privacy to tell their own story.

Sources: Kellett (2011); Roberts, Crosland, & Fulton (2013); Schley, Yuen, Fletcher, & Radovini (2012); ter Huurne, Ostel, de Haan, Drossaert & DeJong (2013); Ungar, Liebenberg, Landry, & Ikeda (2012); Woolford, Patterson, Macleod, Hobbs, & Hayne (2013)

The need to avoid 'labelling' young people

The health professional must take time and care before suggesting a diagnosis or 'label' for the young person with mental health issues (Stasiak, Parkin, Seymour, Lambie, Crengle, Pasene-Mizziebo, & Merry, 2013). A psychiatric diagnosis carries stigma (see chapter 1) and this stigma can add to the young person's distress. A young person will carry this stigma for a long time, on into adulthood.

A young person's emotions and behaviours are expressed along a continuum or spectrum, with differences resulting from personal preference, cultural and religious differences, education, and also their parent's expectations. Variations will also arise from the diverse diagnostic systems used in different countries. For example, the diagnostic criteria for some mental health disorders in the DSM-5 differ from those in the ICD-10. These many factors suggest that deciding what is 'normal' for young people will always involve a degree of subjectivity.

While it is important that young people are provided with a rigorous and comprehensive mental health assessment, it is less important to use the findings of this assessment to develop a diagnosis (Wright, Jorm, & McKinnon, 2011). Instead, the focus of the assessment for the health professional is to find ways to support the young person to manage their emotions, thoughts or behaviours as they move through life. This will include exploring the young person's risk and protective factors, educating the young person and their families, and working with the young person to build on their strengths (Eapen, Lee, & Austin, 2012). It will also include assisting the young person to develop the areas of their life that may be placing them at risk of developing further mental health problems. Ways and means of undertaking this work are discussed in more detail in chapter 12.

UPON REFLECTION

Children's rights

The *Early Childhood Australia Code of Ethics* (Early Childhood Australia, 2006) upholds the protection and wellbeing of children through 12 ethical prompts for professionals who work with young children. The following values and processes are considered central to the Code of Ethics:

- respect
- democracy
- honesty
- integrity
- justice
- courage
- inclusivity
- social and cultural responsiveness
- education.

Questions

1 What similarities do these principles have with the principles of the Code of Ethics that belong to your health profession?

2 What are the differences between these principles and the principles of the Code of Ethics that belong to your health profession?

3 How can you incorporate these principles into your practice when working with young people with mental health problems?

SUMMARY

This chapter provided an overview of the major components of the comprehensive mental health assessment. It commenced by explaining the importance of preparing for an assessment — in particular, health professionals reflecting on their personal values and professional practices. Ways and means of engaging with those who seek help were also described, together with the strategies that can be used by health professionals to establish and maintain a strong therapeutic relationship with consumers. Such relationships support achievement of the best possible outcomes for the person, their spouses or partners, their families, and also the community as a whole.

An outline was provided of the major mental health assessment tools used to guide health professionals who conduct mental health assessments, including the MSE, the clinical risk assessment and the suicide risk assessment. The main diagnostic manuals — the ICD-10 and DSM-5 — were also explained, together with the suggestion that caution must be exercised prior to making a diagnosis, due to the subjective nature and also stigma associated with mental illness.

The chapter then identified the differences between the mental health assessment of adults and young people. The importance of identifying risk and protective factors of young people, including how these relate to their potential to develop a mental health problem, was also discussed. Finally, steps to developing the skills required to communicate appropriately with young people were highlighted, with the assessment of young people recognised as a means of identifying the need for early intervention.

Review questions

1. What is the difference between self-reflection and practice reflection?
2. What is the 'biopsychosocial' approach to care?
3. Define the term 'unconditional positive regard'.
4. What differentiates a therapeutic relationship from other types of relationships?
5. Why is it important to undertake a physical assessment of a person who is experiencing symptoms of mental illness?
6. Identify the similarities and differences between the ICD-10 and DSM-5.
7. What are the main domains of the mental state examination (MSE)?
8. What are the main challenges for the health professional assessing a young person with mental health problems?
9. Identify the main risk factors for young people in Australia developing a mental illness.
10. Why is it important to, wherever possible, avoid labelling a young person with a psychiatric diagnosis?

Discussion and debate

1. How can a health professional integrate person-centred care into a health service that makes constant demands on health professionals to achieve key performance indicators and outcome measures?
2. Discuss the different ways by which the health professional can facilitate their own self-awareness and self-care.
3. Once a health professional has reported findings of an assessment, whose responsibility does it become to follow up? Discuss the practical steps that can be taken in a large health system involving many different health professionals to ensure that people with mental health issues receive continuity of care.
4. Which aspects of the comprehensive mental health assessment do you think are the most important? Justify your opinion.
5. What steps can health professionals take to develop the acumen to work effectively with young people?

Project activity

Mental health assessments in emergency situations
The role of first responders in supporting the mental health of people in distress is under-recognised. For example, first responders (including paramedics and also emergency nurses and medical practitioners) are often required to make decisions regarding violent behaviour, florid psychosis, mania, substance abuse and intoxication, anxiety and panic attacks, and also suicidal behaviour.

1. What assessment tools are available for first responders to support their clinical decision making related to the person with signs and symptoms of mental illness ? (Use the academic databases and online resources to help you identify these tools.)
2. What are the benefits and limitations of these tools?
3. Discuss how first responders can be supported to utilise these tools to more effectively connect with other health professionals to support better outcomes for people with mental illness?

Websites

'Actively promoting the mental health and well-being of infants, children, adolescents and their families/carers', the Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) aims to represent all professions working with infants, children and adolescents and their families in the area of mental health, to formulate principles of best practice, promote research, gather data, disseminate information to professionals and government and non-government bodies: www.aicafmha.net.au

GROW is a national organisation that provides a peer supported program for growth and personal development to people with a mental illness and those people experiencing difficulty in coping with life's challenges: www.grow.net.au

Headspace, the National Youth Mental Health Foundation, provides a range of resources on its website related to young people, assessment, early intervention, resilience, and how to support parents and carers: www.headspace.org.au.

Kids Helpline is a counselling service for Australian children and young people aged between 5 and 25 years (ph. 1800 55 1800). Its associated website provides a safe place for children to hang out, play games and learn. The website also provides information on different mental health related topics they can learn about (including taking risks, peer pressure, and what to do when they have fights with friends): www.kidshelp.com.au

The Mental Illness Fellowship of Australia (MIFA) is a non-government, not-for-profit, grassroots, self-help, support and advocacy organisation dedicated to helping people with serious mental illnesses, their families and friends. Serious mental illness includes schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorders and anxiety disorder: www.mifa.org.au

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The legal and ethical context of mental health care

3

LEARNING OBJECTIVES

This chapter will:

- identify the key legal, ethical and professional principles guiding the provision of mental health care
- describe the challenges for health professionals when making ethical decisions
- discuss the concepts of consent, capacity and competence
- explain the importance of advanced care agreements or directives in the field of mental health
- discuss the concept of duty of care
- outline the use and application of mental health legislation across Australia.

Introduction

The legal and ethical principles that underpin the provision of mental health care in Australia may seem complex to those who practise in non-mental health settings. For example, some health professionals may wonder about the capacity or competence of a person with a mental illness to give informed consent for a medical procedure; health professionals may also be uncertain about their duty of care to the person with a mental illness in particular situations; others again may feel that they lack knowledge of the requirements of the mental health legislation relevant to their state or territory.

This chapter identifies the key legal, ethical and professional issues for health professionals who provide care to people with a mental illness in non-mental health hospital or community settings. It includes a discussion of the concepts of capacity, competence, consent and duty of care. An outline is also provided of the importance of advance care agreements or directives for people with a mental illness. The chapter concludes by explaining the mental health legislation that is in place in states and territories across Australia and how this legislation generally relates to health professionals working in a variety of contexts.

The discussion and examples provided in the chapter are broad in focus. This is because each of the states and territories has different laws. Even so, it is anticipated that this broad focus will enable health professionals, regardless of their location or place of work, to consider how best to integrate the major principles involved into their everyday practice. The broad focus will also serve as a means by which health professionals can increase their overall awareness of the legal and ethical frameworks within which they work and effectively meet the requirements of these frameworks.

The legal and ethical context

A health professional's practice is informed and governed by a variety of factors, including legal, ethical and professional requirements. Each of these requirements guides and affects the way a health professional provides care to those in need. In the field of mental health, the legal, ethical and professional requirements are quite complex. One reason for this is because each state and territory in Australia has enacted its own distinct mental health legislation to guard and guide the way in which people with a mental illness are treated. Some of the specifics are discussed in the last section of the chapter.

This section outlines the legal, ethical and professional principles that guide the provision of health care to people with mental health problems, no matter where they are located geographically, or in what type of health setting they occupy. The outline also includes a brief discussion of the major issues that arise from applying these principles in practice.

UPON REFLECTION

'But I'm not a lawyer!'

Many health professionals are reluctant to learn about the legal and ethical requirements that frame the way they practise. The complexities of this area of health service delivery are such that they would prefer to leave these issues to the lawyers. However, given the political climate of the day, and the knowledge the community has regarding appropriate health care, it is vital that we understand the legal and ethical boundaries that underpin our practice in order to minimise compromising of the care that we provide, as well as uphold our professional standing.

Questions

1. What are the potential consequences for the health professional who does not understand the legal and ethical requirements that frame their practice?
2. What are the potential consequences for the consumer and/or carers when the health professional does not understand the legal and ethical requirements that frame their practice?
3. What are the potential consequences for the health service provider and governments when the health professional does not understand the legal and ethical requirements that frame their practice?

Legal requirements

Australia's legal system was inherited from the British legal system and comprises common law and statute law. The terms 'statute law' and 'common law' will be used throughout this chapter, and so it is important to clarify their meaning. **Statute law** refers to laws that are also known as the 'laws of the land'; for example, the *Aboriginal and Torres Strait Islander Peoples Recognition Act 2013*. These laws are passed by an Act of parliament, whether state, territory or Commonwealth. The relevance of the proposed law and the way it will be enacted in the community is debated in parliament to ensure it reflects the will of the people. **Common law** refers to the principles that guide the interpretation of the law based on decisions made by judges in individual cases. Table 3.1 (overleaf) outlines some of the characteristics of each of these types of laws.

statute law a law made by parliament (Commonwealth, state or territory); the relevance and enactment of this law is openly debated in the parliament prior to becoming law

common law principles based on the decisions made by judges in individual cases

In the health context in Australia, an important statute law is the *Health Practitioner Regulation National Law Act 2009*. This law has given rise to nationwide registration and accreditation standards for health professionals as part of the National Registration and Accreditation Scheme for Health Professionals, which commenced on 1 July 2010. For specific health professional groups across Australia, this law means one national registration fee, one set of registration and general professional standards and one registration process, rather than the previous inconsistent state- and territory-based registration processes. The Australian Health Practitioner Regulation Agency (AHPRA) supports this law, and currently regulates more than 560 000 health practitioners across the country (AHPRA, 2013).

TABLE 3.1 Characteristics of statute law and common law

Statute law	Common law
A law made by parliament (state, territory or Commonwealth). Its relevance and enactment is openly debated in the parliament prior to becoming law. The law is written down and can be consulted and referred to by others. Statute laws take precedence over all other laws.	Also referred to as case law or judge-made law. These are common law principles based on the decisions made by judges in individual cases. The 'Bolam principle' provides an example of case law informing health care practice: the case of *Bolam v Friern Hospital Management Committee* (1957) produced a definition of what is reasonable in terms of the standard of competence expected of health professionals when carrying out their duties.
Statute law is applicable as long as it remains on the statute — the only way for legislation to cease to be law is for it to be repealed.	They may be based on interpretations of statute law (but not necessarily so), or decisions made by a court.
Examples of Commonwealth statute laws relevant to health care include the *Privacy Amendment Act 2004*, the *Freedom of Information Act 1982*, and the *Work Health and Safety (Transitional and Consequential Provisions) Act 2011*.	A further example of common law principles applied to health care is the concept of a 'duty of care'. It has long been established in common law that health professionals and health service providers owe their consumer a duty of care (Aboriginal and Torres Strait Islander [ATSI] Health Practice Board of Australia, n.d.).

Other statute laws that inform how health professionals practise in Australia include privacy Acts, health record Acts and freedom of information Acts. Table 3.2 provides an outline of these and other laws that are particularly relevant for health professionals who care for a person with a mental illness. For example, mental health legislation that has been enacted in each of the states and territories guides the health care and treatment that is provided to people with a mental illness, and guards against human rights abuses. This legislation is discussed in more detail later in the chapter. Also important are the privacy laws that are in place in all states and territories. These laws are discussed in the section 'Confidentiality and privacy'.

TABLE 3.2 Examples of statute laws applicable when caring for people with mental health problems

Statute	Comments
Mental Health Acts (various)	Allows for care, treatment and control of people experiencing mental illness or disorder in either a voluntary or involuntary capacity (Mental Health Coordinating Council, 2011, p. 37). Health professionals need to be aware of the common sections of the Act in the state or territory in which they are practising.

Statute	Comments
Health Records Acts (various), and the *Privacy Act 1988* (in particular National Privacy Principle 6)	Allows individuals to access personal information, including health-related information, unless providing access to the information would pose a serious threat to the life or health of the individual (National Privacy Principle 6.1[b]).
Human Rights Acts or Charters (various)	Enshrined in law are the following civil and political rights (*Human Rights Act 2004* [ACT]): • the right to life • the prohibition of torture and inhumane and degrading treatment • the right to liberty and freedom of movement • the right to privacy and reputation • freedom of expression including thought, conscience, religion and belief • the prohibition of discrimination • the right to humane treatment when deprived of liberty.
Freedom of Information Act 1982 (FOI Act)	Gives the right to access written information from public bodies (including health care providers). Members of the public may request information relating to health services policies (e.g. local policy on the prescribing and administration of medication). It needs to be noted that access to information may be denied in situations where it is considered that disclosure of sensitive information might be detrimental to the applicant's physical or mental health, or wellbeing (Freedom of Information Act s. 41).
Guardianship and Management of Property Acts or Guardianship and Administration Acts (various)	Set out the legal terms under which it is possible to make decisions — including those relating to health care — for people who are not able to make decisions for themselves.

Ethical requirements

All health professionals are required by their professional bodies to practise in a lawful and ethical manner (e.g. Australian Association of Social Workers, 2008; Australian Nursing and Midwifery Council, 2008a, 2008b; Australian Psychological Society, 2007). The primary ethical requirement of all health professionals is to respect the following:

- the right of the individual to make decisions about their care (i.e. autonomy, freedom and self-determination)
- the need to avoid inflicting harm (non-maleficence)
- the need to do good (beneficence)
- the need to treat people fairly and with respect (justice and fairness) (Beauchamp & Childress, 1994).

These ethical principles are particularly important when caring for people with a mental illness in contemporary Australian society. This is because of the way people with a mental illness have historically been treated in Australia.

As noted in chapter 1, it is only since the 1980s that people with mental health issues have been assured the same rights as other citizens — including the right to make their own decisions about their own care, and to be treated fairly and with respect. Consequently, many people with a mental illness may be fearful or suspicious of health professionals and their potential to disempower them. Effective health professionals will learn from the past and work hard to inspire hope in the future of all those for whom they care.

The ethical frameworks provided by the professional bodies also uphold the need to avoid paternalism, whereby health professionals assume they always know what is best for the consumer. While the health professional's motivation may be informed by the desire to do good, this must always be balanced with an individual's right to autonomy. It is the role of the health professional to respect this right and to be aware that notions of 'doing good' are often open to subjective interpretations.

On the other hand, consideration should also be given to the consequences and risks of such a decision when the offer of treatment is declined (Queensland Health, 2011, p. 15). The issues involved, then, are complex — and best dealt with by utilising an approach that involves active dialogue between all members of the multidisciplinary team and the individual concerned.

Secondary ethical requirements are also important considerations for health professionals, and include the principles of truthfulness, equity and equality, respect and dignity, sanctity and quality of life, and privacy and confidentiality. In the course of their work, health professionals interact with a range of people with diverse views, family backgrounds, cultures, aspirations, expectations and behaviours. When caring for a person with a mental illness, the principles of equity and equality, respect and dignity, and privacy and confidentiality have particular relevance for health professionals. Reasons for this include the need to counter the stigma that is attached to people with a mental illness in Australia today. For example, the personal values that a health professional holds in relation to mental health and illness must be set aside in the workplace, and secondary ethical principles must be upheld. The way in which this can be achieved by health professionals is considered in chapters 5 and 6.

Confidentiality and privacy

Confidentiality is both an ethical and legal principle that prohibits disclosure of privileged information without the person's informed consent. This includes information about a person's mental health status. There may be times, however, when such disclosure is necessary.

For example, if the person temporarily lacks capacity and there is no appointed guardian, then the wishes of family members, carers or significant others need to be taken into account when reaching decisions about treatment and ongoing care. However, the eventual outcome is the responsibility of the health professional, based on their assessment of what is in the person's best interests, and the preferences of the person (if known).

The legal context regarding capacity and consent is fairly clear — although the issue of whether a person with a permanent incapacity is unable to give consent has been challenged in the United Kingdom (Dewing, 2001). This has led to calls to ensure that decisions regarding capacity are derived not only from the legal definitions, but also by factors such as personal wellbeing, personhood, previously stated wishes (e.g. an advance care directive), beliefs and preferences.

When caring for people with a mental illness, there are a number of issues around confidentiality and privacy that the health professional may not ordinarily encounter. One of these issues relates to the notions of stigma, as previously noted. For example, many consumers and carers will be sensitive about their clinical record and how the information about their mental health issue is being documented. There can also be issues for partners or carers, who may be anxious about what is happening to their family member and react by pressing the health professional for details or information. This situation can become quite complex as health professionals work to balance the provision of information to partners or carers to assist them in their supportive roles, with the consumer's right to confidentiality and privacy. It is recommended that health professionals discuss such issues as they evolve with the consumers, carers and other members of the multidisciplinary team.

THE BIG PICTURE

The Personally Controlled Electronic Health Record System

On average each year, every person in Australia has approximately 22 interactions with the health system — including general practitioner appointments, medication dispensing, specialist appointments and other health contacts. Additionally, there are in excess of 8 million Emergency Department presentations annually across the country (Department of Health [DoH], 2013). All these contacts generate significant information regarding a person's health and the treatment they receive from various health professionals. This information is not usually stored in the same place, and is not always easy to access in a timely manner.

In a measure to address this issue, the Department of Health and Ageing developed the Personally Controlled Electronic Health Record System (known as eHealth), which commenced in Australia in July 2012. The eHealth record is a secure electronic document that contains a summary of the person's past and current health status. This is a voluntary 'opt-in' program, where any member of the public can choose to register themselves (or their child) for an

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eHealth record. Registering for an eHealth record can be done online, over the phone, by mail or in some Department of Human Services centres where Medicare services are available.

A person's eHealth record can be updated in three ways: by authorised health professionals, by Medicare and by consumers themselves. Health care organisations need to register to enable authorised staff in their facilities to access and update eHealth records of consumers. Once an agency has eHealth authorisation, approved health professionals from that particular health agency may upload information such as discharge summaries, diagnostic test results, referrals and specialist letters. Medicare is able to submit information relating to:

- all Medicare Benefits Schedule (MBS) appointments and Department of Veterans' Affairs (DVA) occasions of service where a Medicare claim is made
- all medication claim details under the Pharmaceutical Benefits Scheme (PBS) or the Repatriation Pharmaceutical Benefits Scheme (RPBS)
- information regarding immunisations and organ donor preferences if this information is recorded with the approved governmental agencies.

Personal details, allergies, current medication and advance care agreement templates can all be accessed and amended by the individual person within the eHealth document.

The advantages of such a system include:

- quick and efficient sharing between health professionals
- health professionals are not solely reliant on consumers' memories for past treatments and procedures
- increased treatment time through decreased medical record retrieval time
- faster access to relevant medical information, especially after hours
- the ability to temporarily access health information in medical emergencies where consumers are unable to give information themselves (e.g. where they are experiencing trauma, unconsciousness or delirium)
- the option for members of the public to cancel their eHealth record at any time.

However, there are a number of disadvantages of the system — for example, the information in the eHealth record may not be accurate, current or complete; the owner of the eHealth record cannot remove or modify a clinical comment made by a health professional; consumers are able to restrict specific information to health professionals via advanced controls settings if they choose; and the eHealth record is certainly not a replacement for the numerous electronic or paper medical record depositories that currently exist. Additionally, there have been concerns raised about the minimum technological and security requirements that are needed to maintain the privacy of such highly-personal information.

Given that health care facilities and selected health professionals need to be registered for this system, the governance of the system is complex. For further information about eHealth, access the Learning Centre at www.ehealth.gov.au, where a large number of fact sheets, frequently asked questions, consumer stories and interactive modules are available for consumers and health professionals. An eHealth helpline is also available (phone 1800 72 34 71) (DoHA 2012).

Professional requirements

Professional requirements are identified for the mental health workforce in general. These are outlined in the *National Practice Standards for the Mental Health Workforce* (2002), which were reviewed in 2013. There are also a number of discipline-specific requirements to guide the way in which a health professional practises, outlined in documents such as the *Code of Professional Conduct for Nurses in Australia* (Australian Nursing and Midwifery Council, 2008b); the *Australian Psychological Society Code of Ethics* (Australian Psychological Society, 2007); and *Practice Standards for Mental Health Social Workers* (Australian Association of Social Workers, 2008). These documents require health professionals to act in the best interests of the health consumer at all times. Although these documents are not legally binding, failure to act within the guidelines constitutes a breach of the code, which could be used to demonstrate a failure to follow approved practice and may potentially lead to civil action or professional registration consequences (ATSI Health Practice Board of Australia, n.d.).

Challenges for health professionals

The nature of mental illness, the presentation of acute distress and the impact of behavioural disturbance can present specific challenges to health professionals within clinical settings. For example, not everyone presenting for assessment or treatment will behave as the health professional expects them to; that is, they may not be cooperative, compliant or adherent, or uncomplaining or grateful. This is the natural consequence of numerous factors that influence the way in which people respond to the experience of being injured or unwell and in need of assistance — including feelings of pain, discomfort, acute fear, stress and anxiety — sometimes leading to difficult or challenging behaviour (see chapters 5 and 6).

On occasion, such challenging behaviour may be manifested by the consumer declining treatment or refusing to accept well-intentioned advice or requests from health professionals. Other examples include occasions when the consumer may lack the capacity to make decisions. Challenging behaviours can also be exhibited by people with marked cognitive impairment or substance abuse issues, someone with an acute exacerbation of a mental illness, or a person who is profoundly depressed and expresses a wish to be allowed to die.

In these circumstances, it is necessary for the health professional to abide by the ethical framework that informs their practice. This will include utilising approaches such as unconditional positive regard (see chapter 5). It is also important to demonstrate an attitude of respect, acceptance, dignity and equity. Further, the health professional would be wise to consider how they can best uphold or protect the human rights of a person in all situations (see chapter 6).

IN PRACTICE

'To tell or not to tell?'

Alan, a recently married 32-year-old man, has been diagnosed with bipolar affective disorder. You and your colleagues have provided Alan with comprehensive information regarding treatment options for bipolar affective disorder, but Alan is very distressed by the diagnosis. Alan informs you that under no circumstances are you to disclose this information to his new wife.

Many health professionals struggle with knowing what information they can legally share with the carers and family of people they provide care to. Some health professionals disclose all information related to the consumer, and others have a position that they share nothing unless the consumer has signed a release of information form.

Questions

1. What are some strategies that may be helpful to health professionals in addressing this issue?
2. What practical role does the multidisciplinary team play in supporting health professionals to achieve a communication balance between consumers and others who have a bona-fide interest in the consumer?
3. What other people in your organisation can assist you with this issue? In what capacity can they do this?

Legal and ethical frameworks

This section provides an outline of the important legal and ethical frameworks or principles that inform the way in which health care is provided in Australia. Topics covered include the individual's right to autonomy, informed consent and the harm principle. Ethical theories and decision making will also be discussed. It is important for health professionals to understand how these frameworks and principles shape their practice. This, in turn, will enable them to comply with the requirements of law and, in so doing, provide ethical and equitable care to consumers with a mental illness.

The individual's right to autonomy

As noted in chapter 1, current health practices have seen a shift away from the conventional model of health care in which the patient is treated as the passive recipient, to one in which the consumer is an active and involved co-contributor who participates in the planning, feedback and delivery of preferred health services for themselves and works with the multidisciplinary team towards a common goal (Association of Relatives and Friends of the Emotionally and Mentally Ill (ARAFEMI), 2011). Consumer-centred models and person-focused approaches to care have given rise to health professionals focusing more upon collaboration and partnerships with consumers and their significant others to achieve better health outcomes for all (Australian College of Mental Health Nurses, 2010, p. 9). One such model is the ‘triangle of care’ model where the consumer, professional staff and an identified support person are all equal partners (National Mental Health Commission, 2012, p. 76) However, ensuring the meaningful involvement of consumers, carers, partners and family in making treatment decisions requires health professionals to employ a sound ethically driven perspective.

One of the fundamental principles framing the sound ethically driven perspectives is the recognition of the individual’s right to autonomy. While this may seem straightforward, respecting the individual’s right to exercise their free will may, in reality, present major dilemmas for health professionals who are caring for a person with a mental illness.

For example, a health professional might wish to prevent a person with a mental illness who is also experiencing suicidal ideation from leaving a clinical setting. Suicide is a major concern for all health professionals (see chapter 8). Of particular concern is the person with mental health issues who is experiencing suicidal ideation — up to 15 per cent of people with serious mental health conditions will eventually die by suicide, compared to an approximate figure of 1 per cent for the whole population (Australian Bureau of Statistics, 2009). Despite this, the individual’s right to autonomy means that they are free to come and go as they please, regardless of whether they have a mental illness. This creates a dilemma for health professionals seeking to provide care to a person considered to be at risk. Action taken by the health professional can sometimes be perceived as denying the individual’s right to free will. To resolve this dilemma, the health professional must be able to demonstrate that the individual’s risk of self-harm is significant enough to warrant limiting autonomy.

Informed consent

Australia’s health care system is based on a doctrine of **informed consent**. This means that an individual has the right to choose to accept or reject recommended medical care. For such decisions to be considered legally and ethically sound, they must be informed and voluntary, and the individual must be competent to make decisions about interventions and consequences that affect them (Queensland Health, 2011).

informed consent when a person agrees to a recommended course of treatment, a medical or surgical procedure, or participation in a clinical trial, following thorough explanation of the proposed treatment, including actual and potential risks involved, which the person has been able to understand

It is important to demonstrate an individual’s capacity to understand their situation, which directly impacts upon their responses. In assessing a person’s capacity to make a decision, the health professional must ensure that the individual:

- has been provided with all of the information needed to make an informed decision
- expresses their decision voluntarily without influence or coercion
- demonstrates their decisional capacity or competency to consent to or refuse treatment
- understands the nature of their condition, as well as the risks, benefits and alternatives to treatment
- appreciates the significance and consequences of their decision and demonstrates understanding of their situation
- displays a logical and coherent process of reasoning with respect to their condition
- holds to their decision based on a consistent set of values (Fallon, 2010).

All adults, including those with a mental health problem, are to be presumed to have capacity until the contrary is proved. Significantly, where capacity is contested, the burden of proof lies with the person asserting the incapacity.

This means that the health professional must be very sure of the way they assess incapacity before presuming a person is unable to consent to a procedure. It is important to note that the vast majority of people with a mental illness are able to give informed consent in the health context. Significantly, this includes the person who has been detained under the Mental Health Act. Generally, health professionals should not make presumptions about a person's capacity, especially when these presumptions may be based upon preconceived ideas. Rather, assessment of capacity needs to be undertaken by a health professional who has specialised in this area of assessment.

The 'harm principle'

Intervention in a situation where an individual chooses to leave a hospital setting without treatment, and against medical advice, is based on the utilitarian ethical philosophy espoused by John Stuart Mill (1963), known as the **harm principle**. Adhering to the harm principle means that a degree of intervention that limits a person's autonomy may be justified in certain situations. The same principle is followed when the Australian government enacts legislation that limits individual autonomy in order to reduce the likelihood of harm to the individual and/or others. Examples of such interventionist policies — or, depending on the point of view, paternalistic legislation — aimed at minimising harm include the legal requirement to wear seatbelts in cars and the ban on smoking in public places. However, a health professional who limits the autonomy of a consumer without first obtaining consent, where such consent is required, may be liable to accusations of battery and assault (ACT Health, 2012; Allston, 2011, p. 8).

harm principle the principle that a person has the right to complete freedom of choices and actions, regardless of what the greater community believes, on the proviso that their actions do not directly harm, infringe or violate the same freedom of choice of others

The harm principle raises interesting issues for those who self-harm. For example, the incidence of self-harm by people post hospital discharge was explored in the Commonwealth Senate enquiry into suicide prevention (Commonwealth of Australia, 2010). The recommendations of the inquiry include establishing protocols for the follow-up support of people who are discharged from hospital after attempting suicide. Additionally, the Northern Territory Government has made a commitment to also provide services to those people who have been assessed as being at risk of self-harm, and those who have been treated following a self-harm episode but not admitted to hospital (Select Committee on Youth Suicides in the NT, 2012, p. xvi). Such protocols may go some way to reducing the burden on health professionals to ensure the safety of individuals with mental health issues who have left the hospital setting.

Concern has also been raised about individuals at risk of self-harm who present at a hospital emergency department, are not triaged appropriately, and leave the hospital without receiving treatment or care. One reason for this concern relates to the way people with mental health issues are triaged (Coroners Court of Victoria 2012). Another reason is the negative perceptions exhibited by some health professionals towards individuals who have self-harmed (see chapter 8). It is important that health professionals are aware of their own values in relation to mental health and ill-health, self-harming, suicide and so on, and do not allow these values to compromise the way they provide health care to people in need (see chapter 5). It is also important that health professionals are aware of the legal and ethical issues involved and, when unsure, refer such situations to the multidisciplinary team for consideration.

Ethical theories

Hand-in-hand with the aforementioned ethical principles are the ethical theories relevant to the provision of mental health care. Ethical theories are based on ethical principles and each person uses their life experiences, personal values system and cultural perspectives to determine the theory to which they align their choices and behaviours. This is especially so when the person faces an ethical dilemma.

Ethical egoism is a term used to describe when the person making the treatment decision decides what is right and advantageous for them even though the decision may not necessarily be advantageous for others. How others view the outcome of the decision is irrelevant, even when the decision is not obviously supported by family, carers and significant others (Townsend, 2003). However, there are occasions when the health professional must make a clinical decision and this is when ethical theories can be helpful.

ethical egoism an ethical theory proposing that people are entitled to make choices and decisions based on their own self-interest, over and above the interest of others

Ethical theories and principles that are useful in assisting decision making when faced with an ethical dilemma include virtue ethical theory, deontological ethical theory, consequentialism or utilitarianism ethical theory, casuist ethical theory, and rights-based theory. Deontological and consequentialism are two of the most important ethical theories and their principles are frequently used when caring for a person with a mental illness.

In short, the principles of deontology ethical theory are that choices and actions are either morally right or morally wrong, and that every individual has a moral obligatory duty to undertake those actions that are morally right. This is illustrated in figure 3.1. For example, a consumer following a deontological philosophy who is prescribed medication while detained under mental health legislation would always take the medication even if they did not believe that they needed the treatment. This consumer would adhere to the prescribed treatment because there is a legal directive to do so and the person believes in being a good law-abiding citizen and will follow the law at all costs.

Conversely, consequentialism ethical theory proposes that the decision to do something is determined by the anticipated outcome, which usually translates to the greatest benefit to the greatest number of people. All options may be considered, and the option for the best outcome is then selected, irrespective of the rightness of the procedures required to obtain the outcome. People subscribing to consequentialism believe that any action taken is acceptable if the best outcome is achieved.

FIGURE 3.1 Deontological versus consequential ethics

Source: Raines and Dibble (2011, p.12)

IN PRACTICE

A father's secret

Amaani is a twenty-year-old single woman of North African heritage, who still lives at home with her parents. Amaani was diagnosed with schizophrenia twelve months ago, and had been prescribed an oral antipsychotic medication. Her medical file shows that at her last psychiatric review a few weeks ago, Amaani informed the psychiatrist that she would no longer take the antipsychotic medication under any circumstances.

Amaani has just been admitted to the orthopaedic unit after she fractured her leg while jogging. When the admitting team asked whether she was taking any prescribed medication, Amaani answered 'no'. After the admission is complete, Amaani's father now pulls you aside and discloses to you that Amaani actually does take antipsychotic medication; she just doesn't know that she takes it. You ask how this can possibly be the case, and Amaani's father informs you that each morning he makes Amaani a strawberry smoothie, which he adds her antipsychotic medication to. Her father clearly believes that he is doing what is in the best interests of his daughter, himself and their family.

Questions

1. What is your immediate reaction to hearing this information? Why?
2. What do you do with this information provided by Amaani's father? Who do you inform, and why?
3. What strategies might be useful in addressing the circumstances of this situation? What cultural aspects, if any, need to be addressed?
4. How can you support the father and the concerns he raises about the wellbeing of his daughter in the long term?

Ethical decision making

ethical decision making a decision based on personal moral, ethical and legal positions that needs to be made between two or more often unfavourable alternatives, in any given circumstance

Ethical decision making by health professionals does not occur in a vacuum, but is informed by a complex interplay of professional judgement, ethical principles and legal requirements. Reconciling all these factors within the health care setting can be challenging, especially when providing care to people with a mental illness. Health professionals are best to seek the appropriate level of advice, support and supervision to enable them to participate in decision making that is based on sound ethical principles. It is also important that health professionals keep up-to-date in their learning and achieve acceptable levels of competence to ensure the decisions made are translated into sound ethical practice.

The process of ethical decision making is supported by a number of professional bodies. For example, the Australian Nursing and Midwifery Accreditation Council has developed a national decision-making framework to assist health professionals to make calculated and informed decisions regarding their clinical work. This framework can be effectively utilised by all health professionals, across the multidisciplinary team, in the course of their work.

In addition to utilising decision-making frameworks, there is a need for health professionals to reflect upon the way in which they enter into a social contract with their clients, other health professionals and the wider community. This social contract demands that health professionals utilise a particular set of clinical skills and demonstrate appropriate ethical, legal and social behaviours (West & Warchal, 2010). Such behaviours include those that are viewed as acceptable by the societies and cultures within which the health professional is located, and uphold the basic values of those societies or cultures. Indeed, there is an implicit expectation that health professionals in Australia will support the moral, ethical and legal principles of the socio-cultural context in which they live. In so doing, their work will serve to maintain the fundamental social fabric of the Australian community and thus improve population health outcomes (see chapter 4).

This section described the most important legal and ethical principles in the provision of health care in Australia today, and applies these principles to situations that involve people with a mental illness. In the next section, notions of capacity and competence are described. Understanding these notions is important for health professionals who encounter people with mental health problems. This is because the perceptions of capacity or competence can significantly affect the type of care and treatment the consumer receives.

Capacity and competence

An understanding of the concepts of **capacity** and **competence** is vital to ensuring the consumer's autonomy and right to self-determination are respected. Under common law in Australia, all adults have the right to refuse any treatment that is offered to them, as long as it can be demonstrated that they possess the capacity to make this decision. This legal right remains, even if the expected outcome could be detrimental to the person concerned. In these situations, people who refuse treatment may pose a significant challenge to the practice of the health professional — particularly if the person's wishes differ from those of the multidisciplinary team, partners, carers, family members or significant others.

Prior to discussing the concepts of capacity and consent, the **doctrine of necessity** needs to be considered. This doctrine or principle is paternalistic in nature. Even so, it allows for the provision of care to a person, with or without their consent, where it is considered necessary to save the person's life, prevent serious damage to the person's health, and prevent the person from experiencing or continuing to experience significant pain or distress (Queensland Health, 2011, p. 9; Allston, 2011). In the field of mental health, an example of the adoption of this principle occurred in August 2009 in the Supreme Court of the ACT when Chief Justice Higgins made a legal judgement that the rights of an elderly man with a history of paranoid schizophrenia who was starving himself would not be violated if medical practitioners intervened to save his life (*Australian Capital Territory v JT* [2009] ACTSC 105). The man was refusing to eat or drink because he believed that fasting would bring him closer to God (Fallon, 2010). Consistent with the doctrine of necessity, he was treated without his consent, and his life was saved.

capacity a legal term that is used as a basis to determine that a person has understood the information provided to them, and that the person has made a decision based on their ability to process this information, including the benefits and risks involved

competence when a person can speak, understand and comprehend the language used to communicate information to members of a community; satisfactory processing of this information allows a person to perform tasks and duties to an expected level within the community

doctrine of necessity allows health professionals to provide non-consenting care to a person in order to save the person's life, to prevent serious deterioration of the person's health and to minimise ongoing significant pain or distress

This example demonstrates that health professionals will sometimes be placed in situations where necessity requires them to act against the specific wishes of a person. When providing care to people with a mental illness, such situations will often be made based upon the level of competence or capacity of the person requiring treatment. Determining competence and capacity, however, is no easy task. This is discussed in the following section.

Principles of capacity and competence

As mentioned previously, in order to determine if an individual is able to give their informed consent to a treatment option, it is important to demonstrate their capacity and competence to make such decisions. It is therefore necessary to understand the meaning of the terms 'capacity' and 'competence' as applied to the health care setting. These principles enable health professionals to determine whether a person has given valid consent for a particular treatment or investigation to be carried out.

In Australia, a person is considered to have the capacity to make decisions about their health care and/or treatment unless it can be demonstrated otherwise (e.g. they have an impairment or disturbance of mental functioning that affects their capacity to make a particular decision). This is the first principle of defining competence. The second principle is that the level of competence required is proportional to the seriousness of the medical decision. This is sometimes referred to as 'requisite competence'. For example, a greater level of competence is required for contemplating whether to consent to a total hysterectomy than choosing between oral and intravenous antibiotic therapy. The final principle is that the determination of competency is only specific to one particular decision and time frame. This is important to remember as consumers who are receiving involuntary care and treatment may still be competent to consent to other medical care (Queensland Health, 2011, p. 13). Moreover, people with a mental health impairment who are considered to have the capacity to make a particular decision have the same rights to make unwise or risky decisions as those without such an impairment.

At the same time, the issue of informed consent is complicated because the individual's capacity to make an informed decision may be compromised by their mental illness. It is therefore important that an assessment is made of the person's capacity to give their informed consent (Queensland Health 2011). Consideration also needs to be given to the 'levels' or 'degrees' of capacity and incapacity.

For example, incapacity may be permanent, temporary or partial. Someone who is intoxicated after drinking a large amount of alcohol may temporarily lack capacity, as could someone who has recently had a general anaesthetic. Other causes of incapacity — temporary, partial or permanent — include:

- progressive neurological disease
- delirium
- emotional shock
- pain
- sedation
- communication disability
- mental illness or dysfunction (especially depression, hypomania and phobic states)
- fatigue

- panic and fear
- the effects of medication (legal or illegal)
- intellectual disability
- acquired brain injury (ACT Health, 2008).

Incapacity is a key factor to consider when determining the ability of a person to make a reasonable or competent decision regarding their health care.

UPON REFLECTION

Assessing capacity and competence

Capacity and competence are key factors when determining the cognitive ability of a person to make a decision regarding their health care.

Questions

1. What factors must a health professional consider when assessing capacity and competence?
2. What tools or information may be of assistance to help determine the decision-making capacity of a consumer?
3. How does the complexity of the proposed health care intervention impact on your determination of whether a person is competent to consent or not?
4. What roles do the consumer and carer play in the assessment of the consumer's capacity and competence?

As already mentioned, an adult is assumed to have competence unless it can be proved otherwise. Devereux (2007) describes three clinical tests to determine whether a person has capacity and is competent to consent to a certain treatment or make a particular treatment decision. The clinical tests for competency must demonstrate that the person:

- can understand and retain the information being given to them, especially in relation to the consequences of having or not having the proposed intervention
- believes the information or advice provided
- can assess and use that information in their decision-making process (Devereux, 2007, p. 200).

In the main, people with mental health problems are able to meet each of these criteria. As already noted, they are therefore presumed by the health professional to have competence until it is demonstrated otherwise.

Incapacity

In Australia there is no single definition for incapacity. Instead, legal definitions of **incapacity** are based on a range of common laws with varying statute definitions. For example, in South Australia, mental incapacity is defined in the *Guardianship and Administration Act 1993* as 'the inability of a person to look after their health, safety or welfare or to manage their affairs as a result of any damage to or illness, disorder, imperfect or delayed development, impairment or deterioration of the brain or mind

incapacity the inability of a person to look after their health, safety or welfare or to manage their affairs due to a cognitive deficit that impairs their decision-making abilities (i.e. brain damage or neurological disease), or any physical illness or condition that renders the person unable to communicate his or her intentions or wishes in any manner whatsoever' (s. 3.1, p. 7).

Others have suggested that a person may not have the capacity to make decisions about certain aspects of their lives but retain the capacity to make decisions about other matters (Privacy NSW, 2004). For example, a person may not be capable of making decisions about their financial affairs or major medical treatment, but still have capacity to make decisions about basic health care and general lifestyle issues, such as who they would like information given to or where they want to live. Notions of capacity and incapacity, then, are very complex.

The notion of incapacity is also enshrined in statute law; for example, various state and territory guardianship Acts. As with common law, the provisions of these Acts assume that a person, including the person with a mental illness, has the capacity to make their own decisions unless it can be proved otherwise. These Acts contain specific provision for the administration of treatment to an adult who is unable to give consent.

UPON REFLECTION

Convenience and consent

It is curious that, generally speaking, when a consumer agrees with the recommendations of the treating team, the competence question is not raised or challenged. However, at certain times, when a consumer does not agree to a treatment proposal, their ability to consent may be further scrutinised.

Questions

1. What are your organisation's processes and procedures regarding the consenting process?
2. What role can the multidisciplinary team play in assisting with consent issues?
3. What systems and supports are in place for people who require assistance to understand information, prior to consenting?

Different types of consent

The concept of consent is derived from the ethical principle of autonomy. As noted, consent to a proposed treatment, intervention or medical procedure needs to be informed. It also needs to be given voluntarily and the individual must demonstrate capacity to provide, understand and communicate their consent (ACT Health, 2012).

In practice, there are three distinct types of consent:

1. *implied consent* — indicated by conduct or action; for example, by proffering an arm when a pathology technician explains that they would like to obtain a blood sample
2. *verbal consent* — when an individual is asked if they agree to information being recorded, accessed or shared
3. *written consent* — when consent is agreed to on a signed paper consent form (Queensland Health, 2011, p. 3).

Although all three forms of consent are equally valid in practice, written and verbal consent need to be obtained for all potentially serious investigations or interventions; for example, surgical procedures and general anaesthesia. In summary, for consent to be valid, it must:

- be based on an informed decision — that is, full information needs to be provided to the person regarding risks, benefits and alternatives
- be given freely and without duress
- be given by someone who is competent to make the decision
- be specific and only cover the proposed intervention or procedure (Queensland Health, 2011; ACT Health, 2012).

Awareness of these different types of consent is especially important when providing care to a person with a mental illness. For example, a health professional may interpret a particular gesture or behaviour as implied consent, when, in reality, the consumer is exhibiting a sign of mental illness. This can create problems as the consumer may then react against the health professional's presumption of consent.

Treatment decisions made by a third party

In Australia there is no consistent nationally recognised process whereby another person (including the individual's relatives, carer or significant other) can consent to something on behalf of another adult (Clinical, Technical and Ethical Principal Committee, 2010). In situations involving minors, it is important to check the relevant state or territory legislation governing consent to health care and treatment for younger age groups, particularly for 14- to 16-year-olds. However, in a medical emergency, health professionals are not required to obtain consent before starting the minimum treatment required to preserve life.

Power of attorney

In some states and territories it may be possible for an individual to appoint another person to make treatment decisions on their behalf; for example, by appointing someone to act in the role of 'enduring power of attorney (medical treatment)'. This allows the person appointed (the 'attorney') to make medical decisions — in consultation with health professionals and other relevant people — when the signatory is no longer capable of making such decisions for themselves. Anyone can be appointed to act in this role. The attorney is not permitted to refuse reasonable medical procedures for the relief of pain, suffering and discomfort or the reasonable provision of food and water, although they can refuse other forms of treatment (The Law Handbook, n.d.).

There are four main types of power of attorney; each state and territory has slightly different types, each with varying uses and powers.

1. *General power of attorney* can be used when an individual is unable to manage their affairs or sign documents because they are overseas or in hospital.
2. *Enduring power of attorney* comes into effect when individuals are no longer able to look after themselves. A general power of attorney would not continue to be effective if the person loses their mental capacity, but

an enduring power of attorney would. In some states and territories there may be some crossover with enduring guardianship.

3. *Medical power of attorney* is known by the names 'enduring power of attorney' (ACT and Queensland); 'enduring power of attorney — medical treatment' (Victoria); 'medical power of attorney' (South Australia); 'enduring guardianship' (NSW and Tasmania); 'guardianship orders' (Western Australia); and 'medical enduring power of attorney' (Northern Territory). The person appointed to take on any one of these roles is able to make life and death decisions about the individual concerned, including whether the individual should continue on life support equipment.
4. *Enduring guardianship* becomes important when an individual is no longer able to make certain lifestyle decisions, such as where and with whom to live, what health care to receive, and daily issues such as diet and dress. An enduring guardian can consent (or refuse to consent) only to treatments that are provided to promote or maintain the health and wellbeing of the person for whom they have been appointed to act. They can make decisions regarding:
   - medical and dental treatment that will promote the individual's health and wellbeing
   - access — that is, who the individual will see
   - restrictive practices function — to protect the individual from self-harm
   - how the individual will receive treatment; for example, whether the individual needs to be registered with a particular doctor.

An appointed enduring guardian cannot provide a lawful consent to euthanasia. In some states and territories the individual may need to appoint an enduring guardian rather than an enduring power of attorney.

It is important that all health professionals have some understanding of the processes related to the appointment of a power of attorney. For example, consumers with a chronic or enduring and serious mental illness may have someone acting in the role of attorney to oversee their finances or to determine what kind of health care they will receive. Health professionals are responsible for checking such arrangements are in place and who with, and for ensuring that the correct processes are followed.

Advance care agreements

Advance care agreements are becoming increasingly important across Australia. These documents are also known in some states and territories as advance care directives, advance health care directives or advance health directives. Advance care agreements are a written record of an individual's wishes about serious and sensitive health care issues, such as their views on invasive medical procedures and appropriate treatments. In the field of mental health, an advance care agreement or directive is written by a consumer when they have the capacity to make decisions about the type of mental health treatment that they wish to be provided when they are acutely unwell or unable to give informed consent.

An advance care agreement or directive can be written only if the individual concerned has the capacity to do so. It can be changed or updated as often as required until the individual no longer has the capacity to change it. These documents can also include directions about life-sustaining treatment. For example, a person with multiple, long-term and/or painful life-limiting conditions may request in their advance care directive that in the event of a medical crisis they are not to be resuscitated. It is essential that family, carers and/or significant others are aware of such requests well in advance of a medical crisis to ensure they understand and support the wishes of the person making the directive.

It is also important for health professionals to clarify whether a person has an advance care directive before initiating treatment. The existence of an advance care directive needs to be recorded in the person's clinical record. The instructions of this document are legally binding in most jurisdictions in Australia, and, if advance care directives are not legislated in a particular state, they may be valid under common law (Australian Health Ministers' Advisory Council, 2011). The directives in an advance care agreement must be respected and considered by health professionals and the multidisciplinary team who are making the treatment decisions.

Legal issues

In Australia today, all mental health legislation overrides advance care directives (Australian Health Ministers' Advisory Council, 2011). The Australian Health Ministers' Advisory Council (2011) has published the *National framework for advance care directives* to educate regulators, policy makers and health care professionals regarding the current position and spirit of advance care directives. This document is not intended for the general public. Further, to assist policy makers and managers, the framework also includes the Code of Ethics and the Best Practice Standards for the development of law and policy regarding advance care directives.

As already noted, the use of advance care directives has gathered momentum in Australia, notwithstanding the very limited Australian case law supporting the legality of advance care directives. Figure 3.2 provides an example that explains why the advance care directive is particularly important for consumers of mental health services and their carers, who are seeking to empower themselves and feel strongly about their right to self-determine.

FIGURE 3.2 Maximising consumers' autonomy, dignity and control

The Mental Health Legal Centre (MHLC) maintains a strong position that each consumer knows best about the lived experience of their 'illness' and that decisions made by others on their behalf will never adequately substitute for the decisions people make for themselves about their own lives. Self-determination is crucial to anybody's ongoing wellbeing. Advance directives provide a more formal means for the declaration of the treatment preferences and carrying out instructions of service users.

We are keen to promote ways that maximise the opportunity for consumers to claim their own power and sovereignty at all times.

Advance directives are one important way that mental health services can be better informed not only about the wishes and preferences of each person, but also consumers in general. It is critical that the service system can demonstrate an understanding of the perspective of people with a psychiatric disability regarding decision-making processes and the experience of being a recipient of mental health services, particularly if under involuntary detention.

Advance directives are one way that consumers can seek to maintain authority over their own lives in a way that will in both the long and the short term keep

(continued)

FIGURE 3.2 *(continued)*

them well. The MHLC is committed to working with people to design advance directives in a way that leaves them with maximum autonomy, dignity and control but without deception about the limitations of the law as it presently stands.

The message coming through loudly and clearly from consumers is that the introduction of living wills or advance directives which have some legal force would mean an improvement in the recognition of their rights. In our view the introduction of some form of advance directive must be pursued with appropriate legal status to ensure that they are considered and respected.

There is also a strong view that, even if they are not legally enforceable, they may be of value for people in both the process of development of the document, and the possibility that mental health workers will give them serious consideration even if they are unenforceable. It is our overwhelming experience that non-enforceable principles of aspiration will be vastly less effective than enforceable rights.

People with psychiatric disability very quickly lose their right to participate in decision making. What people experience is that once they are deemed incapable of consenting, they are excluded from meaningful participation in many life decisions. Participation and consultation are cornerstones of the National Mental Health Strategy. The principle that people should be given the opportunity to influence the treatment they receive, and their preference should be granted wherever possible, is enshrined in the United Nations Principles and National Mental Health Standards, even where they are deemed to be involuntary under mental health legislation. To the extent that advance directives can create the maximum participation possible, they are desperately needed.

Source: Mental Health Legal Centre Inc. (n.d.)

Information required to make an informed decision

To make an informed health care decision, the individual must demonstrate that they understand in broad terms:

- the nature of the proposed intervention
- the purpose of the proposed intervention
- the risks and benefits of the proposed intervention
- the possible risks and consequences associated with not carrying out the proposed intervention
- the possible risks and benefits of alternative interventions.

For consent to be valid it must be given voluntarily and the person must be in possession of all the relevant information pertinent to the intervention being proposed. Consent is not necessarily valid just because the person has signed a consent form. It is up to the health professional to demonstrate that they have provided the information required for informed decision making.

There are some professional codes which provide direction during this type of circumstance. For example, the *Code of professional conduct for nurses in Australia* guides practice in relation to consent and refusal to treatment, stating

> When patients … are no longer legally competent and thus have lost the capacity to consent or refuse treatment and care, you should try to find out whether they have previously

> indicated preferences in an advanced statement. You must respect any refusal of treatment or care when they were legally competent, provided that the decision is clearly applicable in the present circumstances and there is no reason to believe that they have changed their minds (Australian Nursing and Midwifery Council, 2008b).

This statement also reinforces the importance of advance care directives or agreements. A significant role of the health professional, then, is to promote the use of these agreements to consumers and carers. If the preferences of the consumer or carer are clearly articulated and made available to health professionals, then informed decisions are more likely to be made.

Duty of care

Health professionals owe the consumer a duty of care and need to ensure that the consumer does not come to any unnecessary harm as a result of negligence or omission (ATSI Health Practice Board of Australia, n.d.). Duty of care is established through common law and is applicable to all health care settings and individual professionals. Exercising a duty of care means that an individual health professional must take responsibility for ensuring that they are competent to meet the care needs of the people they help or care for.

Health services and other institutions responsible for the organisation and provision of health care also have a corporate duty of care and need to ensure that there are adequately trained staff and facilities to meet the person's needs. A review of these responsibilities is routinely undertaken by agencies such as the Australian Council of Healthcare Standards during the health service accreditation processes.

At times, the health professional's duty of care may appear to be in conflict with a consumer's right to autonomy and self-determination. For example, it can be difficult to reconcile the wishes of an individual client to refuse treatment (autonomy) with the professional and legal obligation to provide care. In essence, health professionals need to demonstrate that their actions are:

- reasonable
- in the person's best interests
- undertaken with the person's informed consent.

An exception to this would be when the person fails the test of capacity. In such cases, the health professional's duty of care will form the basis of subsequent actions.

A prime example of this would be the presentation of a mental health consumer who is exhibiting aggressive or destructive behaviour that seems to be out of control, in the community or in an emergency department. The consumer is unable to give consent and is refusing treatment. To protect the consumer, community members and also the health professionals from physical harm, a decision is made by the medical officers, nursing staff or, in some states and territories, the paramedics, to rapidly tranquilise the consumer. In light of the overall context, this decision is deemed to be reasonable and in the consumer's best interests, even though it is undertaken without their consent and is contrary to the consumer's right to autonomy and self-determination. The decision is also consistent with the doctrine of necessity, the harm principle and notions of duty of care.

IN PRACTICE

Practical issues to consider

Scenario 1

Dr Mooney refers a client to your team for follow-up. Felicity is a 31-year-old school teacher, currently on sick leave, who lives with her husband and 6-year-old daughter in a townhouse in a wealthy part of town. Dr Mooney describes a four-week history of agitation, suspiciousness, paranoid thinking and hypervigilant behaviour that does not seem to be responding to medication. Dr Mooney has found rapport development with Felicity difficult.

You meet Felicity for the first time, and within a few minutes she gives you a packet of oral antipsychotic medication and says, ‘They told me to take this or else they'd put me in hospital. They said it would help me to relax, but I want to know what it is really for’.

Questions

1. Given the clinical picture, is Felicity competent to make decisions regarding her health?
2. What information has Felicity been provided about the medication? Is it enough to enable her to make an informed decision about taking this medication?
3. What is the duty of care of the health professional in this situation?

Scenario 2

Emma, a 27-year-old mother of two, arrives for a final review meeting following ten months of antipsychotic treatment and a course of electroconvulsive therapy to treat post-partum psychosis. At the meeting with Emma, her family and the multidisciplinary team, Emma presents the multidisciplinary team with an advance care directive outlining her wishes regarding the use of psychotropic medication in the event of a future psychosis occurring. Emma has made an explicit request that she not be treated with any atypical antipsychotics in the future because of the unwanted side effects of the medication (i.e. Emma gained 24 kilograms in three months when prescribed this medication). Despite the effectiveness of the medication, Emma is not prepared to tolerate another weight increase and the associated reduced self-esteem and other physical problems.

Questions

1. What do you understand about the term ‘advance care directive’?
2. How would you reconcile Emma's request under an advance care directive if the directive does not fit comfortably with your value system?
3. What are the ethical reasons for your answer?

Reasonable and unreasonable

An important principle in deciding whether to act contrary to a person's expressed wishes concerns the issue of 'reasonableness'; that is, to what extent the health professional can directly intervene in a particular situation or with a particular client. For example, if a person is admitted to hospital following a deliberate overdose of medication, it would be reasonable to ask the person whether they had any substances on them that they could use to harm themselves during their admission in hospital. Such a request is reasonable because of the risks associated with overdose and the likelihood of someone repeating their actions (see chapter 8), even when they are in hospital.

To ask the question of the person demonstrates accountability to the health professional's duty of care and may be considered a reasonable action, illustrating the health professional's commitment to the safety of the consumer. However, despite being aware of the potential risk of repeated self-harm, it would be unreasonable in this situation to search the person and their belongings without the person's permission, as the degree of force associated with this action would be disproportionate to the degree of risk posed (see the following section on restraint).

The principle of acting in a way that is contrary to a person's expressed wishes (or in the absence of knowing whether the person would wish the treatment to proceed) is connected to the health professional's duty of care. Common law provides the legal framework by which health professionals can:

- detain someone against their will
- give urgent treatment in an emergency situation to someone who lacks capacity to give consent.

In practice, common law allows an individual to apprehend or restrain a person if there are reasonable grounds to believe that person poses a significant danger to themselves or others and would continue to do so if allowed to leave a safe environment or to continue to engage in risk-taking behaviours. The degree of physical intervention, such as physical restraint, needs to be enough to bring the emergency situation to an end, but must not be excessive. Any restraint that involves disproportionate force, or which continues after the immediate crisis is over, cannot be justified. Additionally, the person carrying out the restraining action may be legally compromised if they continue to maintain force that is considered unnecessary or excessive.

Least restrictive environment

The principle of 'least restrictive environment' is upheld by the mental health legislation enacted in each state and territory in Australia. This legislation, which is described in the next section, also guides the use of restraint and seclusion of consumers by health professionals. The fundamental issue is that a complete and appropriate assessment of the person's capacity to make a decision must be undertaken prior to initiating action to restrain the individual. This assessment, and any other information that is used to inform the decision to restrain an individual against their will, must be documented.

It is important to note that Australia's ratification of the United Nation's Convention on the Rights of Persons with Disabilities came into effect on 16 August 2008. Australia subsequently lodged an interpretive declaration, the second paragraph of which states:

> Australia recognizes that every person with a disability has a right to respect for his or her physical and mental integrity on an equal basis with others. Australia further declares its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards (Weller, 2009).

This suggests the need to ensure the most appropriate actions are taken and that health professionals act in the consumer's best interests by examining all relevant factors and events that have led to the presenting situation. This will include issues such as the person's previously expressed wishes, the views of family, carers and/or significant others, and an evaluation of the risks and benefits of intervening versus not intervening (AHMAC, 2011). A framework for reflecting in practice is suggested in table 3.3 as a means of planning actions in situations that may be challenging or complex (Harrison & Hart, 2006).

TABLE 3.3 Framework for responding to people who lack capacity

Consider	Rationale
Personal safety — does the person present an immediate risk to self or others?	If refusing the proposed intervention is likely to have life-threatening consequences for the person or others, intervention is justified under common law. If failing to act is subsequently proved to have been negligent, the health professional will be in breach of their duty of care.
Does the health professional possess all the relevant information about the situation?	It is important to obtain as much collateral history and supporting information as possible. Sources of information include: • the person's family/carer or significant other • background to the current presentation • current social or interpersonal difficulties/problems • effects of alcohol or illicit drugs on the person's mental state • effects of shock, sedation or medication on the person's ability to communicate • the person's previously expressed wishes regarding the situation (e.g. have they prepared an advance care directive regarding treatment in this situation?).
The health professional's knowledge and skills base — does the health professional consider him or herself confident to respond to this situation?	• Health professionals and/or their colleagues must have adequate training and access to clinical supervision. • All registered health professionals must be competent in the assessment of capacity (ADASS, 2011). • Ensure the health service has up-to-date policies and clinical guidelines in place for the management of such situations. For example: – Do the health professionals know how to access specialist help? – Are they aware of their role in assessing capacity? – What support and advice — such as additional staff, access to on-site security personnel — can they expect to receive? (See chapter 8 for additional information.)

Consider	Rationale
What alternatives are available to the health professional in this situation?	If the situation is not life threatening, it may be possible to plan alternatives to direct physical intervention. Are there other staff in the health service to whom the health professional can refer for assistance? Queensland Health (2011, p. 14) suggests the following must be considered. • If safe to do so, postpone the decision about intervention until capacity returns. • Secure as much involvement of the person as possible, even if he/she lacks full capacity. • Involve others, such as family or close friends in the decision-making process and the delivery of care. Those who know the person well may be very skilled at reducing the individual's level of arousal and agitation. • Seek a second opinion or refer for a specialist evaluation. However, if this is not possible, a decision regarding an application for Emergency (or long-term) Guardianship may be required by the treating team.
Is the health professional familiar with the mental health legislation of the state or territory in which they are working?	Mental health legislation across Australia only allows for treatment of a mental illness, not a physical illness or treatment of the physical consequences of a mental illness. Given the differences in the federated Acts, there are general core elements that health professionals need to address when considering the use of initiating a course of treatment under their local Act. These elements will be similar to: • the person has a mental illness or mental dysfunction • the person is declining treatment • the person cannot be treated in a less restrictive environment • the person is at risk of harm to either self or others • the person is likely to deteriorate within a short period of time if they are not treated.
The consequences of not acting.	The health professional must be able to defend and justify their actions if challenged. It is therefore important to ensure that the rationale for the chosen course of action is clearly described and documented in the person's clinical records. Details of conversations with partners, families, carers, significant others and colleagues also need to be recorded.

State and territory mental health legislation

In Australia, each state and territory has enacted its own mental health legislation, commonly called a 'Mental Health Act' (MHA). The names of these MHAs are provided in table 3.4 (overleaf). While these MHAs have a number of differences, all are based upon principles ensuring the right of people with a mental illness to autonomy, freedom and self-determination, and the provision of least restrictive health care.

The essential function of each of these MHAs is to protect individual people and the community as a whole. The following interventions may be included and explicitly prescribed in the mental health legislation enacted in the particular state or territory in which the health professional is working:

- mental health assessment orders
- involuntary mental health treatment orders and breach requirements
- restriction orders
- community care orders
- the Mental Health Tribunal membership, function and role
- electroconvulsive therapy and psychosurgery
- referrals by courts
- the provision of official visitors
- private mental health facilities
- the rights of consumers and carers, and the responsibilities of the health professionals
- seclusion and restraint guidelines.

TABLE 3.4 Australian state and territory Mental Health Acts

State/territory	Mental Health Act
Australian Capital Territory	*Mental Health (Treatment and Care) Act 1994*
New South Wales	*Mental Health Act 2007*
Northern Territory	*Mental Health and Related Services Act 2002*
Queensland	*Mental Health Act 2000*
South Australia	*Mental Health Act 1993* (to be repealed); *Mental Health Act 2009*
Tasmania	*Mental Health Act 1996* Mental Health Bill 2012 (introduced in 2014)
Victoria	*Mental Health Act 1986*
Western Australia	*Mental Health Act 1996* Draft Mental Health Bill 2012 (under discussion)

All Australian state and territory MHAs allow for an individual to be detained against their will, sometimes for long periods of time, usually on the basis of what medical practitioners consider that an individual might do, rather than on what they have already done. For example, a person may be detained when they articulate thoughts of harming themselves and/or others, but have not actually attempted to harm the identified person. The MHA is designed exclusively for the treatment of mental illness and mental dysfunction, not physical illness or the physical consequences of a mental illness.

Sectioning and scheduling

Each MHA is divided into several parts or sections or schedules, from which comes the term 'sectioning' or 'scheduling'. Being sectioned or scheduled means an individual has been compulsorily admitted to a hospital for assessment or to receive treatment for a mental disorder. This includes disorders such as schizophrenia, bipolar disorder, depression, anxiety, eating disorders and obsessive–compulsive disorders. There are a number of conditions that must be met before someone can be compulsorily admitted to hospital. For example, in Victoria a person can be compulsorily admitted only if all of the following are met:

- they appear to have a mental illness
- they require immediate treatment, which can be obtained by making the person subject to an involuntary treatment order
- because of the mental illness, they require involuntary treatment for their own health or safety (whether to prevent a deterioration in their physical or mental condition, or for the protection of the public)
- they have refused or are unable to consent to treatment
- they are unable to receive adequate treatment in a less restrictive manner (The Law Handbook, n.d.).

It also needs to be noted that not all sections of the MHAs are relevant to an acute care facility setting, although a number of sections are seen in this setting with some frequency. MHAs are also used to treat people in the community.

The application of the MHA can be a complex and time-consuming process, particularly for health professionals who do not have to deal with this legislation on a regular basis. Table 3.5 provides a brief example of the continuum of involuntary care pathway that is generally followed by mental health legislation across Australia.

Despite the complexities, it is important for health professionals to remember that failure to ensure the MHA is interpreted accurately or to ensure that people are detained only as specified in the legislation, could result in the person being detained unlawfully. Interpretation of a MHA is generally undertaken by health professionals, including medical practitioners, psychologists, registered nurses and social workers. Lawyers and the police also have an important role. This interpretation is supported by a number of legal instruments, protocols and procedures that provide 'checks and balances' to guard against misinterpretation. The protocols and procedures also provide detailed guidance for health professionals to support them in their work of caring for the person with a mental illness.

TABLE 3.5 Example of the continuum of involuntary care pathway provided under Australian state and territory Mental Health Acts

Duration of detention	Reason	Comments*
4 hours	Detention of a person who a police officer or appointed health professional suspects has a mental illness or mental dysfunction that requires urgent treatment	This short detention is a mechanism under the Act to allow the person to be transported to a scheduled or gazetted facility for further assessment. The person detained must be taken to a 'place of safety'**, usually a police station or a hospital.

(continued)

TABLE 3.5 *(continued)*

Duration of detention	Reason	Comments*
72 hours	Detention of a person who requires a further assessment period in hospital	This is the section most likely to be used within an acute care facility and this detention can only be attended and authorised by a medical officer. Treatment without consent (except any that needs to be given as a life-saving measure) cannot be given while the person is subject to the MHA.
Up to a further 7 days	Assessment	The treating team makes an application to the Mental Health Tribunal for a further detention period. This is generally used if the person has no recent history of admission under the Act, or where the diagnosis is unclear, or the response to treatment is slow and risk issues remain. This detention period is approved/declined by the Mental Health Tribunal (or equivalent). The person has the right of appeal to the Mental Health Tribunal.
Up to 28 days	Assessment and treatment	The diagnosis remains unclear and progress is slow. This detention period is approved/declined following an application to the Mental Health Tribunal (or equivalent). The person has the right of appeal to the Mental Health Tribunal (or equivalent).
Up to 6 months	Treatment	The clinical progress is slow and risk issues may still be present. This detention period is approved/declined following an application to the Mental Health Tribunal (or equivalent). The person has the right of appeal to the Supreme Court. People subject to this section are likely to be receiving treatment under the Act in a community or rehabilitation setting.

* Formal documentation accompanies all sections.

** Gazetted facility is not defined in law, but is a matter for local determination. The relevant health services, police force and local government must all agree as to where the local place of safety is. The place of safety should not routinely be the local police station or 'watch house', but rather an appropriate health care setting.

If the MHA is applied inappropriately, the consumer may have a case against the individual health professional or health organisation involved for unlawful detention (false imprisonment) or breach of human rights (Allston, 2011). False imprisonment is the confinement of a person without legal permission, and could be said to occur when the voluntary act of one person directly deprives another person of freedom of movement (Law Reform Commission (NSW), 2004). A high-profile example of false imprisonment is the case of Cornelia Rau, who disappeared from the psychiatric unit of a Sydney hospital in March 2004 and, when subsequently stopped by police in Far North Queensland, identified herself as a German tourist who had overstayed her visa. Initially detained as an 'unlawful non-citizen', Ms Rau spent six months in a Queensland prison alongside convicted criminals before being transferred to the Baxter immigration detention centre. It was not until February 2005 that Ms Rau's true identity became known. Ms Rau has since received a large compensation payment.

The following list highlights some known problems that have occurred during the application of the *Mental Health Act 2000* (Qld), particularly in a non-mental health setting.

- *Incorrect reason for detention*. The MHA only allows for detention and treatment relating to a mental illness; for example, citing the need to give physical treatment for non-emergency medical problems is not allowed, nor is detaining a person who is considered a public nuisance.
- *Forcing physical treatment on a non-consenting person*. Treatment can only be given against a person's expressed wish in certain circumstances.
- *Failing to ensure that the relevant MHA documentation has been accepted by the necessary governing bodies*. If this does not take place within the time frame stipulated in the Act, the health professional may be fined, have penalty points recorded against their name, or be jailed in extreme breaches.
- *Failing to provide the person and his or her nearest relative with written and verbal information regarding their rights*. Under the MHA, people have certain rights; for example, to speak with an advocate and access legal representation. It is therefore essential that these rights are explained in easy-to-understand language.

The appropriate application of mental health legislation requires considerable experience. Even so, health professionals who follow the core principles that underwrite all mental health legislation across Australia are well on the way to providing care that is both legal and ethical. These core principles include upholding the person's human rights, ensuring the care they receive is the least restrictive possible, and providing care and treatment that is appropriate for that person as an individual.

SUMMARY

This chapter summarises the relevant ethical, legal and professional requirements of health professionals in relation to the care of people with mental health issues. Particular emphasis is placed on the need for health professionals to develop clarity regarding the relevant legal frameworks that inform their practice. To assist with this process, the difference between statute and common law is explained. A number of statute laws pertinent to the delivery of mental health care are identified. The impact of common law from the perspectives of duty of care and assault and battery are also discussed.

This is followed by a description of the domains of capacity, competence and informed consent; the harm principle; ethical egoism; and the doctrine of necessity. In particular, it is suggested that an understanding of capacity, informed consent and duty of care is vital if health professionals are to provide care that is legally and professionally accountable and defensible in a court of law.

Consumer autonomy and informed decision-making options for people receiving care for a mental illness are also discussed, including advance care directives or agreements.

The chapter also outlines the mental health legislation prescribing the legal requirements that must be met by health professionals when involuntary detention is authorised. The chapter concludes by identifying the need for all health professionals to meet the legal requirements of the state, territory or jurisdiction in which they work, and the need for all health professionals to have a sound ethical framework that guides their relationships and the care they provide to the consumer, their partner, carer, family or significant others.

Review questions

1. Identify six relevant statute laws from your state or territory that directly impact on your practice.
2. What are the four primary ethical principles that all health care providers are required to practise?
3. What must a person be able to demonstrate for a health professional to determine that the person has the capacity to consent?
4. Name six physical or psychological causes that may temporarily, partially or permanently contribute to a person's inability to provide informed consent.
5. There are three types of consent. What are they?
6. Consequentialism and deontology are just two of many ethical theories. Define these two theories.
7. Define 'duty of care'.
8. What is an advance care agreement?
9. What are the legal requirements for involuntary detention in your state or territory?
10. What does the term 'less restrictive environment' mean?

Discussion and debate

1. In the health context, what constitutes or determines 'risk'? How might risk issues be addressed with people from other cultures?
2. Discuss what you think are the main issues related to notions of 'capacity' and 'incapacity' in the mental health context.
3. What are the main principles that frame all mental health legislation across Australia?
4. Access the mental health legislation (Mental Health Act) in your state or territory and answer the following questions.
    - (a) What are the requirements for detaining someone against their will under your Mental Health Act?
    - (b) Who has the authority to do this?

(c) Who needs to be informed when detention is activated under the Act? How do you inform the relevant body or people? Is there a time frame stipulated to do this?

(d) What information do you need to give to the consumer and their family?

5 Consider the following statement.

> Legislation directs, guides and impacts on the practice of health professionals. Much of the work in a clinical care setting is governed by Commonwealth and state or territory legislation. This legislation is particularly significant for health care practitioners who are working in a clinical setting.

What legislation is applicable on a daily basis for health care practitioners in a clinical setting? How does that legislation impact on your day-to-day work? How can health care practitioners ensure they are performing their role in accordance with the relevant legislation?

6 Describe a potential 'duty of care versus individual rights' conflict or ethical dilemma that may arise in your particular workplace. How might you manage this situation?

Project activity

Advance care agreements or directives are being developed across all areas of health, and in particular aged care, oncology and mental health. Imagine that your jurisdiction is planning to adopt advance care directives as legally binding. Map the advantages and disadvantages for consumers, health professionals, service providers and families if this were to happen. Consider the legal, ethical, clinical and personal domains of all stakeholders in your discussion. How will you manage these competing agendas in your everyday practice?

Websites

The Australian Association of Social Workers is the professional representative body of Social Workers in Australia, with over 7000 members nationwide. The Association is an incorporated company, guided by a constitution and nationally managed by a board of directors, elected from and by the membership: www.aasw.asn.au

The Australian Health Practitioner Regulation Agency is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia: www.ahpra.gov.au

Australian Nursing and Midwifery Accreditation Council is the independent accrediting authority for nursing and midwifery under the National Registration and Accreditation Scheme. It sets standards for accreditation and accredits nursing and midwifery courses and providers: www.anmc.org.au

The Australian Psychological Society is committed to advancing psychology as a discipline and profession. It spreads the message that psychologists make a difference to people's lives, through improving scientific knowledge and community wellbeing: www.psychology.org.au

'Respecting Patient Choices' provides information about advance care planning and agreements in Australia: www.respectingpatientchoices.org.au

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4

Delivering culturally appropriate mental health care

LEARNING OBJECTIVES

This chapter will:

- define the concepts of 'culture' and 'subculture'
- consider the cultural constructions of mental health and illness
- discuss the mental health and wellbeing of the Australian Indigenous peoples
- describe the major mental health issues for people from rural and remote cultures
- outline the most significant aspects of providing mental health care to people from culturally and linguistically diverse (CALD) backgrounds
- explain the importance of providing culturally appropriate care to people with mental health issues.

Introduction

All health professionals, no matter where they work, will interact with people from different cultures. Australia has been described as one of the most multicultural nations in the world (Demetriou, 2010), comprising population groups that belong to the traditional custodians of Australia, the Aboriginal and Torres Strait Islander peoples; and also the cultures of immigrants and refugees — past and present — from Africa, America, Asia, Britain, Europe, India, the Middle East and other regions. In addition, Australia has many different subcultures, a consequence of differences in age, context, education, employment, gender and religion. In the field of health, the influences generated by these cultures and subcultures are inescapable.

In this chapter, health professionals are introduced to the complexities of cultural diversity in the context of mental health and illness. The chapter commences with an examination of the notions of 'culture' and 'subculture'; and goes on to outline the major issues for health professionals when providing mental health care to Indigenous, rural and remote, migrant and refugee populations. A broad approach that includes acknowledging the great diversity between and within cultural groups is recommended, to support the delivery of appropriate mental health care. The chapter also outlines how cultural differences can be effectively negotiated by health professionals, by demonstrating acceptance, respect and a commitment to listen to people from culturally and linguistically diverse backgrounds.

The pervasive nature of culture and subculture

Until the 1970s, with the development of cultural studies as an intellectual movement (Hall, 1980), the meaning of 'culture' was relatively narrow. A person could enjoy 'culture' by going to the opera, ballet or an art exhibition. Alternatively, many nations or ethnic groups could boast of a way of life or 'culture' that was quite distinct from other groups. Today, the meaning of culture is much wider, in that it encompasses notions of knowledge, beliefs, attitudes and behaviours of groups of people.

In this section, the terms 'culture' and 'subculture' are defined in light of contemporary Australian society. Consideration is also given to the way in which cultures and subcultures affect the interactions between health professionals and consumers, together with their carers or family members, friends, and other community members.

Culture and subculture

The Australian culture is difficult to define. For example, some people associate Australia with Bondi Beach, the Outback, and kangaroos or koalas. Others think of 'a fair go' or the ANZAC tradition, or link Australia to sport. But where does that leave the Aboriginal and Torres Strait Islander peoples, multiculturalism, and **globalisation?**

Definitions of 'culture' and 'subculture'

Culture is the accepted patterns of knowledge, beliefs, attitudes and behaviours by which a group of people live — it is the shared history, traditions, values, attitudes,

globalisation the process by which the world's nations, economies and cultures are becoming increasingly interdependent — a result of technological advancement and improved telecommunications infrastructures, transportation and business networks

culture the accepted patterns of knowledge, beliefs, attitudes and behaviours by which a group of people live goals and practices that characterise a group (Gustav, 2012; Jahoda, 2012; Williams, 1963). This means that culture is the means by which people make sense of the world. A person's cultural background shapes and guides every aspect of their life — including their professional life, the way they understand health and ill-health, and how they view and relate to others.

A culture is not the same as a **society**. A human society is a large group of people who are connected by way of proximity, politics, the economy, social status, social networks or some other shared interest (Griswold, 2013). While this description has a number of similarities to the notion of culture, people who make up a society do not always share the same cultural background. For example, the Australian society has the one national government, but comprises many different cultures. In the same way, the capital cities in Australia have quite distinct local economies and interests, and are also made up of a variety of cultural groups.

society a large group of people who are connected by way of proximity, politics, the economy, social status, social networks or some other shared interest

Cultures have grown from the need of people to make sense of their world through shared understandings of 'the way things are' (Bass, Eaton, Abramowitz, & Sartorius, 2012). These shared understandings give rise to cultural groups, which are defined by their own distinct beliefs, values, and ways of life or seeing the world. As Erikson wrote in his seminal work *Wayward puritans* (1966), different societies will develop their own 'cultural space . . . "ethos" or "way"' (p. 10), and live accordingly. This means that each person's sense of 'right' is determined by the societies and also the culture(s) to which they belong; and this sense of right or the best way of doing things in turn leads to each person's adherence to the established social order (Griswold, 2013). For example, if a person desires to be accepted as part of the group, they are less likely to behave in a way that other people in the group view as 'wrong' or 'just not the way we do things around here'. This dynamic provides one reason why cultural influences are so very powerful and able to shape — even control — a group's thoughts, feelings and behaviours.

Another significant aspect of culture is **subculture**, which describes the culture of smaller discrete groups of people located within larger cultural groups. These groups share a subset of common attitudes, values, goals and practices (Loewetitiial & Lewis, 2011; Pargament & Lomax, 2013). For example, a person who has grown up in western Sydney will have a different view of the world, the community and also of what it is to be Australian, from a person raised on Sydney's North Shore or much further afield in Cairns, Launceton or Kalgoorlie. These differences are the result of geographic and socioeconomic factors. Again, an Australian who is a Christian will have a different understanding of the world from an Australian who is a Muslim; an Australian who has lived most of their life in the twentieth century will see things differently from an Australian who has lived most of their life in the twenty-first century. In short, there are now more than 23 million people living in Australia, each of whom will be connected to, shaped by and interpreting the world according to the larger Australian culture while at the same time being heavily influenced by the various groups or subcultures to which they belong.

subculture the culture of smaller discrete groups of people, located within larger cultural groups, who share a subset of common attitudes, values, goals and practices

The influence of culture on health professionals

Cultural and subcultural influences will affect the health professional in a number of ways. Firstly, the culture to which the health professional most identifies will form an integral part of the way they view their work. This is because the health professional's cultural background serves as a filter through which they observe, act, react to and interact with others. It is important, then, that health professionals are aware of the cultural influences that affect the way they live and how these cultural influences will impact their professional roles.

Secondly, cultural influences will shape the way other people relate to the health professional. For example, a person's cultural background affects their response to stress, and also how they communicate or disclose information, complete tasks, and perceive life and death. Likewise, a person's view of health and illness will influence their perceptions of and interactions with the health professionals who are helping them. For example, a positive view of health professionals will support the person who is receiving care and bring about benefits, whereas a less positive view has the potential to reduce the benefits.

Finally, a person's culture and subculture will also affect the way they understand mental health and illness. This includes the way they accept a diagnosis of mental illness and the recommended interventions; the kind of support they receive from their family or community; and, consequently, how they recover. This is discussed in more detail in the next section, together with the way cultures and subcultures shape understanding of the notions of 'normal' and 'abnormal'.

UPON REFLECTION

Culture, subculture, mental health and mental illness

All of us are influenced by our cultural and subcultural 'norms' — that is, the beliefs and values of a group that govern how that group will behave. Such cultural or subcultural norms include our beliefs and values regarding mental health and illness.

Questions

1. What are the main cultural and subcultural groups to which you belong to?
2. What are the beliefs and values of these groups in relation to mental health and mental illness?
3. How much do these beliefs and values influence you as a person and also as a health professional?

Cultural constructions of mental illness

The cultural constructions of mental illness — that is, the different ways in which cultural groups understand or perceive mental illness — have been given considerable attention in the literature (Rosenman, 2012). Seminal philosophers Goffman (1961) and Foucault (1961) were among the first to associate 'madness' with notions of social exclusion, social control, disempowerment and 'other'. Levine and Levine (1970) went on to discuss the arbitrary construction of mental illness in Western societies, noting that during conservative times the causes of mental illness tended to be framed according to an individual's internal make-up; while in times of social and political reform, causes of mental illness were more likely to be related to the influence of cultural environments. This suggests that the way in which mental illness is perceived or understood by a society or culture is not fixed or universal; rather, understandings of mental illness change according to the circumstances of the time and location.

More recently, it has been argued that people with mental health issues will look to those around them — to the communities, and the attitudes, values, goals and practices of these communities — for explanations of their distress (Holland, 2011). In contemporary Australian society, with its diverse cultural histories, practices, spiritual beliefs and life styles, these explanations will differ. A variety of cultural myths abound and include the following beliefs.

- People with a mental illness are dangerous and more violent than other people.
- People with a mental illness are more likely to be victims of violence.
- Schizophrenia is a spiritual problem — the person is possessed by a demon.
- Schizophrenia is the mother's fault and caused by her poor style of relating.
- You will never recover from a mental illness — once you have it, you will always have it.
- People who belong to some cultural groups are more likely to become mentally ill than people from other cultural groups.

As noted in chapter 1, such views are not based on fact. They also have the potential to stigmatise or cause great distress to people with mental health issues. For this reason, it is right to question their validity.

Indeed, it is essential that health professionals think critically about the many cultural issues involved when caring for the person with mental ill-health, and always refer to the best available research evidence. For example, research does not support the view that people with a mental illness are more dangerous or violent than other people (Hiday & Padraic, 2010). In many societies, however, the news media represents them as such. However, this is one representation only — a representation that is based on cultural values rather than facts (Linden & Kavanagh, 2012). Health professionals must differentiate between fact and fiction, between research evidence and cultural myth, while at the same time ensuring that they respect the beliefs of others and deal with cultural differences proficiently. Ways of achieving cultural proficiency are discussed in later sections of this chapter.

Alternative views to mental health care

The vast majority of health professionals in Australia have been educated according to Western biomedical values. As noted in chapter 1, this model is characterised by diagnostic labelling and linear modes of treatment that are prescribed according to a particular set of symptoms. In the field of mental health, such interventions are aimed at modifying thoughts and behaviours so that they are consistent with dominant cultural **norms** (Dalky, 2012). Alternative or 'other' approaches to health care are often given token consideration only (Kim, 2010; Lavelle & Tusaie, 2011; Minority Rights Group International, 2008). It can often be difficult, then, for the health professional to examine these alternatives.

norms the beliefs and values held by a social or cultural group about the way in which members of that group should behave

Even so, such an examination can be helpful. For example, some people strongly believe that the DSM-5 (see chapter 2) is a tool that has been developed by powerful capitalistic and hegemonic influences in the United States (Rapley, 2012). Common behaviours such as 'shyness' have been pathologised into a 'social phobia'; children who 'misbehave' are diagnosed with an 'oppositional defiance disorder'. By prescribing medication or psychotherapy for these so-called 'conditions', it is argued that health professionals and multinational pharmaceutical companies stand to benefit through an increase in business and profits.

While this point of view may have some basis, it differs to dominant understandings of mental health and illness in Australia today. In a multicultural landscape, health professionals need to be aware of and open to ideas of difference. Even the American Psychiatric Association, the creators of the DSM-5, urge health professionals to consider cultural norms before making a diagnosis. Those who do not consider cultural differences are at risk of pathologising variations in behaviour, belief or experiences that may in fact be appropriate in the context of the person's cultural background.

The remainder of this chapter describes the major issues for people from different cultures who live in Australia today and experience symptoms of mental illness. The information is provided in three sections: Indigenous cultures, rural and remote cultures, and other diverse cultures. The information is introductory only, but will nevertheless enable health professionals to develop an understanding of the way in which a person's cultural background influences their perceptions of 'normal'; and the effect of these influences on health service provision.

UPON REFLECTION

Myths surrounding mental illness

Some people continue to believe that mental illness has been caused by family dysfunction. For example, there are those who may blame the mother of someone who develops schizophrenia, suggesting the way she communicates has confused the person to such an extent that their perceptions of reality have changed. Others will blame unemployment, homelessness or drug use.

Questions

1. Consider the 'nature–nurture' debate. To what extent do you think mental illness is a product of nature and a product of nurture? Why?
2. How could the cultural myth that contends that family dysfunction causes mental illness affect family relationships for those with mental health problems?
3. How could the cultural myth that family dysfunction causes mental illness affect the relationship between health professionals and the families of people with a mental illness?

Mental health and Indigenous cultures

Australia is populated by just under 700 000 Indigenous peoples (Australian Bureau of Statistics, 2012c). According to MacRae et al. (2013), the death rate for Indigenous Australians is 1.9 times the rate for non-Indigenous Australians; and the life expectancy for Indigenous Australians is 10–11 years less than estimates for non-Indigenous males and females. The leading causes of death among Indigenous peoples are cardiovascular disease, neoplasms (mainly cancer) and injury; with infant mortality still higher than for non-Indigenous Australians (MacRae et al., 2013). The **burden of disease** among Aboriginal Australians and Torres Strait Islanders is 2.5 times higher (Australian Indigenous Health*InfoNet*, 2009). Also of concern is the mental health and wellbeing of Indigenous Australians (reflected in rates of depression, substance use and also intentional self-harm), for which the associated death rate for Indigenous Australians is 2.4 times that for non-Indigenous Australians (MacRae et al., 2013; Purdie, Dudgeon and Walker, 2010).

burden of disease the overall impact of disease or injury on a society, including that which is beyond the immediate cost of treatment. Burden of disease incorporates individual, societal and economic costs.

The focus of this section is the mental health and wellbeing of Indigenous Australians. Firstly, the diversity of indigenous cultures across Australia is considered, together with the traumas many Indigenous Australians have experienced since colonisation that have led to great psychological and other distress in so many Indigenous communities. It is then explained that there is a dire need for all health professionals to acknowledge the range of significant health issues experienced by Indigenous peoples in Australia, and to work together to redress the inequities involved.

What is meant by 'indigenous'?

The United Nations has reserved the right of indigenous peoples to define who and what is 'indigenous'; and also to maintain and develop their own distinct identities, characteristics and cultures (United Nations Secretariat of the Permanent Forum on Indigenous Issues, 2004). This right to self-define is necessary as it is only through self-definition that indigenous peoples can self-determine. Likewise, it is only through self-determination that indigenous peoples can shape their futures. With an estimated 5000 distinct cultures arising out of the 300–350 million indigenous peoples who are currently living across 72 countries globally, reaching some understanding of what it means to be 'indigenous' is a complex task (International Working Group on Indigenous Affairs, 2001).

Broadly speaking, indigenous peoples may be described as diverse groups of people with similarly diverse backgrounds, who share a number of traditions in relation to religious or spiritual practices, language, lifestyle, and family systems or community beliefs, together with close ties to or long traditions connected to the environment, ancestral lands or 'country' (National Aboriginal and Torres Strait Islander Health Council, 2003; Purdie, Dudgeon and Walker, 2010; Rigby, Rosen, Berry, & Hart, 2011). Figure 4.1 (overleaf) details a number of these common characteristics across the cultural, political, spiritual, ecological and social spectrums.

In Australia, the term 'Indigenous peoples' is commonly used to describe the Aboriginal and Torres Strait Islander peoples, the traditional custodians of Australia. Some groups, however, have challenged the use of the term 'Indigenous'. This is because the term does not acknowledge the significant differences between the Aboriginal and Torres Strait Islander cultures. For example, prior to the British settlement, there were many hundreds of languages and social groups in Australia; today, while less than 200 remain, each group has its own distinct way of understanding the world. Using the plural 'people**s**' after the word 'Indigenous' is one way of acknowledging this diversity (Taylor & Guerin, 2010).

Similarities between the many and diverse indigenous cultures worldwide include:

- distinct traditions in relation to their own spiritual practices, languages, lifestyles, family systems and beliefs, together with a desire to preserve these traditions for future generations
- close ties or long traditions with the environment, land, 'country' or ancestral sites. In some communities, this may relate to notions of managing and protecting the environment and ancestral or 'sacred' sites. In other, now urbanised communities, these ties may be more abstract or metaphorical
- strong family and community connections
- a sense of shared collectivity with other indigenous peoples and cultures, including common ways of knowing the world around them
- a history of repression by the dominant cultures, resulting in current disparities in standards of living and health status
- a common view of the importance to self-determine to enable political, social and economic equity
- a 'whole-of-life' view of health and wellbeing.

FIGURE 4.1 Commonalities shared by indigenous peoples worldwide

Source: National Aboriginal and Torres Strait Islander Health Council (2003); O'Brien (2005); O'Brien and Jackson (2007); Purdie, Dudgeon and Walker (2010); Rigby, Rosen, Berry, & Hart (2011); Roxbee and Wallace (2003)

Indigenous Australians in urban areas

According to the Australian Bureau of Statistics (2012c), more than 30 per cent of Indigenous peoples in Australia live in the major capital cities. The remainder are evenly distributed across inner regional areas (approximately 22 per cent), outer regional areas (approximately 23 per cent) and remote or very remote areas (approximately 24 per cent). Overall, approximately 75 per cent of Indigenous Australians live in areas designated as 'urban'. Consequently, Indigenous cultures and communities across Australia are often described as urbanised (Kingsley, Townsend, Henderson-Wilson, & Bolam, 2013).

The urbanisation of Indigenous populations in Australia has given rise to a number of changes to their socio-cultural practices. For example, urbanisation has meant that many of the traditional structures and beliefs that were so much a part of traditional Indigenous cultures and communities prior to colonisation have been broken down or have disappeared. This has given rise to some Indigenous peoples feeling as though they have lost many of their traditions or lack direction.

Another significant influence on the Indigenous cultures in Australia has been the inter- and intra-generational influences of the Stolen Generations. It has been argued that the forced removal of Indigenous children from their parents up until the 1960s played a pivotal role in the breakdown or disappearance of family structures in many Indigenous communities in Australia (Hastie & Augoustinos, 2012). For example, those who were removed from their parents as children and placed in residential or other facilities that were most often located in urban areas, had no parenting or family role model(s) and were not a part of the communities that are such an integral part of Indigenous cultures. When those who have been removed became adults and began to produce families of their own, they struggled to know how to parent their children or what it meant to be part of an Indigenous family or community (Fejo-King, 2011). They also struggled to find a sense of identity as a member of an Indigenous culture, or a sense of belonging to or connection with the place from which they had been removed and to which they had been taken. Such difficulties have added to the lack of cohesion and breakdown of traditional structures and cultures, caused by colonisation and urbanisation. As discussed later in this section, these difficulties have also challenged the levels of mental health and wellbeing of Indigenous Australians generally.

These challenges to the traditional cultures of Indigenous Australians is further complicated by the fact that many of those who have always lived in an urban centre do not feel closely tied to the land or the country of their elders, past or present. Notions of 'country' are often more spiritual or even metaphorical, than a lived experience (Nelson, Macdonald, & Abbott, 2012). Also, some Indigenous Australians may feel weighed down by the expectations that are often placed on them by people from other cultures. There is a tendency amongst non-Indigenous peoples to stereotype Indigenous populations and presume their lifestyles will be more traditional in remote locations. As a consequence, Indigenous Australians living in urban areas may be perceived as lacking in legitimacy.

The urbanisation of Indigenous cultures, then, has given rise to a number of challenges for Indigenous Australians. This includes those related to the health and wellbeing of Indigenous peoples and communities (Kingsley, Townsend, Henderson-Wilson, & Bolam, 2013). These challenges are described in the following sections.

The indigenous view of 'health'

Generally speaking, indigenous peoples share a **whole-of-life view of health**. This means that notions of 'health' are generally understood by indigenous peoples as a state of wellbeing that is achieved through the balancing of mind, body, emotions, spirit, culture and the environment (National Aboriginal and Torres Strait Islander Health Council, 2003; Ricciardelli, Mellor, McCabe, Mussap, Hallford, & Tyler, 2012). When this balance is upset in one person, it is believed that the entire community suffers as a result and not just the individual alone.

The whole-of-life view of health shared by indigenous peoples has strong links to Western evidence that suggests health is socially determined (Ward, Meyer, Verity, Gill, & Luong, 2011). The **World Health Organization (WHO)** (2008) defines the **social determinants of health** as the conditions in which people are born, grow, live, work and grow old. The social determinants of health are factors that determine the health status of all people, and include income and its distribution, education, unemployment and job security, employment and working conditions, early childhood development, nutrition, housing, social exclusion, social safety networks, health services, gender, race and disability (Shepherd, Li, & Zubrick, 2012). The social determinants of health are also shaped by the general distribution of wealth, power and resources at global, national and local levels (Zubrick et al., 2010). Likewise, proponents of the whole-of-life view of health hold that good health relies on an ability to access the resources that support quality of life and equal opportunity (Australian Health Ministers' Advisory Council, 2011).

whole-of-life view of health an understanding of health as a state of wellbeing that it is achieved through the balancing of mind, body, emotions, spirit, culture and the environment. It is similar to the 'holistic' approach to health.

World Health Organization (WHO) an agency of the United Nations that is an overarching authority on international public health and coordinates public health initiatives. Its headquarters is in Geneva, Switzerland.

social determinants of health the social factors that determine the health status of all people. They include early childhood development, disability, education, employment, gender, health services, housing, income, nutrition, social exclusion, social safety networks and race.

It is significant, then, that:

- at least 25 per cent of Indigenous Australians aged 15 years of age and over live in overcrowded housing
- secondary school retention rates for Indigenous Australians in years 7/8 to year 12 are 43 per cent, compared to 76 per cent for non-Indigenous Australians
- Indigenous Australian employment rates are low compared to non-Indigenous rates
- Indigenous Australian poverty levels are high (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2008).

These indices provide substantial reason why the health, including mental health and wellbeing, of Indigenous Australians is of such great concern (Donato & Segal, 2013; Durey & Thompson, 2012; Shepherd, Li, Mitrou, & Zubrick, 2012).

The social disadvantage experienced by Indigenous Australians has serious consequences. Perhaps most importantly, it leads to lower levels of general health. For example, the prevalence of diabetes among Indigenous Australians is nearly four times that which is reported by non-Indigenous Australians; hospitalisation rates are 12 times higher for care that involves dialysis for Indigenous Australians, and two times higher for both respiratory diseases and injury (MacRae et al., 2013). Other consequences of the social disadvantage of Indigenous peoples in Australia include the high level of emotional stress and other mental health issues they experience (*The Lancet*, 2012).

For this reason, the Australian government has stressed the need for all health professionals to acknowledge that Indigenous Australians have a socially constructed view of mental health and illness, and ensure they take culturally informed approaches to delivering healthcare (Purdie, Dudgeon & Walker, 2010).

International and national directives

Effective health professionals are aware of the international conventions and national policy directives that frame and inform the delivery of health care to indigenous peoples. This includes the directives that drive the design, goals and provision of equitable and accessible, culturally respectful health services for Indigenous Australians. These directives will also influence the work and education of health professionals, and the outcomes of their practices.

The World Health Organization's *Ottawa charter for health promotion* (1986) presented a plan for action to enable 'health for all' by 2000. This included addressing the social determinants of health, such as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. The World Health Organization's *Jakarta declaration* (1997) built on the *Ottawa declaration* and identified urgency for further investment in health, especially for disadvantaged groups such as women, children, older people, and also the indigenous, poor and other marginalised populations. In 2008, the *WHO Mental Health Gap Action Programme* was announced to support the scaling up of services for mental health, neurological and substance abuse disorders in low- to moderate-income peoples, including those who belong to indigenous cultures. These charters, declarations and programs have been the impetus behind a variety of initiatives worldwide aimed at improving the mental health and wellbeing of indigenous peoples everywhere (see Social Health Working Group, 1996; Panaretto et al., 2013).

In Australia, the principles of these declarations are evident in the various national mental health plans that have been developed by the Australian government over the last two decades. The more recent of these plans place particular emphasis on Indigenous communities; and include prioritising the development of community-controlled services to improve the mental health and wellbeing of Indigenous Australians, together with fostering partnerships between sectors, thereby encouraging community services and organisations to work together (Borowski, 2011).

There are many and varied examples of such partnerships already in action. For instance, a locally designed community project for people with mental ill-health, older people and people with a disability was recently established in the Kimberley, in remote Australia (LoGiudice et al., 2012). A model of care was developed from the 'bottom-up' by Indigenous community members to address the unmet needs of the target population and their carers, and has supported a threefold increase in the number of people receiving community care. The project is also important for the way it highlights what can be achieved when a local or community-specific approach is taken, with health care developed according to the socio-cultural, economic, political and ideological needs, rather than biomedical factors alone. Outcomes of this project also demonstrate the effectiveness of empowering communities to plan for themselves, according to their own needs and cultural interests.

Such projects are also valuable because they so clearly role-model the value of involving communities in the provision of their own health care; that is, enabling self-determination (Isaacs et al., 2010). It is not the role of the health professional to tell a person or group of people how they should be living or what they should be doing (Carey, 2013). Rather, the people themselves are the means by which significant changes can be made to the health status of the community.

The mental health and wellbeing of Indigenous Australians

Because Indigenous cultures in Australia share a whole-of-life view of health, it is in fact an artificial process to consider the mental health and wellbeing of Indigenous peoples in isolation from their physical wellbeing. Nevertheless, this differentiation can be helpful for health professionals who belong to other cultures and seek to understand the major issues faced by Indigenous peoples in contemporary Australian society.

As already noted, the concept of mental health in Indigenous communities incorporates much more than the individual and their level of functioning in their environment (Purdie, Dudgeon & Walker, 2010). In Indigenous communities, notions of mental health and wellbeing are linked to connections with the land, spirituality, ancestry, family and community, and how these affect the individual. For Indigenous communities in Australia, mental health and wellbeing encompasses a broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage (Laliberté, Nagel, & Haswell, 2010). In short, when members of an Indigenous community feel connected to their country, culture, spirituality, and also one another, they see themselves as being socially and emotionally healthy (Kingsley, Townsend, Henderson-Wilson, & Bolam, 2013).

Commentators have suggested that there are five broad discourses that frame the mental health and wellbeing of Indigenous peoples:

1. culture and spirituality
2. strong extended family and community relationships
3. historical, social and economic factors
4. fear, shame and stigma
5. an overwhelming sense of loss (Ypinazar, Margolis, Haswell-Elkins, & Tsey, 2007).

For example, the first of the discourses — culture and spirituality — includes the notions of storytelling, ceremonies, ancestors, sacred sites, tribal areas and identity (Lau, Blow, & Thomson, 2012; McMillan, Traynor, & Dewing, 2010). If an Indigenous community feels culturally and spiritually 'in balance', then that community is more likely to feel socially and emotionally well. Alternatively, if a community feels culturally and spiritually out of balance, then that community will feel socially and emotionally unwell (Laliberté, Nagel, & Haswell, 2010; Rigby, Rosen, Berry, & Hart, 2011).

This state of imbalance will express itself in many ways. For example, health professionals from Western cultures may diagnose an Indigenous Australian with clinical depression, but members of their community will recognise the mood or behaviour as a cultural condition known as 'longing', 'crying' or 'being sick for country' (Guerin, Guerin, Tedmanson, & Clark, 2011; Westerman, 2003). In the same way, some behaviours of an Indigenous person may be viewed as 'odd' by people who do not belong to or understand the person's culture, but this behaviour may be due to the Indigenous person or community being unable to achieve cultural resolution to an incident that has occurred, often because of constraints exercised by the surrounding, dominant non-Indigenous culture (Kirmayer, Simpson, & Cargo, 2003; Short, 2010). It is important, then, that the thoughts, feelings and behaviours of a person are interpreted from within their own cultural framework or view of the world (Isaac, 2013). Likewise, it is essential that the mental health and wellbeing of Indigenous Australians is measured according to their own cultural and spiritual understandings.

UPON REFLECTION

Indigenous spirituality, mental health and wellbeing

It may be difficult for a non-Indigenous health professional in Australia to know when someone who belongs to an Indigenous culture is exhibiting symptoms of mental illness or, alternatively, is behaving in a culturally appropriate way.

Questions

1. What can a non-Indigenous health professional do to find out if the behaviour is culturally appropriate or not?
2. What is the role of family and community in the care of a person who belongs to an Indigenous culture?
3. What is the most effective way for a health professional to learn about a person's cultural background?

The remaining four framing discourses — strong family and community relationships; historical, social and economic factors; fear, shame and **stigma**; and an overwhelming sense of loss — also provide fertile ground for exploring aspects of the mental health and wellbeing of Indigenous Australians. For example, links have been identified between the lower levels of wellbeing of Indigenous peoples and the breakdown in family and community ties related to the urbanisation of Indigenous Australians (Shepherd, Li, Mitrou & Zubrick, 2012). To reiterate, reasons for this breakdown include the injustices and **discrimination** that have been experienced by Indigenous Australians since colonisation, such as genocide, where whole families and communities were wiped out; the seizure of their land without recompense; and the Stolen Generations.

stigma an attribute, behaviour or reputation that is perceived, constructed and/or represented by a group of people, society or culture in a negative way

discrimination the unfair treatment of a person or group of people based on categories such as gender, age, class, relationship, ethnicity, culture, religion, health issue or disability

The *Bringing them home* (1997) report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families acknowledged that Indigenous children had been forcibly separated from their families and communities by governments and missionaries since the very first days of European settlement. Events that have occurred in Australia in the last 230 years or so, including intergenerational trauma, grief and loss, a degraded sense of belonging, and low self-esteem, have significantly impacted on the mental health and wellbeing of Indigenous populations (Dowd, 2010). This, in turn, has eroded the general health and wellbeing of Indigenous peoples today, across Australia.

On 13 February 2008, the motion of *Apology to Australia's Indigenous Peoples* was made by the government of the day on behalf of the Australian people. The then–Prime Minster apologised to all Australian Aboriginal and Torres Strait Islander peoples — in particular, the Stolen Generations — for their profound grief and suffering. The apology was perceived by many as a significant turning point in the relationship between the Indigenous peoples and the people who had arrived in Australia since the commencement of European settlement. It was also seen as a turning point for the mental health and wellbeing of Indigenous Australians (Fejo-King, 2011).

However, while some gains have been made in addressing the effects of colonisation on the mental health and wellbeing of Indigenous Australians, many issues remain (Philpot, Balvin, Mellor, & Bretherton, 2013). For example, anxiety/depression and suicide are two of the top four leading causes of illness in Indigenous males; with anxiety/depression the top cause of illness for Indigenous females (MacRae et al., 2013). In addition, Indigenous Australians are more often exposed to activities that impact on their mental health and wellbeing — for example, smoking, poor nutrition, alcohol misuse, overcrowded living conditions and domestic violence (MacRae et al., 2013). These statistics highlight just some of the challenges that face Indigenous Australian communities, health professionals, health services and governments.

Also of concern is the racism that continues in many parts of Australia. For example, Indigenous peoples and cultures are often represented as the subjects of documentary programs and news items that suggest an intractable problem that just will not go away, or frame them as tourist novelties in faraway locations (Waller, 2012). In addition, the Indigenous 'problem' is portrayed as 'distant', belonging to remote outposts 'up north', 'top end', 'outback', and well away from — even irrelevant to — the 75 per cent of the population who live in metropolitan or coastal regions (Due & Riggs, 2011). Alternatively, people with health issues who identify as Indigenous and who live in metropolitan or coastal regions are quickly referred on to Indigenous health professionals, who are expected to assume all care rather than act as cultural advisers (Clark, 2011). Although the publicly promoted attitudes towards people who belong to Indigenous cultures have been sanitised of the overt racism of the past, there is no doubt that Indigenous peoples continue to be positioned as 'other' in Australian society.

One consequence of this is that Indigenous peoples who are affected by symptoms of mental illness are doubly stigmatised — labelled and marginalised for exhibiting symptoms of mental illness, and likewise labelled and marginalised for belonging to a minority racial group (Isaacs, Pyett, Oakley-Browne, Gruis, & Waples-Crowe, 2010). As a result, Indigenous peoples are less likely to disclose symptoms of mental illness, leading to a reduced likelihood of early intervention strategies being implemented in a timely manner (Drew, Adams, & Walker, 2010). The potential consequences of this **double stigma** are serious.

double stigma the stigma experienced by those who have two or more 'labels' that are viewed negatively by a society; for example, a mental illness and racial minority, or a mental illness and unemployed status

In chapter 1, it was explained that stigma is the perception that a person or group of people is less worthy than another person or group of people. It was also explained that when stigma is acted upon and someone is treated differently because they have a mental illness or other condition, this person is being discriminated against. Discrimination is illegal under the Commonwealth *Disability Discrimination Act 1992*. Health professionals are required to practise in accordance with this legislation.

Although overt behaviour can be in-part controlled by the law, it is far more difficult to change the attitudes of individuals and societies. The urgent need for ongoing intervention in this area continues to be addressed in Australia's evolving National Mental Health Strategy, which supports the achievement of better health outcomes for Indigenous peoples by acknowledging:

- the Indigenous heritage of the nation — the unique contribution of Australia's Indigenous heritage and cultures to its society
- the right of Indigenous peoples to status, culture, self-determination and land
- the absolute necessity of upholding these rights.

It is significant that the focus of both the Act and the National Mental Health Strategy is social and cultural, rather than biomedical. The key to improving the mental health and wellbeing of Indigenous Australians, then, lies not with diagnosis and treatment, but with inclusion and upholding the human rights of Indigenous peoples across the nation, including their right to self-determination.

For this reason, all health professionals can assist with the process of closing the gap in the levels of health between Indigenous and non-Indigenous Australians. The first step is mutual resolve. Another, more practical step for health professionals is to ensure that they ask those who attend a health service if they identify as Indigenous. Receiving health care often gives rise to cultural issues that an Aboriginal health worker is best placed to mediate. Some health professionals may think that a person who doesn't 'look' indigenous in appearance could not possibly belong to an indigenous culture. However, it is important to understand that indigeneity does not depend upon appearance, but rather upon heritage. For this reason, health professionals must give each and every individual the choice to speak with an Indigenous health professional, regardless of their appearance.

In addition, health professionals can support the process of improving health outcomes for Australian Indigenous peoples by providing culturally appropriate information to individuals, families and communities. This information needs to include suggestions or options for the person and their family about the health care that is available. Health professionals across Australia are also encouraged to access the Australian government document, *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2010), which is available on the Department of Health website. This document explains the importance of building a workforce with the skills to undertake health promotion and illness prevention activities aimed at Indigenous communities across Australia; to provide culturally appropriate interventions for the grief, loss and trauma experienced by Indigenous peoples; and to contribute to community-driven and culturally appropriate research and evaluation. The document also outlines the ways and means by which health professionals can work together to empower Indigenous communities to self-determine. Aspects of this collaborative approach are described in more detail in the next section.

Issues to consider when supporting the mental health and wellbeing of Indigenous Australians

This section outlines some of the major issues that face health professionals when delivering health care (including mental health care) to Indigenous people in Australia; and the steps health professionals can take to address these issues. Topics considered are the mobility of many Indigenous Australians, the under-representation of Indigenous health professionals in the health workforce, and also the general lack of understanding in the mainstream health workforce about the roles of Aboriginal health workers.

Under-representation of Indigenous health professionals

Indigenous health professionals form an integral part of the Australian health care system (Haswell et al., 2013). The development of the Indigenous health workforce was prioritised in 2002 by the *Aboriginal and Torres Strait Islander health workforce national strategic framework*. This strategy includes recognition of the need for a quality

Indigenous mental health workforce in the primary, secondary and tertiary health care sectors (Australian Health Ministers' Advisory Council, 2002). It also emphasises the importance of supporting and appropriately utilising Indigenous health professionals (Harris & Robinson, 2007).

There are a number of reasons why it is necessary to develop a quality Indigenous mental health workforce. One reason relates to the under-representation of Indigenous health professionals across Australia. Currently, only 1 per cent of the health workforce are Indigenous Australians (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2008; Paul, 2013). In contrast, Aboriginal and Torres Strait Islander peoples account for 2.5 per cent of the Australian population (Australian Bureau of Statistics, 2012c). This under-representation of Indigenous health workers is a significant factor in the lower health status of Indigenous peoples in Australia.

Despite the diversity in Indigenous cultures across the nation, Indigenous peoples from the many different cultures in Australia share enough in common to know the most appropriate ways of providing health care to other Indigenous people. In addition, the development, planning and provision of culturally appropriate health care by Indigenous peoples to Indigenous peoples form an integral part of this self-determination (Doyle, 2012).

It is necessary, then, that governments and employing organisations work to address the under-representation of Indigenous peoples in the Australian health workforce. Likewise, it is essential that Indigenous peoples are empowered so they can bring their cultural and other knowledge, skills, experience and general expertise into the field of mental health. Finally, Indigenous health professionals must be supported by all health professionals and appropriately utilised. The role of the Indigenous health professional is explained in the next section.

Lack of understanding of roles

Today there is no single educational pathway to become an Indigenous health professional in Australia. Nor is there a single condition of employment or way of interacting with Indigenous health professionals (Clark, 2011; Parker, 2003). The roles are many and varied. In addition, the model within which the Indigenous health professional practises does not fit Western-oriented models of mental health service delivery. Consequently, there is a degree of misunderstanding generally about what it is that Indigenous health professionals actually do (Christou & Thompson, 2013). What is certain, however, is that the roles are proving to be effective (Haswell et al., 2013). For this reason, it is important that health professionals support and advocate for the people in these roles; and are aware of the nature of the work of Indigenous health professionals in Australia, especially those located in the mental health specialty area.

Indigenous health professionals are most often employed from within their own community(ies) and work as generalists to support the Indigenous community as a whole, rather than as specialists who provide therapy to individual consumers with psychiatric diagnoses (Panaretto et al., 2013). The different roles undertaken by Indigenous health professionals may include:

- a clinical function, often as the first point of contact for an Indigenous person with the health service, particularly in rural or remote areas

- a liaison function, working with the primary non-Indigenous health professional to mediate cultural issues
- a health promotion and education function in their communities
- a community care, management, policy development or program planning function.

Perhaps what is most important is that health professionals ascertain the availability of an Indigenous health professional in their area and how this person may be contacted. Although Indigenous health professionals are currently under-represented, they are nevertheless there to be utilised wherever possible (Doyle, 2012).

A mobile population

The relative mobility of Indigenous peoples in Australia present some challenges to health professionals and services (Hui et al., 2013; Parnaby & Carapetis, 2010). For example, it is very difficult to provide continuity of care for any person, Indigenous or non-Indigenous, who frequently relocates (Shepherd, Li, Mitrou, & Zubrick, 2012). Also, the vagaries of the Australian health system — which comprises eight states and territories, each with its own clinical records and health related legislation — presents a number of considerable challenges in relation to the transfer of information and communication between health professionals and services; and also for individuals who must negotiate the different systems. In addition, for some Indigenous Australians, moving from town to town, or state to state, can give rise to feelings of disconnection from the communities in which they live. Their own country or mob is in another place and they may feel that they do not belong where they are.

For this reason, it is important that individual health professionals ensure they follow up on the care being delivered to an Indigenous Australian. If the person does not attend an appointment for some time, then the reasons why must be investigated. Questions that need to be asked include: Has that person moved on? Have their clinical records been forwarded to the appropriate services? Does the health professional need to speak personally to health professionals who are now supporting the person? Taking personal responsibility for following up on the health care delivered to a person who identifies as Indigenous is an important means by which health professionals can make a difference.

‘How would you like us to help you?’

Empowerment is a somewhat abstract concept. It is a means by which people develop a capacity to influence the world around them. For health professionals, empowering a person to achieve better health outcomes suggests many challenges. First and foremost, where does the health professional start?

empowerment the process through which people become more able to influence the people and organisations that affect their lives

An important first step involves listening to the person and their preferred family member or community representative, providing culturally appropriate information, and allowing the person and their family or community members to make their own decisions (Doyle, 2012; Robinson et al., 2012). Of particular importance is the role of storytelling for many Indigenous peoples and communities in Australia.

IN PRACTICE

Listening with big ears

Aunty Kerrie Alaylee Doyle, a Winninninni woman from Darkinjung country, is an Indigenous health professional and academic. She has many stories to tell to those who will listen — just as she listens to many of the stories that are told to her.

> I go out and I listen with 'big ears'. It's only with 'big ears' and not 'hard ears' that I can hear what the mob are saying.
>
> If you listen hard enough, you hear the mob groaning. Some of them, they are often told that change is coming and things are going to get better. But when they talk together about their health, they talk about freedom. They talk about being able to live life without the government and police and tourists staring, and of being able to go into a shop without security officers checking up on them, and of being able to find a job that's more than just menial and of being able to do their 'business'. But there's no freedom for some of them now; there's only sadness.
>
> Some of them, they've taken to using drugs and alcohol. They know it makes them sick, but they do it anyway and then they're locked up by the police. But they need help — not jail — but they don't tell anyone that they're sick because they know if they do they'll be moved away, off country. They know it brings shame and the mob will groan even more. Listen hard enough, you'll hear it.
>
> One time, I was looking after this one young lad. He was in prison for break and enter. I was the first Aboriginal counsellor he had seen. His records said he was non-compliant and he wouldn't take his medication and he wouldn't cooperate. I sat with him for a long while and we didn't say anything. Then I asked him where his mob was from. He started to cry. He said he didn't know his country. He was adopted when he was a baby but he was not athletic and his adoptive father had bashed him because he had wanted a boxer. That lad, he grew up in a good white place in the city but he never felt he fitted in, he never felt accepted by his white family or by the local Aboriginal kids or by anyone. So he grew up angry and alone with no one to talk to and no one who wanted to listen. Then they told him he was depressed and put him on medication.
>
> I reckon if those health workers who had been looking after him, if they'd been listening to what he was saying, things would have been better for him. My mob have a saying, we say, you listen with 'big ears', not hard ears that are waiting for

us to make a mistake or ears that think they know better, but 'big ears' that listen to your story. I reckon if those doctors and nurses had been listening with big ears, and not just big mouths, I reckon things might have been different for him.

Questions

1 What is the difference between 'big ears' and 'hard ears'?
2 Which do you find it easier to do — talk or listen? Why?
3 What practical strategies could you adopt to help you to listen first, with 'big ears'?

Listening

Storytelling is an important component of many indigenous cultures and a significant element in the indigenous understanding of mental health and wellbeing, worldwide (Nagel & Griffin, 2012). Carey and Russell (2011) suggest that the stories of indigenous peoples are the means by which they construct, represent and develop their communities, community identity, and also their view of themselves.

oral traditions use of storytelling, song, dance or giving instructions as a means of passing on specific cultural practices and values and beliefs

Storytelling is strongly linked to the **oral traditions** of indigenous peoples. As already noted, these oral traditions include the use of stories, song, dance and craft making; and giving instructions and directions as a means of passing on specific cultural practices and values, language and laws, histories and family relationships, and beliefs (Kirmayer, Marshall, Phillips, Williamson, & Jessen, 2012). As such, storytelling provides an ideal medium by which the major issues and preoccupations of indigenous peoples may be understood and approached. Indeed, it is through their oral traditions that the heart and soul of an indigenous community — that is, the emotions, activities, motivations and insights of that community — may be best observed and understood (Stock & Gary, 2012).

Storytelling, then, enables health professionals to gauge the mental health and wellbeing of the person from an indigenous culture (Kirmayer, Marshall, Phillips, Williamson, & Jessen, 2012). In Australia, a person's stories — cultural stories, community stories, personal stories and anecdotes — will tell of the strength of the person's family and community connections; of the impact of historical, social and economic factors upon communities and their wellbeing; of the fear, shame and stigma many Indigenous peoples feel when it comes to their mental health and wellbeing; and, finally, of the overwhelming burden of loss they carry (Laliberté, Nagel, & Haswell, 2010).

The health professional can connect with the Indigenous Australian and their family or community members through the stories of their communities. Once this connection has been made, the health professional will be more able to build a genuine and trusting alliance with the person, while also working collaboratively with Indigenous health professionals to obtain advice on cultural issues. Helping the Indigenous person will also involve the steps shown in figure 4.2 (overleaf), which outlines a number of suggestions for health professionals who care for people from Australian Indigenous cultures. In short, by involving families or communities, listening carefully to what is being communicated, providing information, and showing a willingness to be flexible to meet the needs of the person, the health professional will be well placed to support the process of making a difference for the mental health and wellbeing of Indigenous peoples in Australia (McBain-Rigg & Veitch, 2011).

Providing mental health care for an Indigenous Australian

- Involve their preferred family and/or community members in discussions about their mental health and wellbeing and ask them what they think is happening.
- Listen carefully to what the person and family may be trying to tell you; that is, listen to their stories. These stories will contain valuable information about the health and wellbeing of the person.
- Involve their preferred family or community members in discussions about possible care or treatment.
- Contact an Indigenous health/mental health professional for advice and support.
- Offer relevant, culturally appropriate information to the family; assess their understanding of the information and offer alternative sources of information if needed.
- If in a hospital, be flexible about the timing of visitors and number of visitors, and enable the person to adhere to their cultural practices and to keep personal belongings nearby. Remember that many people from Australian Indigenous cultures fear hospitals — they have experienced many relatives and friends dying in these hospitals. Fear can sometimes make a person react in ways that may seem inappropriate.
- Be aware that many people from Indigenous cultures feel shame if they or their relative experiences symptoms of mental illness. Discuss the issues and reassure all those involved.

FIGURE 4.2 Checklist for health professionals: Mental health care for an Indigenous Australian

This section identified the importance of Indigenous cultures in Australia and discussed the ways in which Indigenous peoples are disadvantaged in Australian societies, as well as examining the notion of the mental health and wellbeing of Indigenous peoples. Direction was provided for health professionals on how best to provide **culturally appropriate care** to Australia's Indigenous populations.

culturally appropriate care the care that is provided to a person by a health professional that is consistent with the cultural values of the person who is unwell

The next section discusses the mental health of people who live in rural and remote areas of Australia, including both Indigenous and non-Indigenous peoples. The section examines rural and remote cultures, and how these cultures affect the mental health of those who live in relatively isolated areas. This includes a discussion of the major issues faced by people who live in rural and remote locations, how these challenges impact upon the mental health status of isolated populations, and the services that are available to support people who live in rural and remote areas in Australia.

UPON REFLECTION

Everyone's responsibility?

When a particular issue — and the addressing of that issue — is made 'everyone's responsibility', it often becomes no-one's responsibility as people presume someone else will take care of the problem.

Questions

1. How can you, as a health professional, support the delivery of culturally appropriate care to Indigenous peoples in Australia?
2. Name one specific area of your professional practice that you will change, in light of your reading about the mental health of Indigenous peoples.

Mental health and rural and remote cultures

Australia has been described as one of the most urbanised nations in the world, with less than 30 per cent of the population living in rural and remote areas (Baxter, Hayes, & Gray, 2011). This raises many questions, particularly for those who live in the farming communities, mining towns, coastal villages and regional centres located across the nation. For example, how relevant are rural and remote issues to the majority of Australians? How are rural and remote cultures different from the mainstream Australian culture? What role do health professionals play in supporting the mental health of people from rural and remote cultures?

Significantly, many of the answers to these questions relate to notions of equity. Access and equity are two of the foundation stones of public health care (including the delivery of mental health care) in Australia. An important role of the health professional in Australia, then, is to advocate for services and practices that support access and equity for all people, including those who live in rural and remote locations (Veitch et al., 2012).

What is a 'rural' or 'remote' culture in Australia?

Defining 'rural' and 'remote' is no longer an easy task. In the past, Australian rural and remote populations were defined by bush iconography, such as unique fauna and flora, desert or bushland, and a harsh climate, isolation and long distances; agricultural or mining land-use; and populations that were slow-paced, conservative, lacking sophistication, stoical, but also self-reliant, resilient, independent and strongly community-minded (Fraser et al., 2002; Zapf, 2001). Today, with the many advancements that have been made in transport and communication networks, together with the effects of globalisation, there have been profound changes in the way 'rural' and 'remote' are experienced or understood (Pearson & Chatterjee, 2010). Indeed, some commentators now argue that the boundaries differentiating notions of rural, urban, state, national and international have been blurred (Sibley & Weiner, 2011).

The Australian Institute of Health and Welfare provides some direction for health professionals, and classifies rural, remote and metropolitan areas according to population (including density) and distance to urban centres containing a population of 10 000 persons or more (Australian Institute of Health and Welfare, 2004). Also important are socio-cultural characteristics, the number of community resources and the economy (Baxter, Hayes, & Gray, 2011). However, perhaps most telling are the notions of the **rural–urban continuum**, which measure how particular communities conform to varying levels of ruralism and urbanism (Millward & Spinney, 2011; Sibley & Weiner, 2011). Different rural and remote locations and communities — from coastal rural to inland rural and remote areas; and from farmers and miners to the people living in small towns and regional centres that service these industries — all exhibit their own unique cultural characteristics (see figure 4.3, overleaf). The rural–urban continuum provides one means by which the diversity of rural populations and cultures can be

rural–urban continuum a measurement of the way particular communities conform to levels of ruralism and urbanism acknowledged. It also allows for consideration of the complex and evolving nature of these populations and cultures (Kew & Lee, 2013).

It is important that health professionals understand the inherent diversity of rural populations and cultures. Although most health professionals do not work in rural and remote locations, the dearth of services and health resources in these areas means that people from rural and remote locations will often travel to the city to access health care. Another consideration is the increasing number of 'fly-in, fly-out' health professionals now servicing rural and remote locations. Health professionals who are aware of the major issues for rural and remote people will be better equipped to deliver the most effective treatment and care.

Remote ◄——— Rural ———► Urban

Examples of 'measures' of how particular communities conform to levels of rural and urban include:

- distance between urban centres
- population density
- number of community resources
- strength of the economy
- socio-cultural characteristics.

FIGURE 4.3 The rural–urban continuum

Major issues for people living in rural and remote areas

There are many benefits to living in rural and remote areas. For example, life in rural towns is associated with higher levels of resilience and satisfaction with safety and community connections, when compared to the experiences of those living in cities (Buikstra, et al., 2010; Inder, Lewin, & Kelly, 2012; Maybery, Pope, Hodgins, Hitchenor, & Shepherd, 2009). This suggests some reasons why many older people are now choosing to move to rural areas for a 'tree change' or 'sea change' upon retirement.

On the other hand, rural and remote locations have also been linked to discourses of disadvantage. These discourses include geographic isolation from metropolitan centres and services; small, shrinking and dispersing populations and social networks; and structural disadvantage, including poor roads and technology (Novello, Stain, Lyle, & Kelly, 2011). Moreover, when compared to metropolitan Australia, rural and remote populations are associated with a long list of negative indicators, including lower socio-economic indices, lower education levels, higher unemployment rates, higher morbidity and mortality rates in almost all of the health categories, higher rates of hospitalisation, fewer health care services and a lower utilisation of these services, fewer health professionals, and issues around the location or distribution of these health professionals (Allen, Inder, Lewin, Attia, & Kelly, 2012; Kelly et al., 2011; Commonwealth of Australia, 2009a; Commonwealth of Australia, 2009b). In short, rural and remote populations have many social issues that impact on levels of health, including mental health.

Mental health issues for people living in rural and remote areas

Research suggests that the prevalence of mental health conditions in rural and remote Australia is equivalent to levels in the major cities (Black, Roberts & Li-Leng, 2012; National Rural Health Alliance, 2009). The one exception has been the higher rates of completed suicide in rural and remote areas, identified at 1.2–2.4 times higher than those in the major cities (Australian Institute of Health and Welfare, 2005; McNamara, 2013).

The prevalence of mental health conditions in rural and remote Australia is equivalent to levels in the major cities, but there are fewer services.

Despite the general equivalence in mental health status, however, rural and remote Australians face many more challenges when seeking support for mental health problems than people who live in metropolitan areas (Kelly et al., 2011). One reason for this is the difficulty in effectively accessing treatment. For example, and as already noted, there are proportionately fewer health professionals practising in rural and remote areas, with additional issues evident around the location and distribution of these health professionals (Moor, Sutton, & Maybery, 2010).

Another challenge is suggested by evidence that rural and remote people are less likely to seek out health care, and in particular mental health care, than their city counterparts (Perkins et al., 2013). Reasons for this include:

- lack of anonymity in small communities
- less availability and accessibility of services
- cost of travel and accommodation when accessing services in the larger centres
- cultural understandings of mental illness that discourage people from disclosing mental health problems
- greater visibility of mental health issues in small communities
- the stigma associated with the use of mental health services.

This situation raises significant questions about the disclosure rates to health professionals by people in rural and remote locations with symptoms of mental illness. It also raises questions about the statistical equivalence between those with mental health issues who live in rural and metropolitan locations. The lack of anonymity in rural areas as well as the limited available social circles, which are characteristic of rural and remote populations, remain substantial barriers to the diagnosis and treatment of mental illness (Deen, Bridges, McGahan, & Andrews, 2012). This, in turn, suggests yet another challenge to those who deliver mental health services in rural areas: the challenge of stigma or the attitudes towards and of people about a particular aspect of life.

Attitudes and values

The stigma attached to mental health issues in rural areas has been well documented in the research literature (Reavley & Jorm, 2012; Happell, Scott, Platania-Phung, & Nankivell, 2012). For example, people in rural communities have tended to associate mental health issues with ‘insanity’; and to believe that those who are experiencing symptoms of mental illness are best cared for by family or the church rather than health professionals (Quine et al., 2003). One explanation for such attitudes may relate to the value placed by rural and remote people on maintaining performance or productivity, despite adversity (Australian Institute of Health and Welfare, 2004; Cummins, Davern, Okerstrom, Lo, & Eckersley, 2005). This view is consistent with the culture of independence, self-reliance and stoicism, together with notions of 'getting over it and getting on with it' that have been associated with many rural and remote communities (Deen, Bridges, McGahan, & Andrews, 2012). People from rural and remote cultures tend to privilege physical 'strength' — and frown upon emotional 'weakness'. While stoicism provides one way of dealing with hardship, in the long term it may also discourage people from seeking help when they are in need.

It is important, then, that health professionals are aware of this cultural mindset. Likewise, there is a need for health professionals to ask questions of people from rural and remote locations about these potential issues, so they can assist the person and their family members as needed. Finally, it is essential to assure the person from a rural or remote location, especially if they live in a small community, that their answers to questions about their health — in particular, their mental health — will be treated confidentially. The experience of stigma in a small community can be devastating to a person and can challenge their mental health outcomes.

UPON REFLECTION

No longer the Lucky Country?

In Australia, suicide rates among all population groups are consistently higher in rural and remote areas than in metropolitan areas. While the suicide rates of adolescents in rural Australia has fallen significantly during recent years due to the implementation of a range of public health interventions, they still remain a serious concern.

Various predisposing factors have been suggested, including poorer access to appropriate services, fewer supports and resources, lower levels of education, higher levels of unemployment and income stress, stigma and shame, and less likelihood of receiving professional help for mental health (including drug and alcohol) problems.

Questions

1. What other factors may contribute to the trend towards high suicide rates in this population group?
2. How can all health professionals, including those located in urban or metropolitan areas, respond to this trend?

Ongoing loss

As noted in the seminal texts of Ward (1958), White (1981) and Turner (1994, 2003), rural and remote populations have traditionally held a significant position in Australian society and the national identity or psyche. In the past, images such as the outback, pioneers and bushmen have proudly represented what it means to be Australian. However, with the increasing urbanisation of Australian society, notions of 'rural' and 'remote' have lost their status in Australian society. Indeed, some have even argued they are irrelevant to the majority of Australians (Kelly et al., 2011). This has led many people who live in rural and remote regions to feel marginalised and experience a sense of loss.

Compounding the effects of this loss are the ongoing issues of drought, cyclone, flood, fire and plagues that are regularly faced by rural and remote Australians (Stain et al., 2011). Indeed, the cycle of natural disasters experienced by rural and remote Australians can often seem relentless — moving from drought to cyclone to flood to plague to fire and back again to drought. In addition to natural disasters are the other hardships often associated with rural areas, including lower education levels, higher unemployment rates, and higher morbidity and mortality rates than people who live in the cities (Guiney, 2012; Hanigan, Butler, Kokic, & Hutchinson, 2012; Polain, Berry, Hoskin, & Oliver, 2011). The stress and hardship that is experienced by rural and remote populations on an ongoing basis, then, is profound.

The impact of ongoing or protracted loss on the mental health of a person or group of people is significant (Laliberté, Nagel, & Haswell, 2010). Specifically, links have been found between feelings of alienation or detachment, marginalisation, loss of meaning, and levels of depression and suicidality (Kelly et al., 2011). The higher levels of suicide in rural and remote areas are a further indicator (Handley et al., 2012). Other ongoing mental health related problems associated with rural and remote populations include the use of alcohol and other drugs, and the culture of violence (Inder et al., 2012). All of these factors have the potential to impact considerably upon the health outcomes for those who live in a rural and remote area.

IN PRACTICE

Helping rural communities through natural disasters

Some of the ways floods, drought and extreme climate events can affect rural communities include:

- financial hardship for farmers and other rural businesses, which may eventually lead to farms being sold and businesses forced to close
- family and relationship problems (e.g. arguing, disagreements, lack of communication, physical conflict, relationship breakdown)
- job pressure and overworking
- people (particularly those who are young) leaving the community due to a lack of opportunities or income
- environmental problems such as loss of vegetation and animals, drying or flooding of rivers, soil erosion and increased risk of bushfires
- lack of community services, including health care, education, housing and employment organisations

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- higher incidence of physical and mental health problems among community members, as well as an increased risk of suicide
- loss of social networks and a breakdown in community spirit.

Some of the strategies that can be used to help manage the stress of floods, drought and extreme climate events include:

- recognising when the situation seems to be getting too much for those involved
- making sure those involved have the opportunity to talk about what has, or is, happening to them
- helping people to explore the financial help that is available
- encouraging people to visit their GP or other health professional
- making sure children and adolescents have the opportunity to talk about what happened
- teaching people how to manage their stress
- supporting people to be positive and proactive
- encouraging people to seek and accept help from others
- raising awareness about the need for people to seek help if they have thought of harming themselves.

Questions

1 Within the context of a rural community, what signs and symptoms of long-term stress produced by floods, drought and extreme climate events would you likely encounter?

2 Apart from the local GP or health worker, where might a person from a rural area who has experienced a natural disaster seek help?

Source: Lifeline

Systemic issues

There are also a number of systemic issues faced by people with mental health issues who live in rural or remote areas. As already suggested, rural and remote populations receive less treatment for mental health issues than their city counterparts (Wakerman & Humphreys, 2011). In addition, the mental health resources available are more fragmented and limited than those received by the general health sector (Moore, Sutton & Maybery, 2010). Such issues present significant challenges for governments, health services and health professionals alike.

One reason for these inequities is the current trend for governments across Australia, at both national and state levels, to centralise the administration of services. An outcome of this centralisation is a reduced capacity for smaller communities to be involved in shaping the way local services are delivered. The plans and decisions affecting the lives of rural or remote people are often made by distant agents who have little understanding of local issues, local culture and local know-how. With little or no involvement in the way in which services are developed or implemented, people in rural and remote areas are further disempowered and marginalised.

Another inhibiting factor is the **one-size-fits-all or universalist approach** that often characterises the way governments plan and develop health services, including mental

one-size-fits-all or universalist approach an approach or intervention that does not take into consideration diversity or difference; rather it demands that the needs of all people are met by a standardised approach or intervention health services, across Australia. 'Standardisation' is a common catch-cry of health managers and policymakers alike, and is said to assist with managing risks and promoting equity (Handley, Inder, Kelly, Attia, & Kay-Lambkin, 2011). However, such an approach is based on the presumption that all populations have exactly the same needs and that these needs will be met in exactly the same way. As a result, there is the potential to overlook the many cultural, social, geographical and other differences that are evident within and between different localities, populations and cultures.

Mental health service delivery cannot be uniform when considered in light of the multifaceted nature of rural and remote Australia. Instead, addressing mental health issues for those living in rural and remote Australia requires an approach that considers the diversity of the populations and meets the potential needs of each locality (Kenny & Allenby, 2013). For this reason, health treatment and care is best understood in terms of local or community specificity (Perkins et al., 2013). Health services must be flexible and allow communities to develop their own solutions. Likewise, health professionals must be flexible and allow individuals from rural and remote areas to develop their own answers.

Last, but by no means least, there are the problems that are generated by the systemic shortage of suitably qualified health professionals in rural and remote Australia (Bulbrook, Carey, Lenthall, Byers, & Behan, 2012). These problems cannot be overstated. Without a health workforce, people cannot be treated or cared for in their own communities (Conomos, Griffin, & Baunin, 2013). Travelling long distances to consult with health professionals or for admission to a hospital gives rise to multiple issues. These issues include higher costs to access the health services; and also feelings of dislocation for the person with the health issue, who is isolated from the support of family and friends. Indeed, the lack of health professionals who are willing or able to deliver health care in regional, rural and remote locations is an issue for governments across Australia, requiring innovative approaches to delivery health care in these locations.

Addressing the issues in rural and remote areas

Identifying and implementing ways and means of reducing health inequities and closing the **gap in health service provision** to people in rural and remote regions is receiving increasing attention in the delivery of health care in the twenty-first century (Humphreys & Wakerman, 2010). Governments and health service organisations have placed a special focus on addressing the absence or lack of services in rural and remote areas. This can be demonstrated by the large number of innovative projects, programs and initiatives that have now been implemented by the federal, state and territory governments (Taylor, Jones, O'Reilly, Oldfield, & Blackburn, 2010; Wakerman & Humphreys, 2011).

gap in health service provision the descriptor often used by health professionals and health services to refer to the absence or lack of services in a particular location or area of health

For example, a number of different approaches are now being used to attract health professionals to live and work in rural and remote locations, including lifestyle and financial incentives (Conomos, Griffin, & Baunin, 2013; Keane, Smith, Lincoln, & Fisher, 2011). In addition, mobile health teams, telemedicine and video-conferencing services, and online resources have been developed to support health professionals, communities, families and individuals located in rural and remote Australia (Saurman et al., 2011). Another key initiative is the community development work that is being undertaken in some locations to assist rural and remote people to support themselves, with projects taking on a 'capacity building' focus (Fuller, Kelly, Law, Pollard, & Fragar, 2009; Hart, Berry, & Tonna, 2011). This approach is particularly important to enable people who live in rural and remote locations to withstand the natural disasters — including flood, bush-fires and droughts — that are so much a part of the Australian way of life (Wade, Forbes, Nursey, & Creamer, 2012).

Figure 4.4 lists a selection of programs and projects that are currently in progress to support people in rural and remote areas. Although by no means exhaustive, this list provides an introduction for health professionals to enable them to develop awareness of the resources that are available. In turn, the information can be used to support people from rural and remote areas who may be experiencing symptoms of mental illness.

Examples of programs and initiatives that have been developed for or by rural and remote populations include:

- significant expansion in flexible delivery of tertiary and vocational education and training programs, and scholarships and generous incentives, to encourage and support improvements in recruitment and retention of health personnel — including medical, nursing, midwifery, allied health and Indigenous health personnel — to study and work in rural and remote areas
- provision of reliable online resources, including those provided by *beyondblue*, Health*Info*Net and Lifeline. These online resources include up-to-date information, noticeboards and networks, and resources for people interested in all aspects of general and mental health issues for people living and working in rural and remote Australia, and also for health professionals. Of particular interest for health professionals are the assessment tools provided on the Health*Info*Net websites, developed specifically for Indigenous populations
- the University Departments of Rural Health (UDRH) program, supported by the Australian Government Department of Health, which encourages students of medicine, nursing and other health professions to pursue a career in rural practice by providing opportunities to practise their clinical skills in a rural environment. The UDRH program also supports health professionals currently practising in rural settings by employing leaders in clinical practice, research and education to work alongside the rural health professionals as role models, mentors and resource persons
- development and implementation of mental health first aid (MHFA) programs specifically for rural and remote populations and Indigenous populations. These programs aim to improve the mental health literacy in rural and remote areas, and challenge stigma. Mental health first aid (MHFA) also works to build capacity in communities through supporting networks for social support
- development of mental health research centres for rural and remote populations (for example, the Australasian Centre for Rural and Remote Mental Health), which bring mental health and wellbeing programs and solutions to rural and remote Australia's three major populations — that is, Indigenous Australians, those associated with the mining and resources sector, and those linked to the agricultural sector
- the National Rural Health Alliance, Australia's peak non-government organisation for rural and remote health, which aims to support good health and wellbeing in rural and remote Australia; and provides a range of resources on its website to support this vision.

FIGURE 4.4 Rural and remote programs and initiatives

‘Fly-in Fly-Out’

‘Fly-in fly-out’ (FIFO) workers are people who live in metropolitan or urban locations, travel by aircraft to a rural or remote location to work, stay in that location for an intensive period of work (e.g. 1–7 days), and then travel home again. FIFO workers have become an increasingly common feature in rural and remote Australia, particularly in the mining sector (Weeramanthri & Jancey, 2013). However, while FIFO workers have been heralded as an important solution to the problems of providing skilled labour to undertake the available work in rural and remote locations, a number of issues have been identified in relation to the health (including mental health) of these workers; together with the communities into which they fly-in and fly-out of (Joyce, Tomlin, Somerford, & Weeramanthri, 2013).

For the FIFO workers, such issues include those related to the work pressures involved in meeting productivity demands; extended rosters; social isolation (especially affecting those living away from their families); poor help-seeking behaviours; and limited access to support services (McLean, 2012). For the communities into which these workers fly-in and fly-out of, issues include the perceptions that these outsiders are taking their jobs and do not contribute meaningfully to the local communities in which they reside for such a short time (Weeramanthri & Jancey, 2013).

These issues present particular challenges across all government levels and also to the health service organisations who deliver health care in these locations. Questions to be answered include: how can accessible, equitable and effective health care be provided in remote locations to people who live there for such short periods of time? How can health professionals best support the communities into which the FIFO workers are travelling?

FIFO health professionals

One answer to this question has been the development of the FIFO health professional. An increasing number of FIFO health professionals are now flying-in temporarily to rural and remote locations, across Australia, to deliver health services in a range of specialties, including mental health, to the people who live in these locations (Hart, Morris, Collins, McMullen, & Stanis, 2013; Margolis, 2012; Weeramanthri & Jancey 2013). These FIFO health professionals include medical practitioners, including specialists and consultants; nurses, paramedics, and other allied health professionals.

From the point of view of the rural and remote communities, the benefits of utilising FIFO health professionals include the reduction in financial costs that are incurred from travelling and living away from home, for those who would otherwise need to access health care in the cities or regional centres. The use of FIFO health professionals can also reduce feelings of dislocation in rural people. For example, FIFO consultant psychiatrists fly into some rural locations to support GPs who are treating a person with a mental illness in the local hospital rather than transferring the person to a larger facility some distance away (Wakerman, Curry, & McEldowney, 2012).

From the point of view of the health professional, the FIFO option allows them to continue to live in their own home in the city, while at the same time delivering a much needed service to people in rural and remote areas (Hanley, 2012). Some health professionals also enjoy the lifestyle that comes from being paid significant financial incentives to fly into a rural or remote location and stay for several days of intense work, then fly out again to relax for a relatively long period of work-free time.

However, the FIFO approach to providing health care also presents a number of challenges for the communities they visit. For example, FIFO health professionals are not part of the community. Consequently, they lack understanding of the community's major preoccupations, ways of being, and local culture. The lack of involvement of the FIFO health professionals in the community also serves to undermine public health approaches to building resilience and capacity of communities — that is, helping the community to help itself (Perkins, 2012). Instead, the FIFO health professional is inevitably associated with the city — an expert from the outside who arrives to deliver health care, with little commitment to the people or place.

Of course, the FIFO approach is just one way forward. It is important to note that governments and health service providers across Australia will continue to explore ways and means of addressing the issues related to providing health care (including mental health care) to people who live in rural and remote locations. Meanwhile, health professionals can support the progress already being made through maintaining awareness of the major issues involved; and ensuring they take a culturally appropriate approach to helping all people with mental health problems, regardless of their background. The need to take such an approach is discussed in more detail in the next section, which focuses on helping people from culturally or linguistically diverse backgrounds who are experiencing symptoms of mental illness.

UPON REFLECTION

Addressing the challenges

Most people who live and work in urban or metropolitan areas would not consider the option of living or working in a rural or remote location.

Questions

1. If you are someone who lives in an urban location, what do you think are the benefits of living and working in a rural area?
2. What do you think are the challenges of living and working in a rural area?
3. How do you think these challenges could be addressed for health professionals looking to relocate to a rural or remote area to work?

Mental health and multiculturalism

Australia is one of the world's most culturally diverse nations (Gray & Agllias, 2010; van Krieken, 2012). It is populated by over 23 million people, with 43 per cent claiming to have at least one parent who was born overseas, and almost 25 per cent stating they were born in another country (Australian Bureau of Statistics, 2012a, 2012b). In total, Australians have identified more than 200 different countries of origin, with the United Kingdom, New Zealand, China and India predominating. This diversity suggests the need for health professionals to be familiar with the major issues related to the provision of health care to **culturally and linguistically diverse (CALD)** populations.

Multiculturalism has added to the richness of Australia's social fabric; however, it has also given rise to a number of challenges, including how best to deliver health care to people from CALD backgrounds (*beyondblue*, 2013). This section examines notions of multiculturalism as it relates to people with mental health problems who come from CALD backgrounds. Rather than focusing on the details of each of the many and varied cultures and subcultures that are located in Australia today, a broad perspective is taken, with emphasis placed upon the importance of mutual respect for and the acceptance of the differences involved. Also highlighted is the need for collaboration between health professionals, the person and their family members or community, with a view to finding the most culturally appropriate ways of delivering high quality, mental health services.

culturally and linguistically diverse (CALD) a broad concept that refers to the wide range of cultural groups that make up a population or community, and differ according to ethnicity, language, race, religion, social traditions and other factors

The language of multiculturalism

There are a large number of terms and acronyms that are used in relation to multiculturalism in contemporary Australia. These terms include 'acculturation', 'assimilation', 'asylum seekers', 'culturally and linguistically diverse' or 'CALD', 'ethnicity', 'integration', 'migrant', 'nationality', 'non-English speaking background', 'race', 'refugee' and 'transcultural'. When the concepts of 'cultural safety', 'cultural awareness', 'cultural knowledge', 'cultural competence' and 'cultural proficiency' are also taken into account, it is understandable that many health professionals struggle to negotiate this minefield of terminology.

The term 'culturally and linguistically diverse' (CALD) is often used by health professionals to describe the many cultural differences between groups of people — including the way they communicate and dress, their social traditions, food, social structures, art and religion. Another term commonly used in the field of health is **transcultural**. This word describes an approach to health care that requires the health professional to extend or move through more than one culture to focus on each person's individual health needs and the care required (Burns et al., 2010).

transcultural a combining of the elements of, or extending through, more than one culture

Transcultural approaches were first developed by nursing professionals, in particular Madeleine Leininger (1988), who realised that people from different cultural backgrounds had different expectations of the way health care should be delivered. These differences often led to inequities in health care as the dominant culture imposed its way of doing things onto minority groups (Wright & van der Watt, 2010). As a consequence, the health outcomes of these minority groups were compromised.

Leininger decided that health professionals required a theoretical framework with which to deliver culturally appropriate care. She described transcultural health care as:

> a formal area of study and practice focused on comparative holistic cultural care, health, and the illness patterns of people with respect to differences and similarities in their cultural values, beliefs, and life ways with the goal to provide culturally congruent, competent, and compassionate care (Leininger, 1997, p. 342).

Today, transcultural health professionals form an integral part of the health system in Australia. Transcultural practices are person-centred, and seek to meet the specific needs of the person and their family (Maheshwari & Steel, 2012; Scala, 2012).

To support these practices, many states and territories have now developed transcultural health and mental-health resource centres (Castle, 2013). Resources are freely available online, and include leadership in and support for clinical consultation and assessment; transcultural (mental) health promotion, prevention and early intervention; publication and resource development; and education and training. Web addresses related to transcultural approaches are provided at the end of this chapter.

Another descriptor often used in the multicultural context is 'non-English speaking background'. All cultures have their own language(s) or dialect(s). In Australia, the dominant language is Australian English. People for whom English is not a first language may be referred to as having a 'non-English speaking background'. In the health context, this often means that an interpreter is required to assist with communication (Searight, & Armock, 2013). Interpreters are discussed in more detail later in this chapter. At this point, it is important to note that people for whom English is a first language do not always share the same culture as mainstream Australians. For example, although more than 80 per cent of people in Australia speak English at home, their cultural background may be English, Scottish, Irish, Welsh, Canadian or another country that belongs to the Commonwealth (including many African countries) (Australian Bureau of Statistics, 2013). Likewise, there are cultural differences between Australia and the United States — for example, health care is universally available to all Australian residents or citizens at minimal cost, whereas the provision of health care in the United States is different. Any such differences must be taken into consideration by the health professional when helping a person.

Migrants and refugees

Today, people may come to Australia as either a **refugee** or a **migrant**. Health professionals need to understand the differences between these two diverse groups of people so they can appropriately assess their quite different health needs.

For example, refugees have been forced to leave their home country (Department of Immigration and Citizenship, 2011). This is often due to a well-founded fear of being persecuted for reasons of race, religion, nationality or membership of a particular social group or political opinion. Consequently, some refugees may be relieved to arrive in their new country and will settle in relatively easily. Others, however, may struggle to settle in. This could be because of the racist attitudes towards them. It could also be because of their past experiences.

People who are resettled in Australia on humanitarian grounds experience a lower health status than other refugees and migrants (Khoo 2010; Reid, 2012; Newman et al., 2010). Also, many refugees who have witnessed or experienced torture or other significant trauma prior to arriving in Australia — or even after arriving, in detention centres — will be affected by the experience (Cleveland & Rousseau, 2012). Issues that may develop as a result of trauma can include depression, anxiety and also **post-traumatic stress disorder (PTSD)** (McFarlane & Kaplan, 2012).

While many refugees will seek help or support from health professionals to manage their symptoms, others may be less willing to seek out support (Nickerson et al., 2011). This could be because of a lack of knowledge about the kind of help that is available (Drummond, Mizan, Brocx, & Wright, 2011). A lack of willingness to seek out support

refugee a person who leaves the country of their nationality due to a well-founded fear that they will be persecuted for reasons of race, religion, nationality or membership of a particular social or political group

migrant a person who moves from one place, region, or country to another at their own volition

post-traumatic stress disorder (PTSD) a diagnosed mental health condition characterised by the development of a long-lasting anxiety reaction following a traumatic or catastrophic event can also be due to cultural differences (Correa-Velez, Barnett, Gifford, & Sackey, 2011). For this reason, health professionals should ensure that a mental health assessment is conducted as a matter of course on people who have arrived in Australia as refugees. It is also important that these refugees are informed of the many different health services that are available for them to access across Australia.

UPON REFLECTION

Asylum seekers and ethical practice

As a health professional, you may be asked to deliver mental health care to a person who has experienced immigration detention. This person may be an adult or a child.

Questions

1. What is your personal position on the mandatory detention of non-citizens of Australia who arrive without a visa? How does your personal position intersect with your professional obligations?
2. How would you respond if you suspected human rights abuses in relation to immigration detention?
3. How could you help someone who is experiencing mental health issues as a result of immigration detention?

In contrast to refugees, migrants have chosen to leave their country of origin and move to Australia (Flaherty, 2012). For this reason, many migrants will be happy about their move, and settle into their new home with few difficulties. Some migrants, however, may feel homesick and isolated both geographically and linguistically (Newman, Proctor, & Dudley, 2013). Also, some families may prefer to hold on to the traditions of their old country and be reluctant to become a part of the broader Australian culture. While this may provide a degree of reassurance for migrant parents, it can also have a significant impact upon their children. For example, the parents may refuse to allow their children to participate in regular school activities, which leads to issues of marginalisation and a reduced sense of belonging or 'fitting in' for these children (Flaherty, 2012). Other problems for migrants can result when they return to visit their country of origin and find that things have moved on or changed. When this occurs, the migrants can experience a reduced sense of belonging to their old and new countries, leading to further unhappiness, loneliness and depression (Khoo, 2010). Despite initial hopes, then, a move to another country for some people can give rise to profound disappointment.

The quite different experiences of refugees and migrants suggest the need for health professionals to seek out information from the person with a CALD background, rather than make assumptions. Different approaches will be needed to help different people, according to their own particular backgrounds and experiences. To provide the most effective care (including mental health care), health professionals need to familiarise themselves with the backgrounds and cultures of the people they help (Kokanovic, Petersen, Mitchell, & Hansen, 2001; Poon, Joubert, & Harvey, 2013).

THE BIG PICTURE

Children in detention

Under Australia's system of mandatory immigration detention, all non-citizens, adults and children who are in Australia without a valid visa must be detained. According to the Australian Human Rights Commission (www.humanrights.gov.au), the vast majority of children who are in immigration detention have arrived to Australia by boat, seeking asylum.

A National Inquiry into Children in Immigration Detention found that most of the children in mandatory detention had arrived with their families, and that these families had been given no real opportunity to argue their case before an independent tribunal or court (Human Rights and Equal Opportunity Commission, 2004). The 2004 inquiry also found that children detained for long periods of time were at a high risk of developing mental health problems. Recommendations were made to remove children and their parents from immigration detention.

Since that time, a range of measures have been taken to address the issues identified in the Inquiry, including the passing of the *Migration Amendment (Abolishing Detention Debt) Act 2009*. However, while there have been significant improvements to the way in which children without the appropriate visa are now detained — for example, through the adoption of community-based alternatives — the Australian Human Rights Commission, together with health professionals, continue to have serious concerns, particularly in relation to the mental health of the children involved (Australian Hunan Rights Commission, 2013; *The Lancet*, 2010).

The processing of refugees (including children) who arrive in Australia has become something of a political football, with politicians continuing to make promises, debate the matter and negotiate with neighbouring countries; and health professionals continuing to deal with the practicalities of the many issues involved (Dudley, Steel, Mares, & Newman, 2012). All health professionals need to inform themselves and consider these issues, so that they are better prepared to help children who have experienced mandatory detention following the trauma of leaving their homeland and travelling to Australia.

It would be impossible for a health professional to possess enough knowledge of each and every culture in the world to be able to provide culture-specific care to all of the people they encounter. However, one way in which health professionals can develop the understanding required is to familiarise themselves with the major discourses that frame the worldview of different cultures. By familiarising themselves with the most common

cultural discourses shared across the globe, health professionals will be better equipped to understand the major differences between the cultures and adapt their practices accordingly.

In the next section, the major discourses of individualism and collectivism, which inform all cultures to some degree, are discussed. The ways in which gender roles are constructed by different cultures are also outlined, together with the effects of these constructions on health professionals when they are approached for help by people from these cultures. Finally, the outcomes of stigma on people with mental health problems who have CALD backgrounds are discussed.

cultural discourse a coherent body of statements or a distinct framework that represents, maintains or develops 'reality' as understood by a particular culture

Individualism and collectivism

As noted earlier, cultural norms and influences are often invisible or taken-for-granted, and understood as 'fact', 'reality' or 'just the way things are'. To illustrate, many health professionals unquestioningly accept the 'obvious' value that is placed by Australian health services on the individual, through the use of individualised care or treatment plans. **Individualism**, however, is a very Western construct or belief system and stands in contrast to the notions of **collectivism** that frame other systems of belief (Papadopoulos, Foster, & Caldwell, 2013).

individualism a set of beliefs or an ideology where the 'self' is the most important consideration; this includes giving priority to one's own goals and one's own self-definition or actualisation over that of the group

collectivism a set of beliefs that upholds the group or collective/community as more important than the individual; this includes giving priority to the goals or 'greater good' and identity of the group over those of the individual

Generally, individualistic cultures, including the dominant culture in Australia, have the following characteristics in common.

- The 'self' is the most important consideration.
- Priority is given to personal or individual goals.
- Identity is defined in terms of personal or individual attributes or achievements.
- The individual is encouraged to stand out, be unique, express themselves.
- Self-reliance and independence are admired.
- Rules are made to ensure the independence and freedom of individuals, and to promote individual rights and choice. However, adherence or conforming to these rules can be arbitrary or 'individualised', as people are encouraged to make their own way.
- Notions of 'in-groups' and 'out-groups' are less distinct than in collectivist cultures.
- Individualists are more likely than collectivists to pre-judge people based upon their personal attributes (Triandis & Gelfand, 2012).

Examples of countries in which individualism is prominent include Australia, Canada, France, Italy, New Zealand, United Kingdom and the United States (Papadopoulos, Foster, & Caldwell, 2013).

Generally, collectivistic cultures have the following characteristics in common.

- The 'group', 'collective' or community is the most important consideration.
- Priority is given to the group's goals.
- Personal identity is defined in terms of the group's attributes or achievements.
- Each person is encouraged to conform and do what is best for the group.
- Each person is discouraged from openly expressing opinions or beliefs that may contravene the beliefs of the group.
- Group, family or rights for the common good are seen as more important than the rights of individuals.

- Rules are made to promote group stability and order. Adherence or conforming to these rules is essential.
- Clear distinctions are made between 'in-groups' and 'out-groups'.
- Working with others and cooperating is the norm. Refusal to cooperate and wanting to be independent or stand out is seen as shameful. All in the group rely upon each other for support.
- Collectivists are more likely than individualists to pre-judge people based on group identity. As such, the whole group will try to protect a member, and the group itself, from outside influences (Marcus & Le, 2013; Triandis & Gelfand, 2012).

Examples of countries in which collectivism is prominent include Argentina, Brazil, China, Egypt, Greece, India, Japan, Korea, Mexico, Portugal, Taiwan and Vietnam. In addition, many indigenous cultures are framed by the discourse of collectivism (Papadopoulos, Foster, & Caldwell, 2013).

The quite invisible nature of these two worldviews gives rise to a number of issues when offering a health service. For example, health professionals who were born and raised as part of the dominant Australian culture, which is individualistic in orientation, may make assumptions about the way health care 'should' be delivered, based upon their cultural values. Consequently, health professionals may not be able to understand why the person they are trying to help is not interested in, for example, exploring notions of self-esteem or self-actualisation. The health professional may even perceive this person's lack of interest as 'insightless', 'uncooperative' or 'non-compliant'. In reality, the person from a collectivist culture who enters the Australian health system may find themselves separated from the family or the community group to which they belong and through which they find meaning (Nickerson et al., 2011). For this reason, when they are suddenly expected to make decisions about themselves as individuals — a concept that is quite foreign to their system of values — they feel stressed or become anxious or depressed (Triandis & Gelfand, 2012).

Understanding the notions of individualism and collectivism is an essential step towards accepting the fundamental differences between some cultures. Health professionals who are aware of these differences will be more able to adapt their practices to engage the person from a different culture, and develop health care that is more appropriate to the particular needs of the person.

Gender roles

Another crucial aspect of culture that will influence the way health care is delivered to CALD populations is the role of gender (Zhang, Mandl, & Wang, 2011). Every culture also has its own particular understandings, values, traditions and rules — spoken and unspoken — about the role of males and females, be they men, women, teenagers or children. Contemporary Western-oriented cultures have been significantly influenced by the feminist, lesbian, gay, bisexual and transgender, anti-discrimination, and human rights movements, to name a few. Some cultures, however, have a view of gender roles, marriage, relationships, and the place of children that differs greatly from the dominant Australian culture. This may challenge the health professional and also raise significant questions about the role they play in the decision making of people from CALD backgrounds.

IN PRACTICE

Mental health issue, abuse or traditional values?

Aaban is the 16-year-old daughter of parents who moved from Turkey to Australia two years ago. Aaban's teachers are concerned that she has no friends and is making poor progress at school. They tell Aaban that they would like to speak to her parents. However, Aaban tells the teachers that her parents do not go out, except to visit family members or Turkish acquaintances who live nearby. Aaban advises her teachers that it does not matter if she does not do very well at school as she will be leaving soon to get married.

One of the male teachers notices that whenever he tries to talk to Aaban, she seems unable to meet his eyes and begins to shake, as if frightened. When he discussed this reaction with colleagues, they suggest she could be exhibiting the signs of someone who is being sexually abused at home, and decide to refer Aaban on to the school counsellor.

The school counsellor is also male, and he finds it impossible to engage with Aaban. He also wonders whether she is clinically depressed, so he refers her on to the child protection authorities and also the local GP, asking the GP to ensure she is assessed by a psychiatrist as soon as possible.

Questions

1. What circumstances could account for Aaban's situation?
2. Sometimes, health professionals are the only 'outsiders' who are in contact with people like Aaban. How could a health professional ensure that such contact is meaningful? How could they ensure that Aaban will receive all the help she needs?

Of course, it is essential that health professionals assess all situations for the possibility of abuse or domestic violence (Fatin, 2012; Keygnaert, Vettenburg, & Temmerman, 2012). On the other hand, it is also important that the approaches made by health professionals are culturally appropriate. For example, it may be very difficult for a health professional from the dominant Australian culture to understand or accept that a female from a CALD background is required to marry at a very early age or be isolated at home and limited in their education (Shabbar, 2012). However, many cultures will frame this tradition with discourses of 'protection' and 'honour' in relation to women, and see the Western view as equally challenging (Rashidian, Hussain, & Minichiello, 2013). Generally speaking, unless a particular practice contravenes Australian law or a person from a CALD background asks for assistance to deal with problems they have with the lived experience of their culture, it is not the role of the health professional to interfere with cultural behaviours or situations with which they personally disagree. Rather, the focus of the health professional is the health of the person. Health professionals who feel challenged by culturally influenced behaviours are strongly encouraged to seek the advice of the manager or another health professional who has specialised in this area.

Finally, it is also vital health professionals recognise that different cultures have different rules about appropriate male–female interactions, regardless of the context. If unsure, the health professional may consider asking the person from a CALD background or their family members the following questions.

- Is it culturally appropriate for the health professional of one gender to speak to a person of the other gender in this situation?
- Is there a need for a cultural mediator or worker to assist before the interview proceeds?
- Is privacy being protected?
- Are cultural expectations being respected?

Answers to these questions will enable the professional to deliver culturally appropriate health care.

Cultural diversity, stigma and mental illness

As discussed in chapter 1, people with mental health problems are often stigmatised by others. This happens within diverse societies and cultures across the world, including those in Australia (Abdullah & Brown, 2011; Yang, et al., 2013). There are many reasons — cultural, historical, religious, social and political — for stigmatising attitudes (Cheon & Chiao, 2012). However, the consequences of stigma for people with a mental illness are always negative.

The main stigma-related issues for CALD communities in relation to mental illness include:

- limited understanding of the concepts of mental health and illness
- cultural perceptions that any kind of disability is shameful, particularly a disability related to mental illness
- a consequent reluctance to seek assistance for mental health issues (*beyondblue*, 2013; Health Outcomes Australia, 2009).

Of course it is important not to generalise. Different cultures will have different perceptions or understandings of mental health and illness, and this will result in different levels of stigma. Nevertheless, there are many cultural barriers to people with a CALD background seeking help or support for a mental health problem (Maheshwari & Steel, 2012). It is the responsibility of the health professional to be aware of these barriers, and reach out to people with CALD backgrounds.

Breaking down negative attitudes is always challenging. Even so, health professionals can lead the way by providing culturally appropriate information, role-modelling acceptance, and also by developing clear channels of communication (Bond et al., 2007). Some practical suggestions on how this can be achieved are provided in the next section.

Towards providing culturally appropriate mental health care

As part of their duty of care, health professionals are expected to negotiate the many cultural differences of the people they are helping; indeed, the provision of culturally appropriate care is a professional requirement (e.g. Australian Association of Social Workers, 2008; Australian College of Mental Health Nurses, 2010; Australian Psychological Society, 2003). This places a responsibility on health professionals to seek out the information and education they need to support and develop their practice and deliver culturally appropriate care.

There is some debate about the processes involved in providing culturally appropriate mental health care to people with a CALD background. Some commentators have suggested that teaching cultural awareness or knowledge may work to generate an unhelpful 'us' versus 'them' dichotomy, or reinforce views of 'otherness' (Phillips, 2005). For this reason, a broad, respectful and accepting approach is required to enable health professionals to become culturally proficient (Benson & Thistlethwaite, 2008).

Cultural proficiency

Cultural proficiency in providing mental health care occurs when the health professional recognises that a person is from a CALD background and ensures that the person's culture, language, customs, attitudes, beliefs and preferred ways of doing things are accepted and respected (Doyle, 2012). Cultural proficiency builds on notions of **cultural safety**, which originated in New Zealand in the 1990s.

Cultural safety involves providing an environment in which people are safe; where there is no challenge to or denial of their identity; and where their needs are met (Rigby, et al., 2011). A culturally safe health environment will involve respect, shared meaning, shared knowledge, effectives engagement with culturally diverse peoples, and learning together (Bidzinski, Boustead, Gleave, Russo, & Scott (2012).

Cultural proficiency goes further than cultural safety (Doyle, 2012), and includes five broad principles for the health professional:

1. acquisition of a broad understanding of how different cultures may view health, and mental health and illness
2. demonstration of respect for and acceptance of the different cultures
3. a focus on the person together with their families and/or communities, to enable genuine interpersonal or therapeutic engagement
4. support of ongoing mental health education and the provision of culturally appropriate information to people with CALD backgrounds
5. commitment to lifelong learning and development in this significant area of health care provision (Nuri-Robins, Lindsey, Lindsey, & Terrell, 2012).

Proficiency is the stage when health professionals have achieved competence in this area of practice, with added awareness that the process of learning is lifelong and requires constant ongoing reflection upon and development of practice.

To achieve cultural proficiency in mental health service provision, the health professional will move through a number of stages of practice. These include

cultural proficiency a stage of practice that follows on from cultural competence. It is achieved by health professionals when they become advanced practitioners as well as life-long learners in the area of culturally appropriate health care.

cultural safety a state of being, practice or environment that is safe for people from all cultures; it is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening cultural awareness, cultural knowledge, cultural sensitivity and cultural competence (Nuri-Robins, Lindsey, Lindsey, & Terrell, 2012).

Cultural awareness begins with health professionals examining their own personal values-base and beliefs. As discussed at the beginning of this chapter, those who identify with the dominant Australian culture may presume that the values of that culture are 'commonsense' or 'just the way things are', rather than cultural constructions or assumptions that influence the way they understand notions of health and illness (Parker, 2011). Health professionals who are aware of the impact of their own culture on the way they understand the world are more likely to be accepting of and respectful towards those with different values and beliefs (Prasadarao, 2009).

cultural awareness the state of awareness reached by a person who examines or reflects upon their own personal value-base and socio-politico-cultural beliefs in relation to the beliefs of different cultures

Cultural knowledge can be derived from many sources, including anthropology, sociology, cultural studies, psychology, biology, nursing, medicine and the arts. Acquiring cultural knowledge includes understanding the values, beliefs and nuances of a particular culture's perception of health (including mental health); and understanding the societal and organisational structures and accepted practices of each culture (Morton, 2012). This knowledge can assist health professionals to adapt approaches to meet the needs of the person from that culture (McArthur, Greathouse, Smith, & Holbert, 2011). Although it is helpful to have some knowledge of the details of different cultural practices and beliefs, it is impossible for the health professional to have enough knowledge of all the different cultures that comprise the multicultural mix in Australia. The acquisition of cultural knowledge, then, is an ongoing process.

cultural knowledge understanding of the details of a particular culture, including the structures and accepted practices of that culture

Cultural sensitivity entails the development of appropriate interpersonal or therapeutic alliances with people from different cultures. It is important that health professionals examine themselves to identify how they view the cultural differences of people in their care (Phiri, Dietsch, & Bonner, 2010). Questions they may ask themselves would include whether others have an equally legitimate way of life and understanding of the world as the health professional. Reflecting genuinely on the answers to questions such as these will enable the health professional to develop cultural sensitivity.

cultural sensitivity being receptive and responsive to cultural differences as a means of developing appropriate interpersonal or therapeutic relationships with people

Cultural competence is achieved by a health professional when they demonstrate sensitivity to issues of culture, race, gender, sexual orientation, social class and economics in their practice. Cultural competence involves the skills, awareness, encounters, desire and knowledge required to deliver culturally appropriate care (Mancuso, 2011). It is achieved by health professionals when awareness, knowledge and sensitivity are integrated into their practice (Delphin-Rittmon, Andres-Hyman, Flanagan, & Davidson, 2013).

cultural competence a level of practice that is achieved when health professionals integrate awareness, knowledge and sensitivity

Finally, and as already noted, cultural proficiency follows the achievement of cultural competence. A health professional becomes culturally proficient when they have achieved cultural awareness, cultural knowledge, cultural sensitivity and cultural competence — and continues to work on maintaining and building on this state of being on a life-long basis. Cultural proficiency is not static, but rather an ongoing process in which health professionals are actively involved (Campbell-Jones, Campbell-Jones, & Lindsey, 2010).

Health professionals are strongly encouraged to find out more about these various terms and how they apply in practice. This can be achieved by attending training courses on the provision of culturally appropriate care (Like, 2011), which are now required of health professionals by governments and health services across Australia. A list of useful websites is also provided at the end of this chapter.

Culturally appropriate approaches to treating mental illness

The approaches to providing mental health care and treatment to people from CALD backgrounds are as multifaceted as the many different cultures the health professional will encounter (Castillo & Guo, 2011). The health professional who has no cultural awareness may inadvertently discourage the person from a CALD background from seeking help for a mental health issue. This could lead to the under-utilisation of services and poorer outcomes for the person (Scapin, 2011).

While acknowledging that CALD populations are in no way homogeneous and that each person or group will have different issues and needs, there are a number of simple but effective steps a health professional may take to assist people with mental health issues who have a CALD background. These approaches include, but are not limited to:

- ensuring the involvement of a suitable interpreter when required
- providing culturally and linguistically appropriate information and education to the person, their families and the communities to which they belong
- focusing on the personal interactions and the therapeutic alliance relationship (Victorian Transcultural Psychiatry Unit, 2011).

By taking these steps, health professionals will facilitate communication with the people they are helping, which, in turn, will optimise health outcomes.

Ensuring the availability of interpreters

Many health professionals may be uncertain if a person requires an interpreter. It could appear that a person with a CALD background understands what is happening to them because, for example, the person smiles and nods a great deal when questioned. However, the person may only be demonstrating politeness or deference to the health professionals, as is appropriate to that culture. Health professionals must never take the understanding of others for granted.

It is important that health professionals contact an interpreter for a person with a CALD background who also has a mental health issue when:

- the person or family member requests an interpreter
- the person prefers to speak or is more fluent in a language other than English
- the health professional assesses the person as having difficulty communicating in spoken English
- the health professional finds they are repeating themselves in simpler terms to help the person to understand (Thomas, Bracken, Shabbir, & Yasmeen, 2010).

If the health professional is in doubt, it is better to obtain the services of an interpreter than to leave it and simply hope the person with a CALD background understands (Tribe & Thompson, 2011).

Sometimes a suitable interpreter may not be available. There is a general lack of interpreters across Australia (Henderson, Kendall, & See, 2011). The health professional also needs to be aware that there are many different dialects of a language. For example, there are 18 major languages spoken in India and over 1600 regional dialects. Health professionals must also be aware that some interpreters may not be well informed on mental health issues, which will give rise to additional challenges in the communication process. For example, a lack of understanding of the relevant medical terms could lead to the relaying of inappropriate or incorrect information by interpreters to health professionals, or vice versa, which may result in misdiagnosis or inappropriate treatment (Kirmayer et al., 2011). Again, it is necessary for the health professional to check for understanding with the person's family or community member, on an ongoing basis (Culhane-Pera & Borkan, 2012).

For people from CALD backgrounds located in rural and remote areas, or in places where no suitable interpreter is available, interpreters are now available by telephone or video-linkup, and health professionals are encouraged to seek the most appropriate interpreter available. The resource provided in figure 4.5 will also support health professionals in their work.

English proficiency scale

Assess the consumer's need for having an interpreter by using the following scale.

Is an interpreter needed?	
Unable to have an everyday conversation. Is unable to answer simple questions. For example: Clinician: 'Isn't it a lovely day?' Consumer: [No response. Just has a quizzical look.]	Yes
Able to have an everyday conversation but not able to have a detailed conversation about their health. For example: Clinician: 'What have your sleep patterns been like over the last couple of weeks?' Consumer: 'I don't sleepwalk.'	Yes
Able to communicate well, can easily discuss clinical information. For example: Clinician: 'What have your sleep patterns been like over the last couple of weeks?' Consumer: 'I have been constantly waking up at 3 am and not being able to go back to sleep.'	No

FIGURE 4.5 Quick guide to working effectively with interpreters in a mental health setting

Source: Adapted from Miletic et al. (2006, pp. 14 & 43)

Information and education

The lack of culturally and linguistically appropriate information on mental health issues presents significant barriers to people with a CALD background, often preventing them from accessing services and achieving satisfactory health outcomes (Nardi, Waite, & Killian, 2012). Also, without adequate information and knowledge, people cannot consider the different options that are available to them within the community. Information and knowledge are also key factors in challenging stigma, empowering people and enabling participation (Henderson, Kendall, & See, 2011). Further, a lack of knowledge and understanding can generate feelings of anxiety, fear and disempowerment.

There are a number of excellent websites that provide resources and information about mental health issues for CALD populations, and a selection of these are provided at the end of this chapter. It is recommended that health professionals download information from suitable websites and offer this information in paper format to people from CALD backgrounds, as they may be unable or unwilling to access the internet.

Although ethnicity can impact upon a person's ability to seek information and support, and access the necessary services, there will also be times when the system itself fails to deal appropriately with difference or diversity (Culhane-Pera & Borkan, 2012). As already noted in relation to rural and remote cultures, the Australian health system tends to provide a 'one-size-fits-all' approach to providing treatment and care. For this reason, individual health professionals need to adapt their practice to accommodate the needs of the person with a CALD background and thereby facilitate the best possible outcomes for all concerned.

Actively supporting culturally appropriate services

There are many actions a health professional can take to ensure that culturally appropriate mental health care is made available to a person with a CALD background. Some of these actions may relate to ensuring the service is able to deal with diversity (Henderson, Kendall, & See, 2011). Figure 4.6 lists the steps health professionals can take to make a difference for people from CALD backgrounds.

Health professional checklist for culturally diverse consumers

1. Is quality information available to consumers in a range of forms and languages?
2. Are professional interpreters available?
3. Do you provide interpreter services? In the reception area, is there an interpreter sign that can be used by people to identify their preferred language?
4. In the office, are there posters, pictures and other promotional materials that reflect the diversity of the service's consumers?
5. Have all staff and workers received accredited training in providing culturally appropriate health care?
6. Have interpreters been provided with basic information and training about working with mental health consumers?
7. Do your organisation's mission statement, policies, procedures and so on incorporate principles and practices that promote diversity and cultural competency?
8. Do evaluation mechanisms include assessing the number of consumers from diverse backgrounds against ethnic population distribution in the local area?
9. Does the service work collaboratively with local ethno-specific services to draw on their expertise?
10. Does the service provide training to consumers so they can support and work with other consumers?
11. Is the service aware of local ethno-specific support groups? Does it refer to these services where appropriate?

FIGURE 4.6 Things that make a difference for people from culturally diverse backgrounds

Source: Australian Mental Health Consumer Network and Department of Health and Ageing (2004)

Perhaps most significant is the quality of the interactions that a health professional has with the person and their family. To deliver culturally appropriate care, the health professional must build and maintain accepting, respectful and genuine therapeutic relationships (Lane-Krebs, 2012). Ways to enable such partnerships or alliances are discussed in chapter 2. For people from CALD backgrounds, this will also include the health professional:

- acknowledging cultural influences and differences
- taking the necessary time to actively listen to the person and their family to identify how these cultural influences may affect the provision of mental health care and mental health outcomes
- taking the necessary time to develop trust, always accepting and respecting differences
- ensuring support workers are engaged (e.g. interpreters and transcultural health professionals)
- providing as much information as possible to all concerned and discussing what this information may mean for them
- being flexible (Doyle, 2012).

The alliance or relationship between a health professional and the person and their family needs to be mutual and therapeutic; it is the relationship with the health professional that makes the most difference and supports the recovery process. In turn, this alliance will allow the health professional to raise issues such as the mental health and ill-health of the person, and how they can most effectively address any needs.

UPON REFLECTION

Is your practice culturally appropriate?

Many health professionals make the assumption that they are delivering culturally appropriate care. However, few consider just how cultural appropriateness is measured.

Questions

1 What are three steps you can take to gauge your cultural competence or proficiency?

2 What can you do to improve your cultural competence or proficiency in the future?

SUMMARY

There are many challenges to providing culturally appropriate mental health care in Australia today. Australia is one of the most urbanised and multicultural nations in the world. People who belong to Indigenous, rural and remote, CALD or other minority cultures have a lower health status than those who belong to the dominant Western-oriented culture. Health professionals have a responsibility to deliver culturally appropriate care. This includes providing services that are equitable and accessible.

This chapter provided some direction to health professionals to negotiate the complexities of cultural diversity in the mental health context. Cultural constructions of mental health and illness were considered, particularly the way in which these constructions influence the work of the health professional. The chapter discussed the mental health and wellbeing of the Indigenous Australians, as well as approaches health professionals can take to collaborate with Indigenous communities. The major mental health issues for people from rural and remote cultures in Australia were also examined, together with the role of culture in shaping and informing their mental health outcomes. The chapter concluded by outlining the most significant aspects of providing mental health care to people from CALD backgrounds, and explaining the importance of providing culturally appropriate care to people with mental health issues. This includes focusing on the primacy of the interpersonal or therapeutic relationship between the health professional and the person or community with whom they are working.

Review questions

1. Define 'culture' and 'subculture'. How can culture affect the way a person views mental health and illness?
2. Name five broad discourses that frame or inform the understanding of mental health and wellbeing of Indigenous peoples in Australia.
3. How has urbanisation affected the Indigenous populations in Australia?
4. Name at least six of the most common social determinants of health.
5. What are two major issues for people who live in rural areas in relation to accessing mental health services?
6. Differentiate between the terms 'multicultural', 'transcultural' and 'culturally and linguistically diverse'.
7. What are the major mental health issues for refugees?
8. What are the major mental health issues for migrants?
9. Outline the differences between 'cultural safety', 'cultural awareness', 'cultural knowledge', 'cultural competence' and 'cultural proficiency'.
10. What can health professionals do to facilitate the provision of culturally appropriate mental health care to a person with a CALD background?

Discussion and debate

1. In some cultures, 'receiving messages from God', 'having visions', 'hearing voices' or 'speaking in tongues' are highly desirable, whereas in another context such experiences, thoughts and behaviours may be considered to be psychiatric symptoms typically described as hallucinations, delusions, paranoia or psychosis. Similarly, prior to the 1970s, homosexuality was viewed as a mental illness or, in some societies, a criminal offence. Likewise post-traumatic stress disorder (PTSD) only became an official psychiatric diagnosis in the 1980s after the Vietnam War to explain the effects of combat on some veterans. Discuss the cultural and social constructions of these experiences. How do cultural constructions affect the way in which health professionals help the person with a mental health problem?

2 Australia now recognises National Sorry Day on 26 May. How important do you think it was to make the National Apology to Indigenous Australians? What changes has this act generated? How has the National Apology changed health outcomes for Indigenous Australians?

3 Consider the growth in the number of FIFO mining industry workers and FIFO health professionals in rural and remote Australia. What are the benefits and challenges for the community into which the person is flying in and out of to work? What alternatives are there to these FIFO workers and FIFO health professionals who are currently meeting the employment and health needs of rural and remote community?

4 Discuss the issue of children who are refugees being mandatorily detained. What are the risks that detention poses to the child, their family and the community? What are the risks the child, their family and the community face if they are not detained?

5 Consider the notions of 'one size fits all' in the context of health service delivery. When can standardisation here be considered a good thing? How can health professionals ensure that a high standard of equitable health services are maintained, while also allowing for diversity?

Project activity

As a health professional, you are expected to undertake many different roles and activities that are new and challenging. You will also be expected to provide people — patients/consumers, spouses or partners, relatives, colleagues or the community — with information on a variety of topics. Finally, you will be required to work as part of a team. Each of these aspects of the health professional's role has its own particular challenges. This project has been designed to help you develop self-awareness in relation to your capacity to work as part of a team.

Choose at least one other person with whom to work, and form a group. There is no upper limit to the number of people in the group, but it must comprise at least two people. As a group, choose a mental health topic related to cultural constructions of mental health, Indigenous Australians and mental health, rural and remote populations and mental health, or the mental health of culturally and linguistically diverse populations.

As a group, investigate this topic with a view to educating a patient/consumer, spouse or partner, relative or colleague about it. The working group must develop a video presentation aimed at informing patients/consumers, spouses or partners, relatives, colleagues or the community about the topic.

This video clip should be at least 10 minutes in length and no more than 20 minutes in length.

The 'target audience' of the presentation should be clearly identified at the beginning of the presentation.

The presentation can take any form — for example, a power-point presentation, a role play, an 'advertisement' or a dramatic production. You are free to use imagination, innovation, initiative or similar qualities to support the communication of your 'take home message' — but please ensure you consider issues of confidentiality and consent.

Websites

The Australian Indigenous Health*InfoNet* is an innovative internet resource that aims to inform practice and policy in Indigenous health by making research and other knowledge readily accessible. Health*InfoNet* aims to contribute to 'closing the gap' in health between Indigenous and other Australians: www.healthinfonet.ecu.edu.au

Australian Indigenous Mental Health is a website that has been developed by the Aboriginal and Torres Strait Islander Mental Health Committee of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and *beyondblue*. The supports the work of health professionals in improving their knowledge and understanding of Aboriginal and Torres Strait mental health issues and to achieve better health outcomes: http://indigenous.ranzcp.org/index.php

The Australian Refugee Association believes in the desire and capacity of refugees to be part of the culture and economic life of Australia. It provides advice, assistance, advocacy and practical support with settlement services, migration services, employment services, public education, policy and advocacy: www.ausref.net

Multicultural Mental Health Australia is a national program funded by the Australian government to improve awareness of mental health and suicide prevention in CALD communities: www.mmha.org.au

The Victorian Transcultural Psychiatry Unit is a statewide unit which supports area mental health and psychiatric disability support services in working with CALD consumers and carers throughout Victoria: www.vtpu.org.au

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Common reactions to stressful situations

5

LEARNING OBJECTIVES

This chapter will:

- explain the difference between stress and distress
- identify the most common physical, emotional and behavioural reactions to stressful situations
- examine the major factors that influence the way people respond to stress
- describe the main priorities when supporting people through stressful situations
- explain the importance of the provision of information within a consumer-centred health context
- consider the different ways that health professionals can self-care.

Introduction

There is no one 'normal' or routine **reaction** to the stress or distress that accompanies experiences of ill-health, injury, disaster, incapacitation, hospitalisation or rehabilitation. Different people will feel or exhibit different reactions — physical, emotional, behavioural and interpersonal — at different times. That said, there are a number of common reactions that people are likely to experience in stressful situations.

reaction the immediate or instantaneous feeling, action, movement or tendency within a person that is caused by a stimulus of some kind

This chapter examines the reactions of people to the stressful situations encountered in health-related contexts, and describes how best the health professional can respond. The chapter commences by explaining the difference between stress and distress. This is followed by descriptions of the more common physiological, emotional and behavioural reactions of people to stressful situations. The major factors that influence the way in which people react to stress are then considered, including the person's age, background, coping style, experience of disasters, locus of control, resilience and setting. The chapter moves on to explain the main priorities for health professionals supporting people through stressful situations. The need for health professionals to provide person-focused care to those who are reacting to stressful situations is reiterated. Finally, the chapter identifies the need for health professionals to self-care, and outlines strategies to enable them to meet this need.

Stress reactions

Stress occurs when a person's physiological balance or homeostasis is disturbed, presenting a challenge to their emotional, social or psychological wellbeing. Stress is caused by a **stressor** — that is, an event, situation or condition that precipitates stress reactions in a person. Stressors are not always unpleasant. For example, exercise increases sympathetic activity and circulating glucocorticoids in the same way as pain or other adverse events (Miller et al., 2013). Similarly, drinking coffee can fit the definition of a stressor as the caffeine activates a variety of physiological processes in the body to adapt to or oppose the action of caffeine (Owen-Lynch, Robinson, Jones, Hu, & Sunram-Lea, 2012). All stressors, then, produce pleasant and unpleasant stress reactions of one kind or another.

stress the physical, emotional, psychological, social or spiritual reaction that is stimulated in a person in response to a situation, event or condition

stressor any event or circumstance that precipitates a stress reaction in a person

There are many examples of stressors in the health context. Perhaps the most obvious are illness or injury. Other stressors include waiting rooms in emergency departments, health professionals who use jargon, hi-tech machines with arrays of alarms, medical procedures, loss of personal control and dignity, being forced to share a room in a hospital ward, changes in routine, not knowing what is going on, and ongoing pain and discomfort. No less disturbing for many people are the health-related stressors located in the community context, where experiences of ill-health are often marked by chronic illness and pain, the reception of bad news, worry about the future, adaptation to long-term change, and loss and grief.

When a person experiences stress, their bodies produce a range of physiological and, as part of this, emotional and behavioural responses to help them to adapt to or cope with the stressor(s), and return to their pre-stressed state. This pre-stressed state is called **homeostasis**; that is, the tendency in systems (including the human body's systems) to maintain balance or stability, and thereby support the systems' wellbeing. Homeostasis is achieved through stress reactions, which are also called coping or adaptive mechanisms (National Research Council (US), 2008).

homeostasis the tendency in systems, including the human body systems, to maintain the balance, stability or wellbeing of those systems

Coping or adaptive mechanisms are stressor-specific; consequently, the processes by which homeostasis or wellbeing is restored will differ according to the stressful experience (Demakakos et al. 2009). For example, viral or bacterial infection, threat of physical harm, drugs, exercise, sexual activity, high altitude, restraint, hunger and thirst will generate quite different adaptive mechanisms in a person. Some of these mechanisms may be beneficial to the person in the long term because they promote longevity and good health (e.g. stress responses to fight infection). Other stress reactions have the potential to be harmful (e.g. stress responses to prolonged thirst).

The terms 'stress' and 'distress' are often used interchangeably. However, there is growing evidence to suggest that there are differences between a healthy adaptive stress response and the potentially harmful state of distress (Alexander & Klein, 2009; National Research Council (US), 2008). **Distress** is the result of acute, severe or prolonged stressors or multiple and cumulative stressful events. For example, people become distressed when they are unable to adapt to or cope with stressful situations, leading to a compromise of their wellbeing. It is important to note that a person may continue to be distressed, even if they appear to recover rapidly after the removal of the stressor or the conclusion of the procedure.

distress where a person's wellbeing is compromised due to an ability to adapt to acute, severe or prolonged stressors, or multiple and cumulative stressful events

The transition from stress to distress depends on several factors; the first and perhaps most important is the duration and intensity of the stress. For example, a person may adapt well to high levels of pain or discomfort in the short term; however, if this stressor is prolonged, the person will start to show signs of distress. Another factor is predictability and controllability. If a person can predict the onset of stress and/or control its duration, the impact of the stressor will be minimised. This is why it is important to provide a full explanation of a medical or health-related procedure to a person, prior to its commencement. With knowledge of what is going to happen, when, and why, the person will be more able to predict and prepare for the stressful event, feel more in control of their situation, and so feel less stressed (Bodie & Graham, 2012; Maier & Watkins 2005).

IN PRACTICE

Different reactions to stressful situations

Scenario 1

Miranda, 27 years, and Bevin, 29 years, recently became first-time parents to Emily. Although they were very excited about her arrival, they also felt nervous about their brand new parenting role. In particular, Miranda felt as though she didn't know what she was doing and she was often anxious about hurting Emily in some way. Miranda's parents were supportive; however, they lived six hours drive away. Bevin's parents live in England. Both Miranda and Bevin worked hard to follow all the directions of the maternal and child nurses.

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One morning, when the baby is just six weeks old, Miranda goes to the cot and finds that Emily is not breathing. Miranda screams and Bevin immediately comes to her aid. They call 000, but there is nothing anyone can do — Emily is dead.

Miranda is inconsolable. She can't stop sobbing and blaming herself. She is also shaking uncontrollably. The health professionals who attend feel helpless because they have children of their own and know that Sudden Infant Death Syndrome is every parent's worst nightmare. They don't know what to say or do, so decide it best to take Miranda to hospital so she can be sedated.

Scenario 2

Samuel is a 52-year-old male who was involved in a serious car accident three months ago. He has been in hospital since that time, first in the intensive care unit, then in the orthopaedic ward, and finally in the rehabilitation unit where he is undergoing an intensive regimen of physiotherapy prior to discharge.

Samuel is not popular with the multidisciplinary team. He often complains to individual health professionals about the way he is being treated. Samuel's wife has sent several complaints in writing to health service managers and also the local newspaper. She seems distressed, but health professionals find it difficult to empathise as she clearly doesn't appreciate all they are trying to do to help Samuel.

Perhaps worst of all is Samuel's daughter, who constantly badgers the multidisciplinary team for information about her father's progress. It sometimes seems as if she is always 'in their faces' demanding that someone gives her more and more time. Health professionals have provided her with all kinds of brochures, handouts and journal articles related to her father's condition, but nothing seems to satisfy her.

All members of the multidisciplinary team now avoid Samuel, his wife and daughter. In the privacy of the staff tea-room, they wonder if the whole family is 'mad' and look forward to the day Samuel is discharged.

Scenario 3

Claire is a 28-year-old mother of four children who are all under five years of age. The oldest has had a high temperature on and off for over ten days. During the course of this illness, Claire has brought the child twice into the emergency department for assessment.

On the third occasion Claire has her husband and all four children with her. Claire is weeping quietly, the children are howling loudly, and the husband is clearly angry. He presents to the triage window and starts to yell, 'You people just don't care, do you? My child could die and you'd still do nothing!'

The nurse feels quite upset at being spoken to in this way. She also notices that the man has tattoos and multiple facial piercings. She decides he is either an illicit drug user or has a serious mental illness and wastes no time in pressing the emergency button to call security officers for assistance.

Questions

1 Discuss the different reactions to stress that each of the people in these scenarios, including health professionals, may be experiencing.

2 What presumptions are being made by the health professionals in each of the scenarios?

3 As a health professional, how could you have responded differently to the people in each of these scenarios?

Physiological reactions

Physiological adaptive mechanisms can include activation of the sympathetic nervous system and adrenal medulla, secretion of glucocorticoids and prolactin, and mobilisation of the immune system (Wanat et al., 2012). These mechanisms work to manage stressors such as an infection; and also produce the biochemicals that give rise to the emotions.

Another important — and more observable — physiological adaptive mechanism is called 'acute stress reaction'. Any person may have an **acute stress reaction**, particularly after experiencing a highly stressful or traumatic event. It is important to note that it is not necessary for the person to have been physically involved in a trauma to experience such a reaction. For example, a person may experience an acute stress reaction after witnessing the sudden collapse of a family member and/or the frantic attempts by first responders to resuscitate that family member.

acute stress reaction a transient anxiety condition that develops physiologically in response to a traumatic event; usually begins within minutes of the event and disappears after hours or days

Acute stress reactions are usually self-limiting and in most cases do not require any specific biomedical treatments (e.g. medications). However, the symptoms can be severe and distressing for the person, and may include:

- an initial state of 'daze'
- reduced levels of consciousness
- agitation or overactivity
- withdrawal
- anxiety symptoms (e.g. sweating, increased heart rate or flushing).

These symptoms usually occur within a few minutes of the stressful event and disappear within hours or days.

An essential part of the care of a person who is experiencing an acute stress reaction includes the health professional treating the symptoms, as required; and providing explanations and information about the event. Treating the symptoms usually involves first-aid type measures. For example, if someone is shivering, the health professional will provide them with a blanket or other covering. Providing explanations also involves the process of **normalising** the experience for the person. This may include reassuring the person that they are experiencing a common physical reaction to a stressful situation. Providing support must also include the family or significant others, who may be feeling concerned about the way the person is reacting.

normalising the process of reframing a person's feelings or perceptions of an event or situation so that these feelings or perceptions become more acceptable to that person

If symptoms of acute stress reaction persist in their frequency and severity for longer than four weeks, then the condition may develop into a **post-traumatic stress disorder (PTSD)** (Sakoman, 2013). According to the Australian Centre for Posttraumatic Mental Health, the prevalence of PTSD in the Australian population overall is approximately 5 per cent of those who experience significant trauma (University of Melbourne, 2007). For this reason, it is a less common response to a stressful situation and so not described in detail in this chapter (see chapter 7). In general terms, however, the condition is diagnosed in those who have survived specific types of trauma, such as war, terrorist attacks,

post-traumatic stress disorder (PTSD) a diagnosed mental health condition characterised by the development of a long-lasting anxiety reaction following a traumatic or catastrophic event rape or other assault, disaster, refugee experiences, or the sudden unexpected death of a loved one (Nadew, 2012; Silove, Steel, Bauman, Chey, & McFarlane, 2007). PTSD has ongoing lifestyle and adjustment implications and requires referral to specialised mental health professionals for treatment.

Emotional and behavioural reactions

Emotional responses or adaptive mechanisms include any feeling that is produced in a stressful situation. Emotional responses are closely connected to physiological and behavioural mechanisms, which are stimulated through activation of the sympatho-adrenomedullary (SAM) system and give rise to rapid increases in blood flow to the muscles and glucose levels (Centre for Studies on Human Stress, 2007). Behavioural reactions work to enhance the person's capacity for 'fight or flight'. In this section, the emotional and behavioural reactions are considered together because the two are so closely connected. For example, a person who is feeling strong emotions will often behave in a particular way, driven by those emotions.

The more common of the negatively valorised emotions and behaviours produced in the health context are considered in turn: anger, anxiety, denial, fear, grief, and tearfulness. Strategies for dealing with the less common and quite challenging or complex reactions or behaviours which health professionals may encounter, such as aggression and violence, can be found in chapter 6.

What are emotions?

Emotions are integral to personhood, along with the physical, psychological, social, sexual, cultural, spiritual, environmental and functional aspects of being (Corey, 2012; Ruys & Stapel, 2008). Emotions are perhaps best defined by the synonyms 'feelings', 'moods', 'sensations' or 'passions'. Related words describe emotions in subjective terms, such as 'sad', 'glad' or 'mad'. Although subjective in nature, emotions nevertheless have a neurological and chemical basis. Emotions are generated spontaneously in response to a thought, action, behaviour or experience. Once generated, they are given meaning cognitively and expressed either behaviourally (e.g. crying) or through language (e.g. 'I'm upset!'). This suggests that the emotional and behavioural capacities in humans are inextricably connected and influence each other (Corey, 2012; Reid, 2002).

There are many theories about the emotions, including those related to their classification, and cause and effect. For example, some describe the **prime emotions** as the essential or simplest emotions, the building blocks of all feelings (Ruys & Stapel, 2008; Thamm, 2007). It can be important to name these emotions to help people understand the intense and confusing composite of sensations or reactions they may sometimes feel. Some suggest that there are only two prime emotions — love and fear — with all feelings a combination of one or both of these emotions (Corey, 2012). Others have identified up to seven of the more negatively valorised prime emotions: fear, helplessness, hopelessness, hurt, sadness, worthlessness and aloneness. Proponents suggest that it is these seven emotions that drive all human reactions to stress, and that they have the potential to harm health and wellbeing (Reid, 2002).

prime emotion an emotion in its simplest form. It cannot be divided into more than one particular feeling.

The causes and effects of emotions are equally debatable. For example, advocates of cognitive behavioural therapy support the view that emotions are the outcome of thoughts and behaviours (Corey, 2012). On the other hand, advocates of emotion-focused therapy suggest that thoughts and behaviours are an outcome of the emotions (Greenberg, 2010; Pos & Greenberg, 2012). Since there has been less empirical research conducted to support the notion that emotions drive our behaviours, at this point in time, the former view has found greater acceptance.

At the same time, however, it is also important to acknowledge that the emotions, unlike thoughts and behaviours, are difficult to measure empirically. Of course, there are many observable or measurable expressions of emotion. For example, externally, there is laughing, sweating, shaking, flushing, trembling and increased energy; internally, there is pain, tense muscles, diarrhoea, rapid pulse, changes in brainwave patterns and increased respiration. Each of these expressions of emotion can be measured to some degree. Even so, the very subjective nature of emotions presents challenges to researchers — most notably because they fall outside of the parameters of the science-driven biomedical model that underpins the delivery of health services (see chapter 1).

Indeed, it is this scientific, biomedical context that has given rise to the suggestion that emotions are 'unreliable'. To exemplify, people can demonstrate a split between their thoughts and feelings. This is expressed through sentences such as 'I know that to be true in my head, but I don't feel that way'. Moreover, when people are in deep emotional stress, reason and volition are often seen to 'fly out the window'. This explains why descriptions such as 'she's just being emotional' or 'that's a very emotional response' often have quite negative connotations. While the emotions may be viewed by some as unreliable, however, people can be described as 'reliably' emotional!

Individual variations in the expression of emotions are based on a range of factors. In particular, when a person is unwell, their capacity to think, feel, make decisions and behave as expected may also be compromised (Westphal, Seivert, & Bonanno, 2010). It is important, then, for the health professional to have some knowledge of the emotions that are most commonly experienced by people in stressful situations, and the factors that can influence the way a person reacts to stressful situations. Such knowledge will allow the health professional to gauge how best to help the person who is stressed.

Suppression and repression

Pleasant emotions can engender exciting and expressive experiences; people may be motivated and energised. Unpleasant emotions, on the other hand, can have a quite different outcome. This explains why some people may shut down or minimise their emotions by:

- labelling the emotions as irrational and ignoring them
- distancing themselves from their feelings through work, exercise, music
- displacing their feelings onto other people or things (projection)
- compensating for the emotions (e.g. through eating, substance abuse, spending money, work).

Behaviours that shut down or minimise the emotions are learned. The extent to which a person exhibits these kinds of behaviours will vary, depending on a range of factors. These factors are described in more detail later in this chapter.

Healthy people will be aware of their emotions, and be comfortable to feel or express these emotions, appropriate to setting, context and culture (Goldman & Greenberg, 2013). Indeed, emotions are meant to be felt or expressed (Weiner, 2012). There will be times, however, when suppressing an emotion will help a person cope with a particularly stressful event. In the short term, the **suppression** of emotions is a coping strategy to help a person through a difficult time. But if emotions are suppressed over a long period of time, they can immobilise or exhaust the person, or influence them to behave in a way that is unusual for them (Corey, 2012; Greenberg, 2010). Unpleasant emotions that are suppressed long-term become repressed emotions.

Repression of emotions will affect the way a person reacts to stress. For example, an event may occur in the present that is similar to a past event. Emotions that belong to the past event are triggered. A **trigger** is a word, comment, event of other experience that produces an instantaneous and often uncontrollable feeling or reaction within a person. When a current event triggers an emotion or behaviour that belongs to a past event, the reaction is often far stronger than is appropriate in the 'here and now'. This is because past and present emotions join together and the reactions are intensified (Corey, 2012; Greenberg, 2010).

suppression the process by which the person consciously puts feelings aside so he or she can cope with an event

repression an unconscious long-term process where feelings are minimised or ignored

trigger a word, comment, event or other experience that produces an immediate or instantaneous feeling or reaction within a person; a trigger is most often linked to a past event or experience

Stress and the emotions

People who experience stressful situations can feel and exhibit a range of emotional reactions that translate into behaviours. These reactions can be further intensified by factors such as illness, injury, tiredness, exhaustion and feelings of isolation or helplessness. In combination, strong emotions may be expressed by the person who is stressed in ways that may seem inappropriate, even bizarre, to the health professional. For example, some health professionals may view loud and apparently hysterical laughter followed by uncontrollable crying as a sign of an unstable personality, especially if this reaction is prompted by an event or issue that health professionals view as relatively minor. The health professional may react to such behaviours by very quickly referring the person on to be assessed by a specialist — when they could, more appropriately, accept that the person is experiencing a reaction to a stressful situation and listen to the person's concerns.

There may also be times when the health professional feels threatened, uncomfortable, unappreciated or belittled by a person they encounter in their workplace. These feelings may be justified, especially if the person has resorted to aggression or violence (see chapter 6). On the other hand, the health professional's reaction may be the result of their own personal triggers. For example, a health professional may feel uncomfortable because a person is crying and the health professional does not like the strong and inexplicable feelings this may arouse. Rather than allowing the person to express their feelings, the health professional may react by:

- changing the subject to stop the person from crying
- walking away and leaving the person to deal with it on their own
- controlling what is happening through the use of, for example, medication or coercion.

By curtailing the expression of the emotion by the person, the health professional is in essence serving to reduce their own feelings of discomfort. The person, on the other hand, is left feeling frustrated, anxious and misunderstood by the health professional.

In the health context, any number and range of emotions are experienced or demonstrated by people. Those who attend a health facility are generally unwell, injured, or supporting another person who is unwell or injured. In short, they are experiencing stress. The most common emotions generated by the experience of stress in such situations include anger, anxiety, denial, fear, grief and tearfulness. These emotions are now discussed in turn.

Anger

Becoming angry is one way by which people protect themselves emotionally. Generally, anger hides other emotions such as frustration, anxiety, fear, helplessness or hopelessness. As a person struggles to work through a stressful situation, anger may be the outward expression of these feelings. Becoming angry can also temporarily shift the focus away from the issues at hand and onto external objects or subjects. This provides the person with a way to distance or 'externalise' the situation, as they work to come to terms with what is happening to or around them.

It is vital that health professionals understand these dynamics so they are less likely to presume that the anger a person expresses is aimed at them. Moreover, if we allow the person who is angry to express their true feelings, the anger will often diminish. It is also important that the health professional does not dismiss the anger as 'just venting', but rather acknowledges the specific concerns of the person, assures them that they will be taken seriously, and passes on any complaints to relevant managers for investigation.

Health professionals who work in any environment can help the person who is angry or upset to express themselves safely through a process called 'de-escalation'. **De-escalation** is an approach that is often used by health professionals to assist a person to express their anger in a safe context. Figure 5.1 outlines the steps that a health professional can take to de-escalate a situation. These steps include providing a safe environment and supporting the person to express their feelings until their anger is vented.

de-escalation the process by which a person's strong feelings or reactions are reduced in intensity

To 'de-escalate' the person who is angry, the health professional needs to take the following steps.

1. Always treat the person with dignity and respect.
2. Appear calm, confident and patient:
   - stand slightly to the side of and at an angle to the person
   - keep hands in front of the body and in an open position
   - do not fold arms across the chest.
3. Minimise direct eye contact — do not try to 'stare down' an angry person.
4. Allow the person adequate personal space.
5. Use active listening skills and offer empathic responses.
6. Allow the person to talk or ventilate:
   - do not personalise any of the comments made by the person who is angry
   - ignore all insults or threats
   - remember that the angry person needs to express themselves. If the health professional enables the person to express themselves verbally, the anger will most often dissipate.
7. Try to see things from the angry person's point of view (e.g. 'It must be a worry for you, with your child unwell and you not knowing what is going on.').
8. Do not be judgemental, threatening, accusing, give advice, or suggest to the person that they are wrong or in some way crazy. Generally, this will only incite the person to more anger.
9. Be honest — do *not* make promises that cannot be kept.
10. Speak firmly, slowly and clearly, and maintain this approach for as long as it takes the person to say what they want/need to say.

A general attitude of goodwill also helps to de-escalate such situations.

FIGURE 5.1 De-escalating a person who is angry

It is unrealistic for any health professional to expect to be able to de-escalate a situation without practise. It is recommended that health professionals engage with colleagues, away from the clinical front-line, to practise these skills. It is also essential that health professionals are aware of their own personal triggers, and remove themselves from the situation if they feel intense emotion or the urge to react suddenly when interacting with a patient or consumer.

UPON REFLECTION

What are my 'triggers'?

Everyone has their own personal 'triggers'. For example, a health professional may find themselves feeling suddenly angry when a service user tells them they are incompetent or threatens to report them to their manager, says something offensive about the health professional's family or insults their appearance.

Questions

1 What are your personal triggers?
2 What actions would you take to manage your personal triggers in the workplace?

Anxiety

Anxious reactions are common in people who are facing uncertainty about the situation or event they are experiencing. Generally, the more serious the health issue, the greater the anxiety. In particular, the process of attending or being admitted to hospital, with its unfamiliar environment and routines, can be a source of considerable anxiety. Some people, such as the older person or a person from an Indigenous culture, may also associate hospitals with death because they have known relatives or friends who have been admitted to hospital for treatment and died soon after. These people may feel reluctant to share their feelings about the situation with health professionals. It is important, then, to engage with the person's partner, carer or family members, so that they can help with identifying the source of the anxiety.

Anxiety can manifest itself in a variety of ways, including an increased sense of panic, unease and apprehension, along with feelings of irritability, impatience and agitation. Feelings of anxiety will also reduce the person's tolerance to pain and increase levels of physical discomfort and muscular tension. Other common symptoms include palpitations, breathlessness, loss of appetite, insomnia and tightness in the chest. Some people, especially those with a history of acute cardiac events, may misinterpret these symptoms as an exacerbation of their coronary condition. This in turn can lead to the vicious cycle of further anxiety and chest pain, necessitating additional investigations that result in delays to rehabilitation and recovery.

A number of strategies and interventions can be useful to help the person who is anxious. First and foremost, it is vital that the person is provided with information about what is happening to them. This may be enough to reassure the person and reduce their anxiety. Some people, however, may require more specific interventions, such as undertaking diversional activities (e.g. taking a warm bath, talking, engaging in a practical task, or having a warm drink) or learning relaxation techniques. If a person has a diagnosed anxiety disorder, they would best be referred on to a specialist health professional for assistance.

Denial

When people are first faced with a stressful event, the suppression of emotions — that is, transitory denial — is a common reaction. This defence mechanism, usually unconscious, provides a way to limit and manage otherwise overwhelming emotions, and so it needs to be viewed as part of the overall process of coping and adapting. In the first instance, do not force a person to accept or even acknowledge what it is that they are trying to deny (e.g. the unpleasant or challenging situation, an unwelcome diagnosis or a prognosis). As already noted, denial is not necessarily a problem in itself, but rather a short term strategy that is commonly used to deal with pain or incapacity. Consequently, it is more appropriate for the health professional to explore the fears or anxieties that lie beneath the denial by talking with the person and asking them how they are feeling. The denial or related behaviour(s) will most often resolve themselves, depending on the level of support that is available to the person and also the quality of their interpersonal or family relationships at that time.

There may be occasions when a person continues to deny the fact that they are feeling acutely stressed or distressed. This can lead to the appearance of overt optimism in the face of issues that, in the health professional's view, need to be dealt with more realistically. Ongoing denial, without exploration or awareness of the deeper issues involved, may lead to long-term repression of emotion, and eventually give rise to mental health issues. In such circumstances, health professionals are advised to refer the person to a specialist for assessment.

Fear

The events or moments that generate fear in someone are usually very personal. Sometimes, fear can be the result of a lack of trust in others. It can also be a very appropriate reaction to an uncertain or threatening situation. Illness or injury can lead to pain or death; it is understandable, then, that people who are seriously unwell have fears for the future. Treatment for some health conditions can be painful — an unpleasant experience for most people — and so it is appropriate that people view some treatments with a degree of fear.

There are also times when fear can be a useful emotion; for example, in dangerous situations, fear triggers the release of adrenaline that enables a person to prepare to fight or flee. On the other hand, fear can also 'paralyse' a person cognitively, keeping them from making required decisions. Such scenarios provide grounds for why health professionals may sometimes be called upon to support a person through a fearful experience.

While accepting and understanding that a person who is unwell (and their partner or carer) will be fearful, the health professional may also need to check whether the person is harbouring unrealistic fears about their diagnosis or prognosis. To illustrate, a person may fear that a diagnosis of cancer will inevitably be terminal or that all treatments for the disease will cause hair loss. Checking what it is that the person fears provides a valuable means by which the health professional can support the person with reassurance. Quite often, simply allowing a person to talk about the fear and providing them with information will lead to a reduction in the intensity of the emotion.

On the other hand, sometimes the person may not be able to identify the underlying cause of their fear. Instead, they may feel an abstract fear of 'the unknown'; a composite of the many possibilities ahead of them. In this case, the health professional is best to encourage the person to talk about their situation, rather than the emotion, and provide relevant and regular information and explanations as the treatment progresses.

Another key strategy to help people to manage their fear is relaxation therapy. The ways in which an individual relaxes are very personal; some people enjoy lying back and listening to music, and others prefer an activity such as gardening. Health professionals may also recommend muscular relaxation, breathing and meditation to the person. These strategies are most often taught by a specialist, so it is recommended that health professionals ensure they have relevant information on hand about how to access these specialists.

Grief

Many people are familiar with the seminal work of Kubler-Ross and her model of the five stages of grief. These were first posited in 1969 in her book *On death and dying*. Since that time, Kubler-Ross has also applied the model to other grief experiences, including loss of income, divorce, illness and so on (Kubler-Ross, 2005).

According to Kubler-Ross, the five stages of grief include the following.

1. *Denial* — 'This can't be happening to me!'
2. *Anger* — 'Why me? It's not fair! Who can I blame?'
3. *Bargaining* — 'If I can just have a little longer, I promise . . .'
4. *Depression* — 'What's the point of even trying?'
5. *Acceptance* — 'I'm ready for what lies ahead.'

These stages do not necessarily follow the same order in each and every person; nor are all steps experienced by all people. Sometimes people will oscillate between stages; others may never reach the acceptance stage.

An understanding of these stages of grief and how different people may react when they are grieving will assist health professionals to understand why a person is reacting in a particular way. Such knowledge will also help health professionals to accept that grieving is a very human and healthy process. For this reason, someone who is 'emotional' after experiencing a loss should not be labelled as 'depressed' or 'histrionic'. Rather, the health professional needs to support the person through the grief process by listening, showing empathy, and providing explanations. Details on how to provide explanations are provided later in this chapter.

Tearfulness

Tears are a common occurrence in the health context. Tearfulness is often the outward manifestation of inward and painful emotions or distress. People may cry because they feel physically unwell or stressed. Tears are also one way of expressing emotion.

It is essential that the health professional recognises that crying can be a healthy way of releasing suppressed or pent-up emotions. Indeed, many people find crying a cathartic and restorative experience. For this reason, health professionals are wise to allow — even encourage — the person to express themselves through crying, rather than discourage them from crying.

Health professionals can also use the moment, when a person is tearful, to demonstrate empathy or to engage in a supportive conversation. This would include acknowledging the person's feelings. Alternatively, there may be times when the person needs privacy, to cry without interruption. To determine which path to take, the health professional is best to ask the person what they would prefer.

Reactions of families and carers

The previous section outlined the more common emotions that are exhibited by individuals who are unwell, injured, or experiencing a change in health status. This section considers how family members or carers will, in turn, react to the stress generated by such a situation. For example, a partner, carer, family member or friend may feel upset to see their loved one in pain, unwell or incapacitated; and also at being forced to deal with the inevitable changes to their lifestyle that occur as part of the illness or injury. Such changes may include adapting to a disruption in routines and relationships, and learning to deal with feelings of uncertainty, fear or helplessness.

Health professionals need to support individuals, couples, families and significant others as they go through the process of renegotiating the rules and roles in their relationships when a loved one is experiencing ill health. Research suggests that the quality or closeness of relationships between a person and their family or significant others is a major factor in influencing their levels of stress when they are unwell (e.g. Manne & Badr, 2008). By supporting the family and carers through the process of adaptation, health professionals are providing for the best possible outcomes for all those involved. The type of support the health professional can provide may include listening to the family members or partners and friends, following through with requests wherever possible, giving information, and linking them to support services such as Centrelink, community health centres and support groups. Health professionals can also refer families on to specialists for more focused interventions, such as interpersonal therapy.

Interpersonal therapy (IPT) is an approach that focuses on a person's current relationships with peers and family members, and the way in which that person perceives themselves in those relationships. The goals of IPT are to reduce relationship difficulties and improve social adjustment by helping people to identify and modify interpersonal problems; and to understand and manage relationship problems (Spurling, 2012). The issues most often explored in IPT are unresolved grief, role disputes, role transitions and interpersonal deficits.

interpersonal therapy (ITP) a time-limited therapeutic approach that aims to improve social adjustment by focusing on interactions that occur in current relationships, and the way a person perceives themselves in those relationships

Communication with families and carers

Health professionals are wise to recognise that the levels and quality of communication between people will vary, largely determined by established interpersonal patterns of relating that have developed over years and possibly decades. It is extremely unlikely that such interpersonal patterns of communicating will suddenly change for the better when one member of a couple or family becomes unwell. It is more likely that the stressful situation will test these interpersonal patterns, and exacerbate dysfunctional patterns. It is important that health professionals take this likelihood into account when interacting with a person who is experiencing stress and adapt their own communication patterns accordingly.

Relevant discussions with couples, families and carers need to include how the health issue or injury is affecting them, as well as exploring ways they can cope with or manage the physical, psychological and social demands of the situation. Often, family members will be concerned or curious about things such as:

- how the health issue came about
- whether anyone did something to cause it or if anyone is 'to blame'
- whether something could have been done to prevent it
- whether it is contagious or can be inherited
- how long the health issue could last
- what supports are available in the community.

In cases of sudden injury or trauma, concerns may include:

- how long the person could be in hospital
- who will pay the medical expenses
- what the family needs to do in the short term
- when the family can expect to 'get back to normal'.

The health professional has a key role to play in supporting and guiding the person and family members through their quest for knowledge about the health issue and its possible consequences.

It is also important that health professionals are aware of the high rates of depression in individuals who care for a person with chronic health issues (Fenton & Riley, 2007; Ranmuthugala, Nepal, Brown, & Percival, 2009). Caring for a partner, family member or friend who has chronic health issues inevitably involves long-term stress for the carer, social restrictions, limitation on the choices open to them, financial constraints and physical demands. Regularly checking with partners, carers or family members in relation to their health status, including their social and emotional wellbeing, is a necessary part of providing comprehensive health care to the individual.

Finally, in certain instances — particularly those involving chronic illness, terminal care or death — discussions with partners and carers about advance care agreements (see chapter 3), wills and other family arrangements may be essential. In these circumstances, the partner or family members may also be struggling with the anticipated loss of their loved one. First and foremost, the health professional needs to listen to the person and allow them to express their feelings. As previously explained, grief is a common and quite reasonable reaction experienced by people located in the health context. The effective health professional will understand this and give people the time, space and acceptance they need to work through their feelings.

In some instances, it may also be appropriate for the health professional to convey the message that all relationships are time-limited, and it is possible to live life more fully in the present and enjoy the 'here and now' rather than postpone fulfilment based on an illusion of infinite time (Rowland, 2004). For example, family members and partners can be encouraged to make the most of the time they have left with the person by planning some special activities to share together. In situations such as these, however, it is advised that health professionals also refer the person on to specialist support services for assistance, including the palliative care team, counsellors or chaplains.

IN PRACTICE

Common sense or unethical behaviour?

Navayah's son is critically unwell in the intensive care unit. Navayah and her relatives have just been told by the medical practitioner that nothing more can be done for him. Navayah begins to wail uncontrollably. Her relatives join in. Even though they are in a private consultation room, everyone in the intensive care unit can hear the wails, and those visiting other patients are starting to look anxious. The health professional tells Navayah and her relatives that this is a hospital and they must either be quiet or leave to do their grieving in a more appropriate place.

Questions

1 Is the health professional's behaviour common sense or unethical? Justify your answer.

2 How can health professionals support people from culturally and linguistically diverse backgrounds to express themselves and grieve?

Factors that influence stress reactions

Most people feel stressed when they experience significant and adverse changes in their levels of health. An experience of illness or injury may be new, unpredictable or uncontrollable, and will invariably involve a degree of change and loss. The impact of such events will be very much influenced by the person's perception of what is happening to them, and what the experience means for them. Similarly, the way in which a health professional reacts to a stressful situation will depend upon many factors, including the systems and structures that frame their work, their understanding of how people cope and adapt to stressful situations, and their own personal beliefs about the expression of emotions. In this section, the factors and influences that shape the way all people react and respond to stress are examined.

Age

People from across the lifespan — for example, children and adults — tend to respond differently to stressful situations. Children who are stressed are less likely to express their feelings using words and more likely to use behaviours to express or 'act out' their emotions.

For example, toddler and preschool age children who are stressed typically demonstrate increased attachment to their parents, high levels of crying, developmental regression, distress when left alone, eating difficulties and an acute sensitivity to their immediate environment. In early to middle childhood (5–11 years), behaviours of children who are stressed commonly include problems associated with sleeping, gastrointestinal irritation, avoidance of social interaction, regressive reactions such as bed-wetting or thumb sucking, learning difficulties at school and general withdrawal. Early adolescents may exhibit a continuation of avoiding social interactions — often in their relationships with friends and family — while stressed adolescents (14–18 years) may experience nightmares and/or excessive sleeping, difficulty focusing on tasks, and symptoms such as skin irritations and headaches (RealAge, 2012).

Likewise, older people may react differently to adults in stressful situations. For example, older people often exhibit fewer physiological or emotional reactions because their previous life experiences, including hardship or difficult times, have given them the opportunity to develop coping skills and resilience. On the other hand, older people may have physical limitations that add to the difficulties experienced in a stressful situation. For example, a deteriorating health status can lead to reductions in mobility and, consequently, their independence.

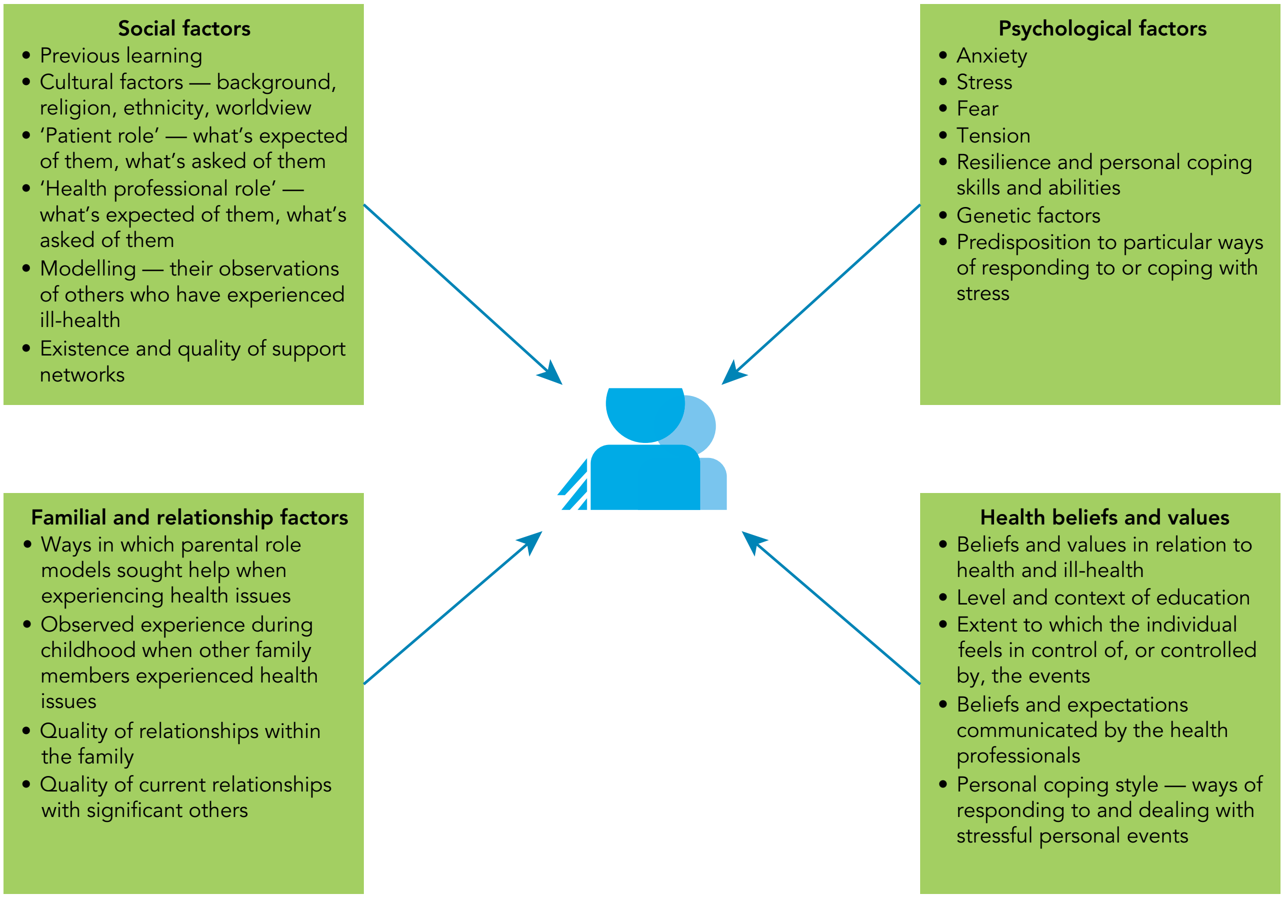
It is important that health professionals consider the age of the person when helping them through stressful situations. Younger people and older people alike will need additional understanding and support to minimise the effects of stress.

Background

A person's background will influence the way they respond to stressful situations. For example, the dominant culture in Australia tends to discourage the expression of painful emotions. This has developed from the 'stiff upper lip' Anglo tradition of the first white settlers, who had to be strong, indomitable and 'in control' in a country that seemed so hostile. Certainly, there have been changes to this tradition due to the influences of multiculturalism, postmodernism and the questioning of traditional norms. Even so, many people who live in contemporary Australia continue to believe that showing emotion is a sign of weakness; or that those who struggle to deal with stressful situations should just 'get over it' or 'get a hold of themselves'. The socio-cultural background of the person plays a large role in the way they perceive and respond to stress.

The many different factors involved in shaping the way a person responds to stress are outlined in figure 5.2 and include social, psychological and family factors, as well as health beliefs and values. The extent that each of these factors affects the person will be determined by:

- the degree to which the person feels 'in control' of what is happening to them
- the person's current social, interpersonal and spiritual contexts
- the person's resilience or repertoire of personal coping skills or techniques
- the way the person has dealt with past stressful situations and life events.



Social factors

- Previous learning
- Cultural factors — background, religion, ethnicity, worldview
- 'Patient role' — what's expected of them, what's asked of them
- 'Health professional role' — what's expected of them, what's asked of them
- Modelling — their observations of others who have experienced ill-health
- Existence and quality of support networks

Psychological factors

- Anxiety
- Stress
- Fear
- Tension
- Resilience and personal coping skills and abilities
- Genetic factors
- Predisposition to particular ways of responding to or coping with stress

Familial and relationship factors

- Ways in which parental role models sought help when experiencing health issues
- Observed experience during childhood when other family members experienced health issues
- Quality of relationships within the family
- Quality of current relationships with significant others

Health beliefs and values

- Beliefs and values in relation to health and ill-health
- Level and context of education
- Extent to which the individual feels in control of, or controlled by, the events
- Beliefs and expectations communicated by the health professionals
- Personal coping style — ways of responding to and dealing with stressful personal events

FIGURE 5.2 Factors influencing the person's experience of stress

It is important to note that people will most often move within and between their family and social contexts. Likewise, they will draw on any number of social, psychological and familial factors, and a range of beliefs. This makes it difficult to reduce a person's reactions to stress into a single, cause-and-effect relationship that is easily 'fixed' or dealt with. For the health professional to do this would be to minimise the richness and diversity of the person's life, relationships, situation, and circumstances.

To provide the most appropriate and comprehensive care, the health professional needs to consider the complex factors that have made the consumer the person they are. To do this, the health professional must talk to the person about the way in which these background factors affect them, and work with the person to determine the best options to support them through the stressful experience.

Coping style

A person's reactions to stress will also be influenced by their individual style of coping. For example, some people will cope with a stressful experience by limiting the amount of information they receive. This is demonstrated by behaviours such as not asking questions or avoiding discussion about the implications or effects of the health issue.

Others may deal with their stressful experience by actively seeking out information or repeatedly requesting reassurance and explanations from health professionals.

The coping process

People may experience a range of stressful events or situations that affect their health — including accidents and injury, disasters, acute or chronic illness, ongoing treatment, hospitalisation, rehabilitation and extended recovery. The process of coping with such situations is complex. It is perhaps for this reason that there are so many different associated theories to explain the dynamics involved.

One of the simpler models to explain the coping process has been described by the seminal author Moos (1984) and includes the following factors:

- thinking about the health issue and the changes it has generated in the person's life
- identifying ways to cope with, respond to, or deal with the experience
- planning and implementing particular strategies and responses.

The **strategies** that are used by a person will depend upon the skills or actions that have been utilised by the person in the past when dealing with stress. These strategies will differ from individual to individual, and may include:

- reducing or changing harmful external conditions
- tolerating or adapting to negative events
- maintaining a positive self-image
- decreasing emotional stress and working to maintain emotional equilibrium
- maintaining satisfactory relationships with others
- maintaining satisfactory relationships with the environment
- obtaining information about the health issue
- developing new skills to help them to cope (e.g. yoga or relaxation techniques)
- seeking out practical, social or emotional support (e.g. joining a local support group, consumer forum or church/spiritual group)
- developing new or additional interests to divert their attention (e.g. gardening)
- expressing their distressing feelings constructively (e.g. journalling, artwork or counselling).

strategies the actions taken by a particular person after due consideration has been given to the possible and/or actual affects and outcomes of a stimulus

One person may find one or more of these strategies helpful, while the next person may find that other strategies help them. The health professional should not push any particular activity onto a person, but rather provide options from which the person can choose.

Some people, when stressed, may gravitate to activities that can be less than helpful. Examples of such unhelpful strategies may include:

- ignoring or denying symptoms. This unhelpful way of dealing with stress will sometimes delay the person seeking help. Denial can also influence the degree to which the individual and their family is able to collaborate and cooperate with decisions around care and treatment (e.g. taking medication)
- unrealistically hoping that the condition will go away or be resolved of its own accord
- focusing excessively upon specific symptoms or deficits caused by the experience, to the extent that health gains are adversely affected
- blaming someone or something else when there is no legitimate reason for doing so.

Health professionals are well placed to help the person examine the ways in which they are coping and identify how useful their coping strategies may be. Figure 5.3

provides a diagrammatic summary of the coping process for those who are experiencing health issues, and outlines the influence of context, the type of change in health status, and the different ways of coping and adapting.

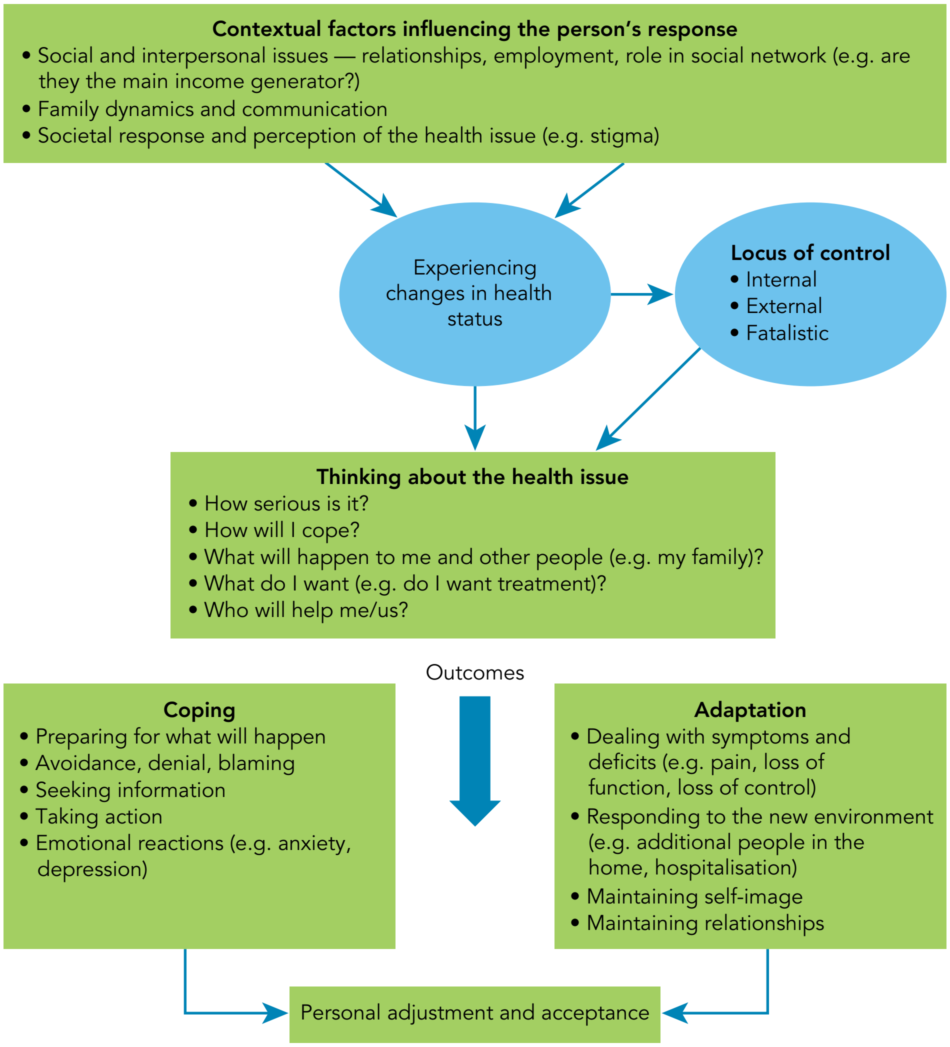


FIGURE 5.3 The process of coping with health issues

Source: Eysenck (2004), Ogden (1996), and Weiten & Lloyd (2006)

Health professionals are wise to remember that a person's choice of coping strategies is unlikely to be a conscious one. It is only when a person becomes aware of the coping strategies that they tend to use 'automatically' that they will be able to think about developing more functional ways of coping, if this is required.

Disasters

Australia is known for its challenging environments. These challenging environments are encapsulated in Dorothea Mackellar's famous poem *My country* ('I love a sunburnt country'), written in 1904, in which she refers to ongoing droughts and flooding rains.

In addition, there are severe storms, episodes of prolonged high temperatures, bushfires and cyclones. Over the years, such events have been identified as disasters because of the widespread damage and loss of life they generate.

The Australian government has defined a **disaster** as a serious disruption to community life, which threatens or causes death or injury in that community and/or damage to property, and requires special mobilisation and organisation of resources (Australian Emergency Management Institute, Attorney-General's Department, 2011). For the individuals, communities and also the nation as a whole, disasters fall on the high-end of the spectrum of stressful situations. This is because disasters can have very significant personal, social, economic and environmental outcomes, with the potential to affect the health and wellbeing of people and communities for many years afterwards. One of the most obvious adverse health outcomes of a disaster is death.

disaster a sudden event, such as an accident or a natural catastrophe, that causes great damage or loss of life

Significantly, in the past century or so, the disasters that have caused the most deaths have been heatwaves (1911, 1912, 1913, 1926, 1939, 2009) (Australian Emergency Management Institute, Attorney-General's Department, 2011). Many people are unaware of, or underestimate, the high risk of prolonged high temperatures and the stresses they can place on the human body. For this reason, it is essential for health professionals to educate people (particularly children and older people) about the importance drinking well and staying inside during a heatwave. Cyclones in 1911, 1912 and 1935 also caused a significant number of deaths, ranging from 122 to 178, while the Black Saturday bushfire in Victoria caused 173 deaths (Australian Emergency Management Institute, Attorney-General's Department, 2011). Although the death tolls of the 1983 Ash Wednesday bushfires (75 deaths), the Granville rail crash (83 deaths), and Cyclone Tracy (65 deaths) were likewise significant, they are not in the ten worst Australian disasters in terms of death toll.

It is also interesting to note the specific years in which the most number of death occurred. Generally, Australia is becoming better at managing its disasters. This includes the development of a new health discipline, **disaster health**, which has grown out of the need to address the health needs of individuals and communities who experience a disaster.

disaster health an interdisciplinary approach to the prevention of, preparedness for, response to, and recovery from the various health issues that arise from a disaster

Identifying ways and means of supporting the health and wellbeing of communities after a disaster is important in light of the increasing number of incidents affecting Australians. The most likely reasons for this increase in incidents is climate change. The relative frequency of disasters in Australia over the past decade is illustrated in figure 5.4 and shows that a number of the disasters are due to human factors (e.g. transport, chemical industrial accidents) as well as natural disasters.

Australians are also affected by overseas disasters. For example, the 2004 Indian Ocean tsunami killed over 270 000 people across numerous countries, including 20 Australians, with many others injured or experiencing adverse health outcomes (Johannesson, Lundin, Frojd, Hultman, & Michel, 2011). Acts of terror also have disastrous consequences, with the 2002 bombs in Bali causing 202 fatalities, 88 of which were Australians (e.g. Chim, Yew, & Song, 2007). Many casualties from this disaster were also transported to Darwin for treatment by Australian health professionals; while a large contingent of Australian health professionals travelled to Bali is assist in 2002 and also 2005, when there were further bombings.

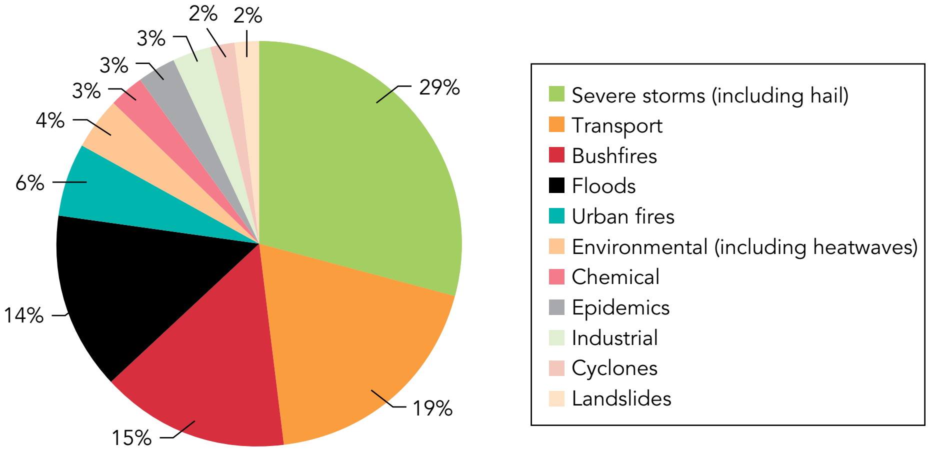


FIGURE 5.4 The relative frequency of specific disasters in Australia in 2000–2009

Source: Australian Emergency Management Institute, Attorney-General's Department (2011, p. 3)

There is a growing expectation that health professionals will be prepared to respond appropriately to the stress people experience as a result of disasters. For example, while many people show great courage and resilience during and after a disaster, others will experience a long-lasting impact on their mental health (Shephard, 2013). Stressors include near-death escapes; or being unable to save family or friends and watching them die (Australian Emergency Management Institute, Attorney-General's Department, 2011). Ongoing stressors include the difficult task of dealing with the practical aspects of daily life after the disaster — including finding water, food and shelter; living in crowded temporary accommodation; cleaning up the physical damage; dealing with insurance companies and a bewildering range of community services; and constant reminders of the personal and community loss (Bordelois, Galea, Norris, Tracy, Koenen, & Cerda, 2013). Post-traumatic stress disorder and depression can emerge in people months later, placing additional strains on relationships and giving rise to family and relationship conflicts. This distress is further compounded if the person is dislocated from their local community or has experienced breakdown in their usual support networks.

THE BIG PICTURE

Disaster resilient Australia

Every year, Australian communities face devastating losses caused by disasters. Bushfires, floods, storms, other hazards and their associated consequences have significant impacts on communities, the economy, infrastructure and the environment.

In 2009 the Council of Australian Governments (COAG) agreed to adopt a whole-of-nation resilience-based approach to disaster management, which recognises that a national, coordinated and cooperative effort is needed to enhance Australia's capacity to withstand and recover from emergencies and disasters.

➜

The Australia–New Zealand Emergency Management Committee (ANZEMC) subsequently developed the National Strategy for Disaster Resilience (NSDR) which was adopted by COAG on 13 February 2011.

The NSDR is the first step in a long-term, evolving process to deliver the sustained behavioural change and enduring partnerships that are essential to building disaster resilient communities.

It is expected that state, territory and local governments will use the NSDR to inform local action and business and community leaders, as well as the not-for-profit sector are also encouraged to embrace this approach. It is hoped that all Australians develop a shared understanding of the critical part they play in developing their own disaster resilience and that of their communities.

Locals begin the clean-up operation as water recedes after the 2013 Bundaberg flood.

Key messages

As part of the promotion of the NSDR, six key messages have been developed that embody the fundamental principles of a disaster resilient Australia.

They are available for use by all jurisdictions and agencies and are designed to support consistent messaging about disaster resilience to all Australians.

The messages are as follows.

- **Disasters will happen.**
  Natural disasters are inevitable, unpredictable and significantly impact communities and the economy.
- **Disaster resilience is your business.**
  Governments, businesses, not-for-profit organisations, communities and individuals all have a role to play and need to be prepared.
- **Connected communities are resilient communities.**
  Connected communities are ready to look after each other in times of crisis when immediate assistance may not be available.
- **Know your risk.**
  Every Australian should know how to prepare for any natural disaster.
- **Get ready — then act.**
  Reduce the effects of future disasters by knowing what to do.
- **Learn from experience.**
  We reduce the effects of future disasters by learning from past experiences.

Source: Australian Government, Attorney-General's Department (n.d.)

Locus of control

Experiences of illness and injury can often result in the person feeling that they have lost control. One way these feelings may be explained is through the seminal psychological approach known as the health locus of control theory (Rotter, 1966; Wallston,

Wallston, & DeVellis, 1978). The term 'locus of control' describes the extent to which a person believes they can control the events that affect them. In the health context, the **health locus of control** theory explains the degree to which a person believes that their health is controlled by internal, external or fatalistic factors. In short:

- *internal factors* include those that are the direct result of the person's own behaviour or actions (e.g. smoking cigarettes, eating fatty foods, playing high-impact sports)
- *external factors* include factors such as powerful others (e.g. employers, health professionals), peer pressure (e.g. 'everyone does it!'), genetics, culture, age or gender
- *fatalistic factors* include influences such as fate, luck, chance or God (Schultz & Schultz, 2009).

The impact of these beliefs upon a person's capacity to change are outlined in table 5.1.

health locus of control the extent to which a person believes that their health is controlled by internal, external or fatalistic factors

TABLE 5.1 Health locus of control and its impact on people

Perspective	Description	Possible impact on recovery
Internal health locus of control	People who believe health is determined and influenced by their own behaviours and actions	More likely to take personal responsibility for their health and wellbeing View themselves as working in collaboration with the health professional to overcome health issues More likely to assimilate health promotion messages and to act on these; for example, adopting a healthier lifestyle to prevent ill-health or to aid recovery
External health locus of control	Individuals who believe health and illness or injury is something that has occurred or has happened to them as a result of external factors, such as an epidemic, genetics or family history, significant or traumatic experiences, relationships, and so on	Likely to demonstrate a passive response to illness or injury Unlikely to take the initiative in determining how they will overcome or deal with their health issues
Fatalistic perspective	An extended example of an external locus of control Occurs when a person believes that health and illness or injury is largely influenced by factors such as fate, luck or God	Likely to demonstrate a fatalistic view of what has happened or is likely to happen to them May appear indifferent towards health promotion information or advice given by health professionals May not implement changes in lifestyle designed to reduce risk, as they believe such changes are unlikely to make a difference May demonstrate this type of belief system with statements such as, 'Well, it's got to happen to someone' Unlikely to take responsibility for initiating strategies to promote or enhance recovery

Source: Based on Grady & Wallston (1990); Maltby, Day, & Macaskill (2007); and Morrison & Bennett (2009)

The health professional who understands a person's individual locus of control can help that person to recognise what lies behind their reactions or behaviours. It is important to note, however, that the health locus of control theory is only one of many perspectives to be considered when helping people who are experiencing health issues. In practice, there is a complex interplay of various social, historical, psychological and interpersonal factors that will influence how anyone reacts to, copes with and adapts to a significant change in health status (Morrison & Bennett, 2009). As a result, adapting to an experience of injury or illness can be described as a dynamic process for the person, and it will be influenced by any or all of the internal and external factors.

While it can sometimes be tempting for health professionals to focus exclusively on a simple explanation that has been provided by particular psychological models, it is more important to listen to the person, support them through the crisis or situational stress, and address longer term issues related to locus of control at a later time.

Resilience

Despite the prevailing biomedical model, there has been some movement away from the reductionist, problem-oriented approaches to providing health care, and towards the approaches that focus on nurturing a person's strengths. Strengths-based models of health care were described briefly in chapter 1. Largely, they have grown out of the observation that, while one person may require very little support when experiencing stress, the next person may require considerable support. This raises questions for health professionals, such as why it is that one person seems to be more resilient than another.

resilience the psychological and emotional strengths, assets, stamina and endurance of a person to adapt to changed circumstances

Resilience is an abstract concept that is difficult to pin-down. It involves a person's capacity to maintain a healthy, symptom-free functioning that follows a stressful event (Almedom & Glandon, 2007; Knottnerus, 2011). It also involves the inner strengths, assets or stamina/endurance of the person, not only to survive stressful experiences, but also to cope with and adapt to changed circumstances, and sustain normal development (Richardson, 2002; Soares, Jacobs, Huber, Gomes, & de Carvalho, 2012). Generally, people who are resilient are able to:

- think optimistically
- build and maintain meaningful and trusting relationships
- set realistic goals and carry them through
- have a clear set of values
- open themselves to new experiences
- accept what they cannot change and/or adapt to change.

Resilience then, relates to the way a person thinks, acts and feels about themselves, others, and the world around them.

While some may argue that resilience is 'hardwired' into a person, the Australian government funds programs for children, in all states and territories, with a view to developing the inner qualities required to withstand or adapt to stressful situations (Department of Education, Science, and Training, 2005; Windle, 2011). Likewise, it is the work of health professionals to encourage people to build upon the internal and external resources they already possess, as a means of dealing with the stressful situation (McAllister & McKinnon, 2009). In line with all the strengths-based models of care, the health professionals do this by collaborating with the person, focusing on what a person *can* do rather than what they cannot do, developing the person's strengths, and supporting the person as they adapt to new situations.

Setting

The way health professionals think about and approach their work is inevitably constrained by their setting. This setting will include the systems and structures that frame their place of work and also the focus of their role. These factors, in turn, will influence not only the person they are helping and the way that persons reacts when stressed, but also how the health professional responds to that person. For example, the health professional who works as a 'first responder' will take a different approach to helping people than the health professional working in the acute, subacute, rehabilitation or community contexts.

As noted in chapter 1, the biomedical model or approach to the treatment of illness dominates the Australian public health care system. In short, this model is a product of the philosophical view that the body and mind are two separate or distinct entities. The body is the major focus of biomedicine.

It is important to recognise the impact of the biomedical model on the delivery of health care in contemporary Australia. Indeed, the biomedical model influences not just treatment regimens, but also the way health professionals act or react in their place of work — and, by association, the way the patient or consumer acts or reacts (Caldwell, Sclafani, Swarbrick, & Piren, 2010). While the mainstreaming of mental health services has brought about many changes in the delivery of health care (see chapter 1), the continued dominance of the biomedical model means that emotional aspects of a person are often overlooked or dismissed as peripheral to the disease process. This is most apparent in the hospital setting, where health professionals are required to provide care within a system that has been designed primarily to treat acute physical health issues. Social, emotional and mental health issues tend to be given a much lower priority. Moreover, the education and training of health professionals mirrors this demarcation, with the separation of health disciplines into broad biomedical, psychological, social and functional categories.

The Australian health system can present many challenges to health professionals committed to providing person-centred, biopsychosocial or comprehensive 'all-of-health' care to a person. Likewise, the system can present challenges to health professionals who seek to help people who are experiencing strong emotions. For example, emotions cannot be rationalised in a scientific or biomedical sense. When a person is stressed, their reactions will often fall outside of the biomedical framework or, alternatively, they may be pathologised as 'histrionic' or as showing symptoms of a 'mental illness', and treated with medication. As a consequence, the expression of emotion is often actively discouraged by the system, and the person is limited in the way they are permitted to behave or feel. Likewise, if the health professional focuses predominantly upon the physical signs and symptoms of stress, they risk overlooking the emotional aspects of the person and providing only limited assistance.

Effective health professionals, then, need to work against these systemic influences and actively accept as ordinary human behaviour the demonstration of strong emotions by those who are experiencing stress. It is only by reframing their approach that health professionals will be able to provide comprehensive care to all people.

UPON REFLECTION

Providing emotional support

Consider the following statements made by health professionals working in various contexts.

'It is not our job to provide emotional support to people. I'm a first-responder — my job is to save lives!'

'Of course we talk to the patient. We always have a chat when we give them their medications.'

'There's no time to talk to our clients anymore. We have too much paperwork to do. You can blame for management for that!'

'I don't spend too much time talking to the consumers — for their own good. I don't want them to become dependent on the health service.'

Questions

1. In the context of these statements, how can the health professional balance the provision of social and emotional support with the more tangible or 'practical' tasks often expected of them?
2. What are some of the strategies that you could use to make time to talk to the people you are helping?

Priorities when supporting people through stressful situations

There are a number of priorities for health professionals to consider when supporting people who experience stressful situations, so they need to manage their time effectively. Many health professionals work in an environment that is task-oriented, and the volume of work they are required to complete each day is enormous. In addition, there are stressors such as the political imperative to reduce response times, wait times, and lengths of stay in hospital. Sitting with a person to talk about their feelings does not help to alleviate such pressures. Further, there is often no 'quick fix' to stop a person from feeling stressed. This can be frustrating for health professionals who have been educated and trained to alleviate pain with medication or other physical or pharmacological treatment. As a consequence, the health professional may choose to avoid the person who is expressing strong emotion, rather than finding the time to help them.

As a part of the caring professions, it is important that health professionals think about the competing priorities they face in the workplace and decide which of these priorities is the most important. There will be times when these priorities change, depending on the setting, situation and circumstances. Generally, however, there are three main priorities for health professionals who provide support to the person or people who are experiencing stressful situations. One of these priorities is to engage with the person and their partner, carer or family, and to establish a personal connection.

Another important priority for the health professional is to form a therapeutic relationship with the person. The third priority relates to referral. If the health professional is unable to support the person or their family member for whatever reason, it is important that they make a referral to another health professional. These three priorities are now discussed in turn.

Engagement and collaboration

The active participation of consumers and carers in the planning, development and provision of health services across Australia has become an expectation of the Australian government and a key component of health policy across the nation (Commonwealth of Australia, 2005, 2009). Consumer and carer involvement is vital as it enables engagement with and ownership of the Recovery process and higher rates of satisfaction, leading to better health outcomes (Duncan, Best, & Hagen, 2010; Shanley & Jubb-Shanley, 2007; Pryor & Buzio, 2010). Consequently, the health professional is responsible for involving a person and their partner, carer or family members in decisions about their treatment regimen and the services they require.

Of course, in some circumstances, a consumer may request that family members are not informed of the specific details of their care or treatment, and such wishes need to be respected (see chapter 3). At the same time, requests by a consumer that family members are not included in discussions about their health can, in themselves, provide a useful opportunity for discussion. For example, the health professional may take the opportunity to ask the person about their anxieties and the concerns that have led them to this decision, the emotions that may be influencing them, and the likely consequences of keeping information from a relative.

Health professionals also need to consider the context of and the resources that may be available for the partner, carer or family. Individual circumstances will vary. In particular, time and financial constraints will always determine the ability of family members to be involved. The health professional must not make presumptions about a person's preferences or availability. Instead, it is important that invitations are extended to partners and carers; and that every effort is made to engage with and involve the person and their significant others.

Therapeutic alliance or relationship

The reactions and responses of people to stressful situations will vary. To provide effective support to all concerned, health professionals need to make effective use of the therapeutic relationship. The elements that are essential for establishing an effective therapeutic relationship are outlined in chapter 2. In short, health professionals need to ensure they:

- are aware of verbal and non-verbal communication (e.g. they use appropriate eye contact, tone of voice and body posture)
- use active listening when talking with the person (e.g. they avoid excessive note taking during an interview or conversation)
- use open-ended questions (e.g. 'In what way has this issue affected you?') as a means of encouraging expression and clarifying problems
- make empathic comments (e.g. 'This seems to be a really difficult time for you.')

- respond to verbal and non-verbal cues (e.g. if the person becomes guarded when discussing a particular subject, it may be appropriate to pick up on this, 'You seem to find it uncomfortable when we talk about this relationship.')
- pay attention to contextual, relationship and family issues (e.g. what is the person's history and experience of ill-health and treatment within the family); and ask how family members perceive the problem and how the current problem is affecting other members of the family (e.g. children)
- identify the person's unique concerns — while these may be relatively straightforward, they may also be causing some distress to the partner or their carer (e.g. how will the person's partner get to hospital to visit them if they cannot drive?). As with all other aspects of the person's care and treatment, social and emotional support needs to be addressed systematically. If a systematic approach is not taken, the need for social and emotional support can easily be overlooked, which means the care provided is not comprehensive.

Gask and Underwood (2003) identify three essential components of providing emotional support to a person and their family or significant others.

1. *Negotiating a care (or recovery) plan*. As already noted, every attempt needs to be made to actively involve the person and their family or significant others in the development of a plan of care and treatment. This could include a Care Plan or Recovery Plan (see chapter 1). Whatever the type of plan, it will include ascertaining the expectations of the person and their family, responding to requests for information and advice on particular treatment or care options, and developing and documenting what will happen and what the person can expect. While paying attention to the person's underlying health beliefs and coping style(s), it is also important that the health professional check the person's understanding of what is going to happen next. This might include the use of a brief written summary for both the person and their family.
2. *Using appropriate reassurance*. Providing reassurance is a significant activity undertaken by the health professional — however, it is only ever useful if the health professional knows what it is the person is concerned or worried about. Clichéd phrases such as 'everything is going to be just fine', 'it will all work out for the best, I'm sure', 'there's every hope' or 'there's nothing to worry about' will have a quite empty ring in the face of very real fears. There are many, more constructive ways a health professional can provide reassurance — for example:
   - being calm
   - being available
   - asking what is troubling the person
   - listening carefully
   - being empathic
   - responding openly to the person's questions
   - following up questions you are unable to answer or issues that the person has raised, and reporting back to the person in a timely way
   - using physical touch (e.g. a gentle hand on the arm), if appropriate.
3. *Providing information.* The provision of relevant information is an essential component of supporting a person who is experiencing a stressful situation. It is quite paternalistic to limit the amount of information provided to a person because 'they

wouldn't understand anyway' or 'they would only worry'. Indeed, the notion that 'the less they know, the less they worry' is a dangerous myth (Nichols, 2003). This is explained at length in the 'Providing information' section, which details *why* it is necessary to provide information, and how best to present it to the person who is experiencing a stressful situation.

Referral

There may be occasions when the health professional decides that the person who is experiencing a stressful situation requires the support of a specialist to help them through what is happening to them. There are many support services in the health and community contexts that can assist people who feel unable to cope with stressful situations. It is recommended that health professionals familiarise themselves with a variety of options so they can make appropriate referrals — including the counselling, psychotherapy, pastoral care or social support services provided by health services, community-managed organisations and faith-based organisations. These services may incorporate approaches such as personal and family therapy, teaching the person relaxation strategies, and helping the person to build resilience. In light of this chapter's earlier focus on the more negatively-valorised prime emotions, it is also important to consider the therapeutic value of the positively-valorised prime emotions that have been the focus of much research. For example, Alston (2009) explored the use of laughter as an important means by which people handle stress and trauma.

UPON REFLECTION

The ethics of black humour

Research suggests the role of black humour, drawn from shared experiences of stressful situations, helps to 'glue' together first responders and health professionals (Old, 2012; Scott, 2007). By normalising a situation through humour, a stressful encounter can be made more manageable, with humour allowing people to control their feelings of fear or vulnerability.

Questions

1. How ethical is it for health professionals to use black humour?
2. How can humour help people to control their feelings of fear or vulnerability?
3. In what circumstances is laughter an appropriate or inappropriate reaction?

Providing information

This section emphasises the importance of providing information to people (in particular, those who are stressed), and details how to do so. Providing information to people is an essential activity of the health professional — information will help to alleviate confusion and will also support them to feel more in control of the situation, thereby reducing their levels of stress. Just as importantly, it is through being informed that people are able to make the best possible decisions or choices. Information and the knowledge it generates empowers people. If a health professional does not inform a person about what is happening to them and why, in the health context, the health professional is effectively disempowering that person.

In the past, information has been provided to a person based on what health professionals think the person needs to know or should know. In a consumer-centred context (see chapter 1) in which person-centred approaches are utilised, information needs to be provided in a way and at a time that is driven by the person(s) receiving the information (Heinstrom & Ek, 2011; Nichols, 2003). At the same time, health professionals need to remember that information can act as a form of reassurance and emotional support for the person. This, in turn, can reduce anxiety.

The provision of information to educate people about their health and ill-health has now become a key sub-specialty for health professionals. Health and **mental health literacy** is discussed in detail in chapter 12 and includes helping people to become more 'literate' or knowledgeable about health issues. To assist a person to develop health or mental health literacy, the health professional needs to:

- provide information that explains how to seek out the information
- explain risk factors, options for self-treatment or self-management, and where to go for professional help if required
- promote attitudes that improve recognition and appropriate help-seeking.

mental health literacy the knowledge and understanding about mental health issues that assist people to recognise, manage or prevent mental health issues

Providing this kind of support is valuable for helping people to know when to seek help, how to seek help, where to go for help and what services are available (Francis, Pirkis, Dunt, Blood, & David, 2002).

In the course of informing people about their health status or treatment, the health professional also needs to review the amount and type of information available. A person who has experienced injury or is unwell may not feel able to absorb huge amounts of technical information and the health professional must consider this as part of the process. The effective health professional will also assess the impact of cognitive impairment, sensory limitations, or learning difficulties in relation to a person's capacity to understand (see chapter 3). In addition, it is important to consider how cultural differences may influence the giving and receiving of information (see chapter 4).

Alternatively, a person may be able to absorb the information provided, but be unsure about what information they need. It is important to remember that people do not know what they do not know. For example, while it is important to ask a person, 'Is there anything you would like to know?', quite often a person will not know what it is that they need to know. For this reason, the health professional is advised to give the person some general information at the outset, then go back to that person to ask them more specifically about where they are having difficulties or issues and whether they may need more information about them.

Understanding information in stressful situations

When people are stressed they will often feel overwhelmed and struggle to keep pace with what is going on. Information can be relayed to them by a health professional, who may go on to assume the information has been understood by the person. Even under normal circumstances, however, only 30 per cent of the information a person receives is retained (Kessels, 2003). Moreover, there is evidence that people retain far less information in more stressful situations (e.g. when they are given an unwelcome diagnosis) (Brooke, Hasan, Slark, & Sharma, 2012; Warnock, Tod, Foster, & Soreny, 2010). For example, research has demonstrated that family members of people who are treated in the hospital context will often say that they have not been given information, despite health professionals recording that it has indeed been provided (McPherson, Higginson, & Hearn, 2001; Harding et al, 2008). Consequently, health professionals need to provide information to people more than once, and on an ongoing basis.

When checking that the person has an understanding of the information that has been provided, the health professional needs to consider if the person's health status allows them to:

- understand what they are being told
- retain the information
- weigh up options on the basis of the information given
- make a clear decision with an understanding of the implications of that decision.

A person will only develop an understanding of what is happening, in relation to their context and individual circumstances, over time. This is why the health professional needs to make use of techniques such as:

- checking that the person has understood the information by making the time to sit down with the person and asking them to repeat what was communicated
- making recordings or leaving written information with the person and their family or significant others
- documenting that the information has been provided
- following up with the person and their family to answer any questions, discuss any issues and provide more information if required.

This approach ensures that the dialogue continues for as long as is necessary and the person receives adequate and appropriate support.

Preparing information

When considering how to provide information, it is worth finding out who will be involved in the activity. How many people will be in attendance? Will there be partners, carers, family, friends or children? What are their learning preferences — written, visual, verbal? Who is best placed to provide the information? Some people may prefer the medical practitioner to provide the information; others may feel they share an affinity with another member of the multidisciplinary team and prefer to interact with them. There may even be times when the person prefers to speak to a student health professional, perhaps because they are less intimidating or have more time for them.

Initially, even before thinking about what information to give the person, there has to be clarity regarding the reasons the information is being provided. As noted earlier, there was a time when health professionals routinely withheld information, believing it to be damaging for the person who is ill (e.g. Oken, 1961). However, approaches to providing health care have now shifted from paternalism to consumer-centred models. Information is now provided as a matter of course. It is vital, then, to give the person the opportunity to express their views about what information they might wish to receive, how they want to receive it, and who they would like to be in attendance.

The clarity of what is said, the way in which it is said, and the environment in which the discussion takes place, will also have a significant impact on relationships between the health professional and those to whom they provide a service (McPherson et al., 2001; Warnock et al., 2010). Questions the health professional may ask could include the following.

- 'What have you been told about your situation?'
- 'What do you think about your situation?'
- 'What do you think will happen with your health issue?'

Each of these questions seeks to explore the person's ideas and feelings or interpretations regarding their condition, which may be very different from the situation as it is understood by the health professional.

There may also be times when a person asks a surprise question and the health professional feels unable to respond. Rather than inventing an answer, it is better for the health professional to ask the person if they are happy to wait while they locate the information and return to discuss the matter at the earliest opportunity.

Table 5.2 provides a summary of do's and don'ts to consider when providing information to a person. This table is a useful tool for health professionals to guide them to provide the most appropriate information at the most appropriate time and in the most appropriate way.

TABLE 5.2 A summary of do's and don'ts when providing information

Do	Don't
Be guided by what the person has said they want to know about their health issue	Provide information that is irrelevant or not required
Think through and prepare carefully what it is that needs to be communicated, including body language and non-verbal cues as well as verbal cues	Rush into providing the person with information because the opportunity seems to present itself or you have been asked an awkward question
Find out what the person already knows about their health issues and how they understand the information	Assume you know what the person knows
Have written information available about the person's health issue, including different options for addressing the issue	Begin the discussion without adequately preparing
Invite family, carers or significant others to attend	Begin without knowing who is in the room, whether the person wants them there, or if there is someone else the person wants to be present but who is not there
Prepare the physical environment in which the dialogue will take place	Allow interruptions such as pagers, mobile phones, or colleagues 'wanting a moment'

Do	Don't
Use simple language with as little jargon as possible	Use jargon
Actively listen to all stakeholders	Disregard or selectively listen to stakeholder feedback
Find out the person's agenda and align yourself, without giving up the need to provide information	Trivialise the information or the person's experience (e.g. 'Everything will be all right' or 'I'm sure you'll cope very well')
Lead up to the key points you would like to impart	Become defensive or critical of others involved in the person's treatment and care
Clarify the person's understanding of what has been said	Make glib promises you may not be able to keep (e.g. telling the person 'Everything will be okay', or 'There's no need to worry')
Use reiteration	Make assumptions
Use and tolerate short silences	Allow insufficient time for the discussion
Explore the person's feelings and reactions	Leave the meeting without having checked what ongoing support they think they may need
Use open questions, always listening for cues from the person	Use closed questions, which don't give the person the option to talk freely
Use diagrams to illustrate difficult technical concepts or anatomical information	Assume the person always understands what is being said, particularly if the information is complex
Leave written information for the person and significant others to read in their own time	Assume the person has absorbed all the information in one session
Tell the person about other sources of information (e.g. the internet, self-help organisations and leaflets)	Limit the information or choices, nor assume the person can find the information themselves
Assure the person you will get back to them with answers to questions to which you don't know the answer	Invent answers to questions to which you don't know the answer
Follow up with the person — particularly if you have told them you will get back to them	Leave following up with the person to someone else, or forget about it altogether
Document, in detail, what has been discussed and feedback to the multidisciplinary team	Underestimate the importance of clear communication
Follow up the initial discussion with further discussions	Assume that you will only need to provide the information once

UPON REFLECTION

Brochures: 'The good, the bad, and the ugly'

Brochures and flyers are a common and quite useful tool to support health professionals when they provide information to people. However, many people complain that health professionals do nothing more than hand them a brochure about a health condition or health service, with the apparent expectation that this brochure is all they will need.

Questions

1. Consider the last time you were handed a brochure. What did you do with that brochure? Where is that brochure now? What happens to most brochures?
2. How could brochures and flyers be used more effectively to communicate health information to people?

Self-care

Health professionals are people with their own emotions, experiences, agendas and idiosyncrasies. It is impossible for the health professional to leave their personal beliefs about health behind them as they walk into their place of work. For example, a health professional may have had personal experience of domestic abuse, physical assault or relatives dying, and may therefore feel stressed when re-exposed to events at work reminiscent of these personal experiences. Another health professional may have years of experience of dealing with angry or aggressive people at work and so have developed a hard, protective shell. Every experience over years of service adds another dimension to the way in which a health professional views a situation or event, and also to their overall development as a practitioner. Past experiences will also affect the way a health professional responds to stressful situations.

The same factors that influence the way in which the person who is unwell responds to stressful situations will influence the health professional at work. It is essential, then, that health professionals consider the impact of each of the factors described in earlier sections of this chapter upon their own reactions to stressful situations. This is because health professionals will experience many and varied stressful situations in the course of their work. Awareness of their own reactions to stress, and what has shaped these reactions, will enable health professionals to respond more appropriately to any given situation in the workplace. Indeed, health professionals who have developed an acceptance of who they are — as individuals and also in their relationships with others — will be more able to understand and accept the beliefs, perceptions and reactions of other people. This understanding and acceptance will in turn enable the health professional to more effectively provide support to the person who is experiencing stress.

Some health professionals may not know where to begin to gain this kind of personal awareness. The sections that follow provide steps in the process of awareness-raising. It is also suggested that health professionals read relevant self-help books, attend suitable courses, or seek the help of a specialised health professional in this area.

UPON REFLECTION

What is 'professional'?

Some practitioners believe it is unprofessional to feel emotions in the workplace. Rather than recognising what is happening to them in a stressful situation, working through their own reactions and then learning appropriate strategies for dealing with the stress, they deny their feelings and react in a manner that may not be helpful to others in the workplace.

Questions

1. What strategies could you, as a health professional, use to help you manage the stress that may be generated by the following experiences?
    - **(a)** A patient is angry and yells at you, blaming you for something you didn't do.
    - **(b)** You contact the on-call medical practitioner about a patient's deteriorating health status. They question you in a way that suggests they think you are incompetent.
    - **(c)** A colleague's ongoing behaviour suggests that they are not handling a difficult situation, making it difficult to cooperate as a team. However, when you try to talk to them about it, they insist that everything is 'just fine'.

Reflective practice

The first step for health professionals in managing their reactions to stressful situations is to explore the feelings that are engendered by the stressful situation. This will involve a degree of self-reflection. Questions health professionals could ask of themselves are as follows.

- Where do I feel these emotional reactions? (e.g. 'in my stomach', 'in my throat')
- What name could I give these emotional reactions? (e.g. anxiety, anger, fear)
- How strong are the reactions, on a scale of one to ten?

The health professional then needs to consider the cause of the emotional reaction. For example, each time a health professional attends a MET (medical emergency team) call, they may feel tightness in the stomach. This health professional would be wise to put some time aside to consider that tightness in the stomach and what it means. Is it anxiety? Is it fear? If so, what factors have given rise to this anxiety or fear? What steps could the health professional take to reduce the level of this emotion?

Another common myth in our society is that other people are responsible for making us feel a certain way. For example:

- 'He upset me.'
- 'You scared me.'
- 'She made me feel so anxious!'

When a health professional lays the blame for a feeling on another person, they displace their personal responsibility and walk away as 'the victim'. However, effective health professionals accept that feelings are an inevitable part of a stressful situation.

It is important that health professionals identify these feelings and deal with them as they arise. For example, health professionals may ask, 'What is going on for me that I am having such an intense reaction to that person yelling?' When they allow themselves to explore what is happening within, they learn more about their emotions. This, in turn, provides them with insight regarding how to manage or deal with their emotions.

The key for health professionals is to understand that feelings are meant to be felt. When they are ignored, suppressed or dismissed, there is a build-up of emotional energy. Of course, in the workplace there will often be times when health professionals are required to delay feeling the emotions until a more suitable time, that is after they have dealt with the situation at hand. However, when the occasion arrives and they can give full attention to the feelings or reactions, health professionals may then ask themselves questions such as the following.

- What thoughts, feelings and actions was I experiencing during that stressful situation?
- What will happen if I allow myself to sit with the unpleasant feelings right now?

This strategy will help the health professional to feel the emotions and thereby reduce their intensity.

Finally, it is not uncommon for people, including health professionals, to find that they are unable to perform this self-caring work without assistance. It is therefore recommended that the health professional talk to a colleague about the situation or seek advice from a trusted friend, colleague, counsellor or specialised mental health practitioner who will teach them the skills they need to manage their own reactions on an ongoing basis.

Another way the health professional can reflect upon their practice is through the process of journalling. Some health professionals use journalling as a tool to consider practice issues or personal interactions that may be troubling them. Specific questions that the health professional could ask themselves might include the following.

- What assumptions are being made by me or others in this clinical practice situation?
- What are the 'causes and effects' of this situation?
- How could I do things differently in future?

Regularly journalling in this way can help the health professional to reflect upon stressful situations and think about ways to improve their practice.

Other health professionals may prefer to participate in practice reflection by verbalising. This can be achieved by identifying another health professional and forming a mutually trusting peer relationship that enables both participants to explore professional issues and practices in a safe environment. Such informal discussions can also be undertaken in groups.

Clinical supervision

In the mental health context, **clinical supervision** is a formal and ongoing process of giving and receiving professional support through reflective practice (Driscoll, 2007; Wright, 2012). It provides an important means by which health professionals can access professional support and education. Clinical supervision, which can be received one-to-one or in a group, enables health professionals to reflect upon and discuss ways of developing their practice (Roche, Duffield & White, 2011).

clinical supervision a formal and ongoing process of giving and receiving professional support through reflective practice

Recently, national initiatives such as Health Workforce Australia (HWA) have used the term 'clinical supervision' in the medical sense; that is, to describe the supervisory relationship between the expert practitioner and student who is practising their skills in a 'real world' context (e.g. Chipchase, Eley, McAllister, & Strong, 2012).

The appropriation of the term by HWA is unfortunate as it has created some confusion. It is important to understand then, that clinical supervision is not about precepting, facilitating or supervising students in a clinical context. Nor is it about line management or performance appraisal.

Rather, in the health profession context, clinical supervision is about helping the health professional to consider their practice and discuss insights or issues with another (senior) health professional, with a view to improving their knowledge and competence (Schofield & Grant, 2013; White & Winstanley, 2009).

There are two broad aims for clinical supervision. The first is to provide health professionals with a confidential, safe and supportive environment to critically reflect upon their professional practice and improve their self-awareness (Taylor & Harrison, 2010). The second is to improve the mental health practice of health professionals and, as a consequence, outcomes for consumers (Turner & Hill, 2011). Significant outcomes of clinical supervision include supporting the practice and mental health of health professionals, safeguarding practice standards, and improving the quality of care that is being provided to the consumer (Winstanley & White 2011).

In Australia, health professionals who work in all areas of health care provision are encouraged to participate in clinical supervision on a regular basis (Lynch, Hancox, Happell, & Parker, 2008). In particular, those who work in stressful workplaces have found clinical supervision to be a useful tool that enables them to examine situations that are challenging. In addition, health professionals who participate in clinical supervision have higher levels of satisfaction with their work and are less likely to 'burn out' (Cross, Moore, & Ockerby, 2010).

It is essential that health professionals feel supported — and, indeed, *are* supported — in their workplace. Clinical supervision provides one way this can occur. Health professionals are encouraged to ask their manager how they can regularly receive clinical supervision from another trained health professional.

Time out

Health professionals work in a very demanding field. Many health professionals find the nature of their work to be stressful and may leave working in the health context for less demanding work. For this reason, it is crucial that health professionals undertake pleasurable self-caring activities that can be equated with 'time out'. The nature of these activities will vary according to personal preference. As a general rule, however, the following activities are recommended for those who work in stressful occupations:

- pleasurable social activities
- other personal/individual pursuits that give pleasure
- developing or pursuing significant relationships with others (personal, social, spiritual)
- regular sleep, preferably eight hours per day
- exercising regularly
- minimising alcohol intake
- not smoking

- healthy eating
- taking regular breaks.

Health professionals must also ensure that they manage their own general health and wellbeing. Many health professionals are so busy assessing the health status of other people that they forget about, ignore or continually postpone thinking about their own health. It is essential that they make regular visits to a general practitioner (GP) or other health professional who will be able to assess their general health and wellbeing.

Health professionals who regularly self-care will be better able to manage their reactions to stressful situations as they arise. Likewise, they will be better able to respond to stressful situations in a considered way.

SUMMARY

This chapter outlined the physiological, emotional and behavioural reactions most often experienced by people in stressful situations. Such reactions include the acute stress reaction; together with emotional and behavioural responses such as anger, anxiety, denial, fear, grief and tearfulness.

There are factors that influence the way people respond to stress and stressful situations — for example, a person's age, background, coping style and locus of control. The chapter also identified context and setting as important. For example, people and communities that experience a disaster will often experience high levels of emotion. Similarly, a person who is in a hospital setting may react quite differently to a person who is in a community setting.

The chapter then considered the main priorities for health professionals who support people who are experiencing stress. The need for health professionals to find the time to support people through stressful situations was also discussed. In addition, it was recommended that health professionals work to engage with the person and their partner, carer or family, to establish connections and form therapeutic relationships. Recommendations were also made for health professionals to refer the stressed person on to a specialist for assistance when appropriate.

The next section detailed how and when to provide information to people who are stressed. This includes a description of how to prepare the information. Finally, the chapter identified the value of self-caring activities for health professionals, outlining some strategies to support health professionals to this end.

All health professionals have a unique role to play in helping to bridge the gap between the biological, psychological, emotional, social, spiritual and functional elements of care. An improved understanding of the impact of ill-health or injury upon a person, and the way the person is most likely to react, ensures health professionals develop the confidence to reclaim this important aspect of treatment and care.

Review questions

1. What is the difference between stress and distress?
2. Explain what an acute stress reaction is. How you would support a person who is experiencing an acute stress reaction?

3. What are the most common emotional reactions to stressful situations? How would you support a person who is experiencing these reactions?
4. What are the major factors that influence the way people respond to stress?
5. Outline the steps required to 'de-escalate' a person who is angry.
6. Explain the five stages of grief.
7. Define 'resilience' and describe why it is important.
8. Name three factors involved in the coping process.
9. Identify the important steps a health professional needs to take to provide information to people who are experiencing stressful situations.
10. Identify four ways in which health professionals can self-care.

Discussion and debate

1. Most contemporary health services in Australia have policies that promote a 'zero tolerance' of aggression or violence in the workplaces. Discuss how these policies may influence the way we allow a person who is distressed to vent their feelings.
2. What is the difference between anger and aggression?
3. Children react quite differently than adults in stressful situations. As a health professional, what are the most important strategies you can use to support children who are experiencing high levels of stress?
4. 'People are by nature resilient. It is not a quality that can be nurtured.' Discuss this statement in relation to (a) the self-care of the health professional and (b) health promotion activities.
5. What are the different factors that attract people to work in the health professions? How can these factors work for and against people staying in this line of work long term?

Project activity

Identify one (1) disaster that has occurred in Australia. This disaster could be the result of an extreme weather or man-made event.

1. Describe this disaster in detail.
2. Identify and prioritise the short-, medium- and long-term health needs of those directly affected by the disaster. Justify the way in which you have prioritised these health needs.
3. Identify and prioritise the short-, medium- and long-term health needs of health professionals (including first responders) who have supported those directly affected by the disaster. Justify the way in which you have prioritised these health needs.
4. How has the community recovered since experiencing the disaster?
5. What did the authorities do well in their disaster response? How could the disaster response have been improved?

Websites

The Australian Centre for Grief and Bereavement is an independent, not-for-profit organisation which opened in January 1996 and is the largest provider of grief and bereavement education in Australia. Registered as a public benevolent institution, the centre receives operational funding through the state cancer and palliative care program of the Victorian Department of Health: www.grief.org.au

The Australian Emergency Management Knowledge Hub is an important resource for both those in the emergency management sector and the general public. Its features include research and news relevant to emergency management, statistics and information, photos, video and media about past disaster events, and a community forum to discuss relevant issues: www.emknowledge.gov.au

Helpguide is a not-for-profit resource providing free information to help empower people with knowledge, support and hope to improve their mental health: www.helpguide.org

Lifeline provides access to crisis support, suicide prevention and mental health support services. People call Lifeline's 24-hour crisis support service, 13 11 14, about many things, including anxiety, depression, loneliness, abuse and trauma, physical or mental wellbeing, suicidal thoughts or attempts, stresses from work, family or society, and information for friends and family. Lifeline also provides national services and campaigns that promote emotional wellbeing, encourage help seeking, and address suicide prevention and awareness: www.lifeline.org.au

'Live Life Well' is a NSW Health initiative that provides basic information and tools for people to start making healthier changes to 'live life well'. This includes information on quitting smoking, eating better, being active, limiting alcohol, maintaining a healthy weight and managing stress: www.livelifewell.nsw.gov.au

The Mental Health Council of Australia is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians: www.mhca.org.au

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6

Caring for a person displaying challenging behaviours

LEARNING OBJECTIVES

This chapter will:

- explore the nature of challenging behaviours
- define reasonable and unreasonable behaviour
- identify the most common causes and triggers of challenging behaviour
- describe challenging behaviours exhibited by health professionals
- explain the clinical, legal and ethical principles to follow when addressing challenging behaviours
- outline the process of risk assessment and management strategies.

Introduction

Chapter 5 explained that different people will have different reactions to the stress they experience in the health context. It noted that the provision of effective care involves health professionals practising acceptance, respect and a commitment to listen. Indeed, fraught situations can most often be effectively managed by health professionals who allow consumers to express their feelings, deal appropriately with the consumers' complaints or issues, and provide consumers with information. There will occasionally be times, however, when a consumer does not respond to this approach, and his or her behaviour becomes challenging for the individual health professional, the multidisciplinary team, health service managers and the health organisation as a whole.

Challenging behaviours are not necessarily the consequence of a mental health problem. Significantly, however, people with challenging behaviours often end up in the mental health system, and are labelled accordingly. But such a label is a misnomer. This is because challenging behaviours can be the consequence of any number of factors — emotional, psychological, communication or systemic. Challenging behaviours are only occasionally related to symptoms of mental illness.

Challenging behaviours can include aggression and violence, assault and property damage; behaviours related to intoxication by alcohol or withdrawal from drugs; and staff splitting. Many health professionals also view self-harming behaviours (see chapter 8) as challenging, together with the behavioural and psychological symptoms of dementia (see chapter 11). Others find the behaviours that are often associated with borderline personality disorder difficult to manage.

The focus of this chapter is the *un*common reactions or challenging behaviours exhibited by people, and how health professionals can best manage these behaviours. The nature of challenging behaviours is explored, and the terms 'the difficult patient' and 'manipulative behaviour' considered. The context in which challenging behaviours occur is discussed, including external factors that can influence the behaviour of the consumer, partner, carer or family member, and health professional. This is followed by an outline of the causes and triggers of challenging behaviours. Risk assessment and management strategies are identified as vital to the process of providing care to the person with challenging behaviour. The chapter concludes with a debate about the proactive methods of addressing the issues involved, including ways and means of minimising the negative impact of the behaviour on all those involved.

The nature of challenging behaviours

Health services across Australia have adopted **zero tolerance** of aggression, violence, assault, bullying or any other act of violence in the workplace. Quite rightly, governments, industrial organisations and health services alike are upholding the right of all staff to work in a violence-free workplace (e.g. Australian Nursing Federation, 2012; NSW Health, 2005; Queensland Health, 2008). Consumers and their partners, carers, families and friends also have the right to receive health care or visit a health care setting that is free from risks to their personal safety.

zero tolerance an occupational health and safety principle that proscribes workplace violence. This includes physical and non-physical violence that may result in physical harm or psychological harm.

This section discusses the nature of behaviours that are a risk to health professionals and others in the workplace. Wherever possible, the term 'challenging' behaviour is used in preference to 'violent' behaviour. This is because 'violence' has many negative connotations. In Australia, violence is understood as the use or expression of force — physical, psychological or emotional — against one or more people for ends that are selfish or regardless of basic human rights. In the health setting, violence and aggression most often, although not exclusively, involves the behaviour of consumers towards health professionals.

It is interesting to note that different people have different views of what constitutes a violent act. Indeed, notions of violence are often culturally, even politically, constructed. For this reason, the discussion in this chapter is based upon the premise that people, apart from a few rare exceptions, are not inherently violent. Rather, some people will occasionally behave inappropriately, and this behaviour can be difficult or challenging to manage.

THE BIG PICTURE

Responding to violence

Immediate response options

Every effort should be made, via the risk management process, to prevent violence occurring. However, in the event that a violent incident does eventuate, it is important that staff are aware that they do have a range of response options. These responses will depend on a number of factors including the nature and severity of the event; whether it is a consumer, visitor or intruder who exhibits violent behaviour; and also the skills, experience and confidence of the staff member/s involved. Responses may include calling for backup, security or local police.

When a consumer becomes violent, consideration should always be given to the possible clinical aspects of the behaviour. A violent outburst by a consumer waiting to be seen by a doctor in the emergency department may be secondary to a number of medical conditions. After ensuring staff and other consumers' safety, initial clinical assessment and prompt treatment should be of primary concern.

Health services will have in place local procedures and protocols to support the range of available options. Procedures must be communicated to staff, and staff should be provided with training to enable them to exercise the options appropriately and effectively, particularly those involving clinical restraint.

Post-incident response

When the incident is concluded, staff should be provided with clear guidelines regarding support services (if they have not already been provided), and the option of time out from duties. Appropriate psychological and operational debriefing should be set up and coordinated. In addition, a management review of the incident by appropriate staff and experts, such as a security consultant, should be included. The purpose of a review is to critically analyse how the incident was managed with a view to setting new standards for management of future incidents.

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Incident reporting

Violent incidents must be reported and recorded using the appropriate local format; for example, an employee incident form, or database, and forwarded to the manager or supervisor and occupational health and safety personnel. In Western Australia, for example, depending on the nature of the incident, it may also necessitate reporting to external agencies such as Workcover WA, WorkSafe WA, the WA Police or other appropriate external organisations.

Incident investigation

The most effective way to prevent a recurrence of an incident is to determine why it happened and if it was preventable. Incident investigations should:

- be undertaken promptly by the manager or supervisor in consultation with an occupational health and safety representative and/or relevant clinical and non-clinical staff
- not apportion blame
- be conducted in a supportive and non-judgemental way
- identify underlying root cause/s and contributing factors
- consider all sources of relevant information; for example, witnesses, incident reports, relevant work policies and procedures, the working environment, equipment used, level of supervision at the time, relevant training provided and expert advice including occupational health and safety or risk management staff
- include an operational review, if relevant
- identify and recommend control measures to prevent a recurrence.

Source: Department of Health, Western Australia (June 2004, pp. 17–18)

Reasonable and unreasonable behaviour

Notions of 'reasonable' and 'unreasonable' were discussed in chapter 3, in light of the legal, ethical and professional parameters of providing health care to people with a mental illness. In this section, these notions are considered again, this time in the context of managing challenging behaviours that are occasionally exhibited in the health context.

In an ideal world, people will behave reasonably. For example, in the ideal health setting, people who seek help from the health professional will politely and courteously accept the assistance they are given. They may even express their thanks. Likewise, health professionals will treat one another with courtesy and equity. This is not an unreasonable expectation. Unfortunately, however, the ideal health setting does not exist.

Defining the difference between reasonable and unreasonable behaviour is not easy. The seminal playwright and author George Bernard Shaw once noted that 'the reasonable man adapts himself to the world; the unreasonable one persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man.' The point of Shaw's observation is that it is often only by challenging the status quo — that is, by being unreasonable — that improvements can be made. This philosophy applies to all occupations, professions and settings, including those in health-related fields.

Unreasonable behaviour, then, can sometimes lead to change for the better. Similarly, behaviour that seems unreasonable but in fact has a purpose, may be viewed as reasonable in the long term or according to context. As noted in chapter 5, people in the health context who are fearful or angry may behave in ways that are reasonable when considered in light of the given situation, but which would be inappropriate in a different context. For example, it may be quite reasonable for someone who is concerned about a partner or family member who has been seriously injured to make emotional demands for information from health professionals about the person's condition. However, it would be unreasonable for that person to physically or verbally assault health professionals in the process of obtaining this information.

This raises a number of questions. For example, where is the line between reasonable and unreasonable behaviour, between anger and aggression, between common and uncommon reactions, between acceptable and challenging behaviours? Farrell, Shafiei, and Salmon (2010) provide one way forward with their suggestion that **challenging behaviours** are 'of such intensity, frequency or duration that the physical safety of the client or others is at risk' (p. 1423). This suggests that the determining factors are safety and risk (Crocker, Braithwaite, Laferrière, Gagnon, Venegas, & Jenkins, 2011). At the same time, risk covers many areas in the health context, not just the physical dimension. For this reason, in this text, behaviours are defined as challenging when they are of such intensity, frequency or duration that the physical, emotional or social/relational safety of a person or persons are at risk.

challenging behaviour
behaviour of such intensity, frequency or duration that it places the physical, emotional or social safety of one or more of those involved at risk

Challenging behaviours in children

While this chapter focuses on adults who display challenging behaviours, there may be occasions when a child or adolescent displays behaviours that are considered unreasonable or unacceptable in a health care context. Many challenging behaviours of children are considered normal and part of expected developmental pathways. For this reason, specialists in child and adolescent services should be consulted when children or adolescents present with ongoing disruptive behaviours that cannot be adequately managed in a health care setting.

The Australian government Health website (www.health.gov.au) also has a number of fact sheets available to parents, carers and health professionals on the management of challenging child behaviours.

UPON REFLECTION

The impact of population screening

The Australian government initiated the Medicare Healthy Kids Check in July 2008. This initiative was to monitor physical health, general wellbeing and development in preschool-age children. In 2011, funding for the Healthy Kids Check was expanded to include elements of social and emotional wellbeing, commencing in 2012–13. The expanded monitoring initiative created robust discussion within the health industry regarding the appropriateness of population screening in 3–4-year-old children, and the usefulness of emotional and behavioural monitoring in this

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age group. Some health professionals feared that the expanded screening would involve predicting the likelihood of the child exhibiting ongoing developmental and behavioural problems, and placing parent–child relationships under scrutiny (Daubney, Cameron, & Scuffham 2013; Kowalenko 2012).

Questions

1. How would a health professional go about differentiating between normal and challenging behaviours in a 3- or 4-year-old child?
2. Do you consider that social, emotional and behavioural observations of a 3- or 4-year-old child is a good indicator of how the child will emotionally and behaviourally develop as an adolescent? What factors do you base your answer on?
3. What are some of the potential ramifications for the parent(s) and family, school environment and other relevant stakeholders, in labelling a child with emotional and behavioural problems?
4. What are the clinical and ethical risks of pathologising behaviour in a young child?
5. What are the possible advantages of using age-specific population screening in this program?

The 'difficult patient'

According to Koekkoek, van Meijel, and Hutschemaekers (2006), the 'difficult patient' is a well-known figure in the everyday health context, adding that the term 'difficult' is often used to describe a 'lack of cooperation between the consumer and health professional' (p. 795. See also Bos, Kool-Goudzward, Gamel, Koekkoek, & Van Meijel, 2012; Koekkoek, Hutschemaekers, van Meijel, & Schene, 2011;). This is exemplified in the following list of behaviours that some health professionals may perceive as 'difficult':

- constant complaints against staff members
- 'splitting' and/or 'staff splitting' (see figure 6.1 later in this chapter)
- non-adherence to investigations or treatment
- the consumer whose health status does not improve — for example, someone whose pain cannot be controlled or who presents a new set of symptoms as soon as a previous set of symptoms has resolved
- sexual disinhibition
- non-cooperation with staff requests
- discrimination (gender, sexuality, race, religion)
- silence and/or withdrawal
- asking too many questions
- dependence, which can manifest itself through constant demands for attention from health professionals or an insatiable desire to be noticed
- confusion, wandering
- self-harm.

In light of these characteristics, it would seem that notions of 'difficult' are mostly defined by a health professional's perception of how much or to what degree the person is complying with the traditional role of the 'ideal patient'; that is, someone who is patient, passive, compliant and grateful. In short, if the person is demanding, active, non-compliant and ungrateful, they do not meet the health professional's expectations of how the recipient of a health service 'should' behave. This, in turn, may lead to a perception by the health professional, conscious or unconscious, that the consumer does not deserve their attention or care. As a result, the health outcomes for that consumer are challenged.

Corrigan (2006) goes on to suggest that the term 'difficult patient' also has a stigmatising influence. This is because:

> it frames a person's experience in the pejorative. It implies that people … are responsible for the symptoms and disabilities they face. It is patriarchal and suggests that the service provider, not the person, knows what is best. It chastises the person … for having a poor relationship with the health care provider. True, some of the relationships between consumer and provider may be difficult. But the difficulty lies between the two parties and should not be blamed solely on the one person … Research has shown that resolution of difficult relationships requires equal interactions by all parties (p. 1218).

The term 'difficult patient', then, needs to be avoided by health professionals as it labels and stereotypes. It is also negates the principle, described in chapter 5, that each person is unique and complex, a product of their upbringing, experiences, culture, education and circumstances (McKay, McDonald, Lie, & McGowan, 2012). Indeed, some behaviours that seem unacceptable may actually be the consequence of unusually challenging situations (Farrell & Salmon, 2009/2010). Given a particular set of circumstances, every person is capable of behaviour that may be considered inappropriate. Before labelling a person's behaviour, then, it may be helpful for the health professional to stop and consider how they themselves might react in a similar situation (Kahn, 2009).

Koekkoek and colleagues (2006) go on to identify four categories of 'difficult' behaviours:

1 withdrawn and hard to reach
2 demanding and claiming
3 attention seeking and manipulating
4 aggressive and dangerous.

Although these terms are broadly self-explanatory, the term 'manipulating' needs some explanation. The *Macquarie Dictionary* defines the word 'manipulate' as 'to handle, manage, or use, especially with skill, in some process of treatment or performance'. Significantly, this dictionary meaning is neutrally valorised. In Australian society, however, the term 'manipulative' tends to have a negative connotation. Indeed, 'manipulating' is seen as the way a person manages or uses or even orchestrates a situation for their own ends. The consumer whose behaviour is manipulating, then, is often viewed as self-seeking, to the detriment of others.

Based on a comprehensive research of literature undertaken between 1979 and 2004, Koekkoek et al. (2006) identified three separate subgroups of 'difficult' behaviours. These are:

1 unwilling care avoiders who do not consider themselves to be ill and resent 'interference' by health professionals
2 ambivalent care seekers who have a serious illness but are unable to maintain a relationship with caregivers
3 demanding care claimers who may not need long-term care but who could benefit from short-term care (Koekkoek et al., 2006).

The general characteristics of each of these are outlined in more detail in table 6.1. It is interesting to note that consumers who exhibit these general characteristics are either relegated to the mental health services, the forensic services, or excluded from service or treatment altogether. In short, due to the challenging behaviour, health outcomes are challenged.

TABLE 6.1 Characteristics of the 'difficult patient'

'Types' of 'difficult patients'			
Characteristic	Unwilling care avoider (Group 1)	Ambivalent care seeker (Group 2)	Demanding care claimer (Group 3)
Diagnosis	Psychotic disorder, Personality disorder, cluster A, especially paranoid personality disorder	Depressive disorders, Personality disorder, clusters B and C, especially borderline personality disorder	Substance use disorder, Depressive disorders, Personality disorder, cluster B, especially antisocial personality disorder and narcissistic personality disorder
Gender	Male	Female	Male
Difficult behaviours	Withdrawn Hard to engage Aggressive	Demanding Claiming Self-destructive Dependent	Attention seeking Manipulating Aggressive and destructive
Acceptance of sick role:			
• by the consumer	No	Yes	When opportune and expedient
• by the health professional	Yes ('mad')	Alternating ('mad' or 'bad')	No ('bad')
Prevailing discourse	Medical psychiatric Difficult to treat the consumer	Mixed Difficult consumer	Social-moral Difficult non-consumer
Probable treatment setting	Mental health care	Usually mental health care, risk of no care	Justice or forensic health

Source: Adapted from Koekkoek et al. (2006, p. 796)

Outcomes of labelling

When managing challenging behaviours, avoiding labels is especially important because they tend to target the person rather than the action or behaviour, thereby perpetuating notions that the person rather than the behaviour is the problem. Outcomes targeting the person are rarely positive.

Indeed, the impact of labelling on a person who exhibits challenging behaviours, and also on their partner or carer and family members, is always detrimental (Halls & Arshad, 2011). One reason for this is the negative attitudes of health professionals that labels perpetuate. For example, a consumer may be labelled 'difficult' by a health professional shortly after they present to the health service for assistance. The perception of 'difficult' could be due to any numbers of reasons; for example, the consumer does not fit the role of a 'good patient' for this particular health professional because they asked too many question in a demanding tone of voice. The label of 'difficult' is then passed on or handed over by the health professional to the next health professional, and then the next health professional again. Consequently, all of the health professionals concerned have preconceptions about the person that are based upon little more than the original health professional's idealised personal values system. These preconceptions go on to influence the way all of the health professionals interact and engage with the consumer.

Significantly, Farrell and Salmon (2009/2010) describe certain behaviours, ranging from violence to 'eccentric habits', and suggest that the challenging behaviour is not necessarily measured by the acuity or intensity of the behaviour, but rather by whether health professionals have the skills and resources to manage their interactions. Indeed, labelling various types of behaviour as 'challenging' often comes down to the degree of the behaviour and also to what is considered reasonable or acceptable behaviour in a particular setting. For example, a man who has spent several hours in a hospital emergency department might raise his voice to express concern about the fact that his wife has not yet been attended to. In this case, the health professional has to decide whether this behaviour could escalate to physical violence (WorkSafe, 2008). While the raised voice should be viewed as a 'risk factor', the intensity or degree of the person's frustration or anger must also be considered. As noted in chapter 5, anger can most often be de-escalated by a health professional by allowing the person to vent in a safe environment, treating them with unconditional positive regard, listening to and addressing their concerns, and practising empathy.

Defence mechanisms

Defence mechanisms refer to a way of theorising about how people unconsciously respond to threats or anxiety when faced with unpleasant thoughts, feelings or behaviours. Defence mechanisms are used by everyone from time to time to deal with stressful situations; they are one of the many coping strategies used by people to help them deal with the challenging aspects of their daily lives.

Projection is one example of a defence mechanism used by an individual to protect themselves against the fear, anxiety or other emotion generated in reaction to a challenging situation. Projection can reduce the emotions involved by allowing the individual to unconsciously express their unwanted unconscious impulses or desires by 'externalising' them (Smith & Allan, 2010). For example, an individual may be feeling guilty because they are partly responsible for a family member being injured. To help them to cope with their feelings, they blame other people, including the health professional. This behaviour can easily be interpreted by the health professional, who may feel attacked by the individual, as 'challenging'.

defence mechanisms normally unconscious mental processes that can help to reduce potentially negative feelings such as anxiety, shame or fear

projection the process in which one person assigns (or projects) their uncomfortable thoughts or feelings onto another person

Splitting is another defence mechanism that often challenges health professionals. As with all defence mechanisms, splitting is a strategy that any person might employ given a certain set of circumstances, in particular when they are stressed or feeling vulnerable. Splitting occurs when an individual unconsciously separates notions of 'good' and 'bad' in situations that evoke powerful feelings (Smith & Allan, 2010). This leads to the individual viewing people and situations in a polarised way; for example, with feelings of either love or hate, attachment or rejection. At the same time, the person is unable to accept or integrate their own positive and negative qualities (Arntz & ten Haaf, 2012; Stuart, 2008). In reality, however, situations or circumstances that involve people are almost never black and white, but rather a complex mix of many feelings and perceptions. The individual who is splitting, however, is unable to accept this.

splitting where an individual is unable to see that people are complex beings with both positive and negative attributes who may behave differently according to context. Instead, the individual reduces people and behaviours into simplistic and often polarised categories.

An example of splitting is the child who is abused by the father she depends on for love and protection. She separates the father who abuses her from the father she depends upon. This allows her to preserve an image of a 'good' father, but this comes at great cost. The child is left identifying herself as 'bad' in order to make sense of the abuse. In turn, as she grows up, she is unable to reconcile these two parts — nor the idea that no one is all good or all bad. As an adult, this may become a problem when she feels stressed or vulnerable. She may view the situation as all good or all bad. Likewise, she divides health professionals in categories of good or bad, and seeks to gain support for her views from other service users and even other staff members. This becomes the challenging behaviour known as 'staff splitting'.

Staff splitting

Staff splitting manifests itself when a consumer asks different members of staff for the same thing until they get what they want (McGrath & Dowling, 2012; Perlin, 2001). This dynamic is often viewed as 'manipulating' behaviour. The process of staff splitting is particularly evident when the multidisciplinary team has suggested treatment options or management strategies, and the consumer is ambivalent about these options or strategies. Consequently, the consumer may move from health professional to health professional, testing their commitment to the treatment options and making judgements about the health professional based upon their response to the consumer's requests. This can be reminiscent of a child playing one parent against the other.

staff splitting a defence mechanism that occurs when a consumer idealises a health professional and manipulates them to meet their own needs; this behaviour challenges consistency of care and creates tension in the multidisciplinary team

Another example of staff splitting is when a consumer is struggling to deal with the stress of illness, injury or even hospitalisation. To protect themselves against the anxiety or other feelings that the stress has generated, the consumer finds a health professional who seems responsive and willing to meet their needs. The consumer then begins to idealise this health professional — and criticise other health professionals. The idealised health professional finds it difficult to resist the temptation of being viewed as 'special' and begins to treat the consumer, likewise, as 'special'. Such treatment may include meeting the consumer's needs regardless of the circumstances or setting, by going that extra mile or, on occasion, bending the rules of the health service to suit the consumer. This leads to tensions in the workplace between members of the multidisciplinary team (McGrath & Dowling, 2012).

In the previous example, however, the health professional will inevitably betray the consumer's idealisation — health professionals are human, with human frailties. When this happens, the consumer, overcome by the anxiety this generates, turns on the health professional and attacks them — physically, emotionally or personally. The consumer then moves on to find another health professional to idealise and use as a means of coping with the anxiety or other feelings the situation is provoking in them. The first health professional is left feeling demeaned, humiliated and attacked; and so the process continues.

The dynamic of staff splitting is further exemplified diagrammatically in figure 6.1, which shows how splitting may affect relationships between consumers and health professionals, and also between health professionals themselves on the multidisciplinary team. By way of explanation, the behaviours and communication of the Consumer and Health Professional B are negative, reinforcing the consumer's worst feelings about him or herself. On the other hand, the behaviours and communications of the Consumer and Health Professional A are far more positive. These two health professionals then replicate the consumer's own internal 'split' in their own discussion and enact the consumer's internal conflicts as they cannot agree about the consumer's behaviour and health care needs.

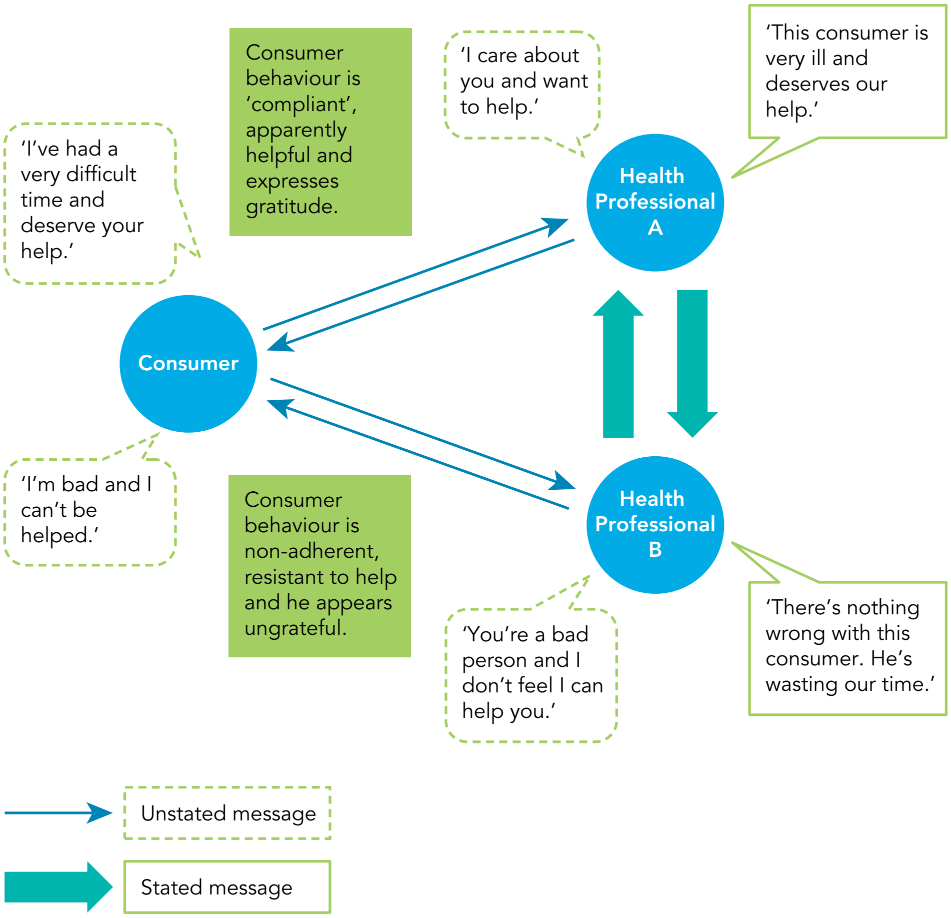

FIGURE 6.1 The process of staff-splitting

Source: Adapted from Perlin (2001)

Challenging the process of staff splitting can be difficult for the health professional and also the multidisciplinary team. In general, the following steps must be followed:

- clear communication between the multidisciplinary team about the care and treatment decisions made with the consumer
- understanding of and regular communication between the multidisciplinary team about the dynamic of staff splitting
- ongoing support and clinical supervision provided to all members of the multidisciplinary team when caring for a consumer with these behaviours.

It is also important to note that health professionals who demonstrate respect, professional integrity, skills competency and a willingness to provide the consumer with meaningful control and choice in their own care, are more likely to be effective in their interactions with the consumer.

On the other hand, many health professionals may project an authoritarian attitude or demeanour towards a person they perceive to be 'manipulative' or 'difficult'. Such an attitude may help the health professional feel more in control of the situation, but it is actually counterproductive. As noted by Björkdahl, Palmstierna, and Hansebo (2010) an authoritarian attitude will most often lead to a power struggle between the consumer and health professional, with neither players benefiting in the long term.

Control and power

Many consumers feel helpless or powerless when dealing with health professionals (Dickens, Piccirillo, & Alderman, 2013). There is an obvious irony in this, as many health professionals ascribe great power or control to individuals engaged in challenging behaviours, demonstrated by the health professional's intense emotional reactions to the challenging behaviours of the consumer, and expressed by language such as 'He makes me feel like . . .' As noted in chapter 5, such language suggests one way the health professional blames the other person, displacing their personal responsibility and walking away as the 'innocent victim'. In reality, however, it is the health professional who holds the balance of power.

Indeed, challenging behaviours often result in a struggle for control or a series of responses from health professionals that do not address the problem, but instead establish a conflictive relationship (Thakker, Bamidele, Ali, & Hassiotis, 2012). These forms of response merely perpetuate the problem and increase levels of frustration, since all parties involved are likely to become dissatisfied with the way they interact and with the outcome of the conflict (Raub & Robert, 2010; Ross, Bowers, & Stewart, 2012).

It can sometimes be easier for a health professional to focus on the task at hand rather than to make an effort to interact on a personal level with an individual who is exhibiting challenging behaviours. This is especially true when the health professional has made a negative assumption about the person. Instead, health professionals need to recognise that people react and respond to both verbal and non-verbal cues — in short, body language is just as important as verbal messages (Farrell, Shafiei, & Salmon, 2010). People will react to what the health professional says and also to the way they say it. If the health professional holds preconceived ideas, expectations or negative perceptions about a particular 'type' of consumer, it is very difficult for them to conceal it. Their attitudes will almost always be betrayed through the language they use or the attitudes they display. It is therefore critical for the health professional to be aware of their belief system and personal judgements about people who are exhibiting challenging behaviours; and challenge attitudes that are counterproductive (Farrell, Shafiei, & Salmon, 2010; Greenland, 2005). A more detailed explanation of how the health professional can develop self-awareness is provided in chapter 5.

The next sections consider further the power imbalance between consumers and health professionals, and how this power imbalance can affect the behaviour of the consumer. The discussion is undertaken in light of the causes and triggers of challenging behaviours. Prior to this, brief consideration is given to the influence of the health professional in determining the nature of a challenging interaction.

The influence of health professionals

There is now a growing body of literature that supports the suggestion that aggression, violence and other challenging behaviours are mediated by the levels of education and training, and skills or competence of the health professional, as well as their attitude towards the consumer (e.g. Duxbury, Hahn, Needham, & Pulsford, 2008). The quality of the relationship between the consumer and health professional is also significant to decreasing aggressive incidents (e.g. Bowers et al., 2009). For this reason, it is important that health professionals consider the role they have played, after an aggressive incident has occurred. Questions they may ask themselves may include the following.

- ‘Who is it that finds this behaviour unpleasant, difficult or problematic?’
- ‘What is it about this person’s behaviour that is specifically difficult to manage?’
- ‘From the person’s point of view, is it legitimate and understandable?’

As noted, the influence of control and power when dealing with the consumer is important. Just as influential is the attitude, behaviour, the internal world, and also the situational context of the health professional at the time of the incident. For example, what has been happening to or for the particular health professional before an incident that led to the interaction becoming challenging?

Such practice reflection would ideally include the health professional participating in regular in-service education about managing people who exhibit challenging behaviours, and also regular clinical supervision (see chapters 5 and 12). Indeed, it has been shown that this kind of practice reflection leads to reductions in challenging behaviours and to positively altered perceptions of the problem in health professionals (Turner & Snowdon, 2009).

clinical supervision a formal and ongoing process of giving and receiving professional support through reflective practice

Clinical supervision is a formal and ongoing process of giving and receiving professional support through reflective practice (Driscoll, 2007). It is through clinical supervision that health professionals are helped to consider their practice and discuss insights or issues with a senior health professional, with a view to improving knowledge and competence (Gonsalvez & McLeod, 2008; White & Winstanley, 2009). A significant outcome of clinical supervision is an improvement in the quality of care that is being provided to the consumer — including the quality of care provided to the consumer who is exhibiting challenging behaviours. Clinical supervision can also help health professionals to reduce the likelihood of burnout, which can be a consequence of dealing with the challenging behaviours of others in the workplace (Gascon et al., 2013).

UPON REFLECTION

The use of labelling . . .

The impact of labelling a person who exhibits challenging behaviour as 'difficult' is usually detrimental to that person.

Questions

1. Consider an occasion when another health professional indicated that a particular consumer was 'difficult'. Given this information, did you change your behaviour or approach toward the consumer? Was the approach you took genuine, non-confrontational and person-centred? What was the outcome of the interaction?
2. What strategies could you use to address 'difficult patient' labelling within your discipline or clinical area?

Causes and triggers of challenging behaviour

Although challenging behaviours may have their origins in the more extreme reactions and responses of people to the stress they experience in the context of receiving health care, it is important to give wider consideration to the issues involved. Feelings of vulnerability and powerlessness can arise from the experience of illness and the need to seek help (Hahn, Hantikainen, Needham, Kok, Dassen, & Halfens, 2012).

First and foremost, consideration needs to be given to whether the challenging behaviour has been precipitated by an organic cause. For example, aggression in an older person may be due to a delirium or dementia (see chapter 11). In particular, a delirium can be life threatening and must be immediately assessed by a medical officer. Again, the challenging behaviour of an apparently intoxicated person may not be alcohol related at all, but rather due to a head injury that has not been identified.

Alternatively, challenging behaviour can often be perpetuated by extenuating circumstances (Webster, 2011). A literature review conducted by Gillies and O'Brien (2006) identified a number of triggers that could lead to violent behaviour. These include:

- demands made upon the consumer by the health professional, perceived as being unreasonable
- the health professional's (negative) attitude to the consumer
- attempts to pressure the consumer into taking medication they are unsure about
- disputes with other consumers.

As previously identified, challenging behaviours may be the result of the power imbalance that is inherent within the relationship between the health professional and the person they are assisting (Dickens, Piccirillo, & Alderman, 2013). Indeed, many consumers feel powerless and open to exploitation simply by presenting themselves to a health service for assistance. Reasons for this can include the experience of illness itself, including feeling weak, nauseous and generally unwell. These feelings are often exacerbated when faced by a bureaucratic health care system with long waiting times, where health professionals often seem more concerned with maintaining routines than with helping people. Other reasons for feelings of vulnerability and powerlessness in consumers include:

- the unfamiliar environment in which they find themselves
- needing assistance with personal care
- belonging to a marginalised group
- experiencing an unfamiliar loss of self-determination (Australian Nursing and Midwifery Council, 2008).

Effective health professionals will consider these factors when helping a person with challenging behaviours, and explore ways and means by which the person can be empowered. These will include actively preserving the dignity of the consumer by practising kindness and unconditional positive regard; and also by being aware that the consumer may be feeling vulnerable and powerless.

Feelings of vulnerability and powerlessness can arise from the experience of illness.

Communication and challenging behaviours

Davison (2005) has identified a high correlation between a person's subjective experience of anxiety and sense of powerlessness, and aggression. Figure 6.2 illustrates the process of communication involved. An external stimulus is received and the person tries to make sense of it by placing the event or situation into context. However, this is mediated by their personal or individual experiences and perceptions (Nau, Halfens, Needham, & Dassen, 2010). The cognitive process overlaps with the emotional responses and the impulse to act is based upon the judgement reached.

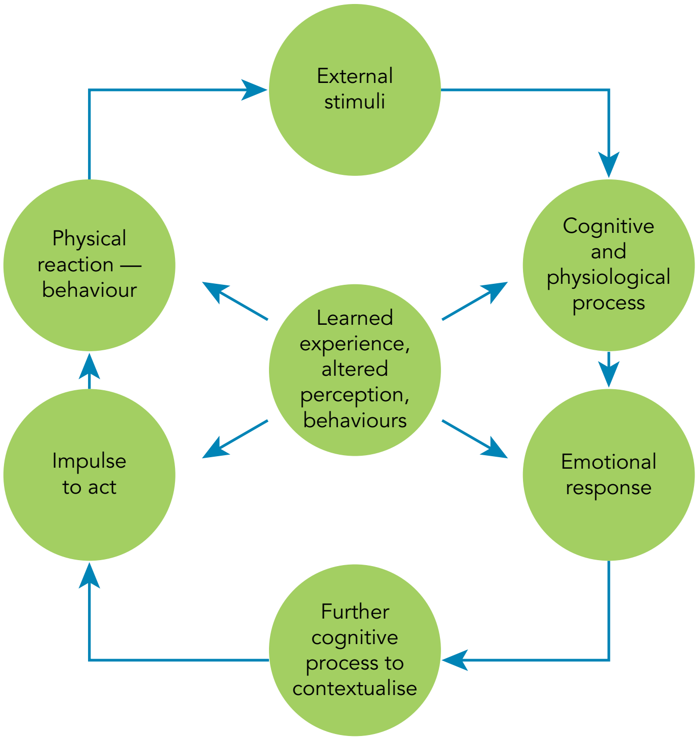

FIGURE 6.2 A model of communication for understanding challenging behaviours

It may well be argued, then, that challenging behaviours are often used to communicate what the individual has otherwise been unable to articulate (Kynoch, Wu, & Chang, 2011). If this is the case, it is unlikely that the person with the challenging behaviour has any conscious or developed understanding of the process; that is, they are unaware that there are more constructive and effective ways of communicating. For the health professional, reframing the situation or interpreting the behaviour of the consumer as a reflection of their inability to more constructively communicate their feelings is one way to manage the situation more effectively (Cookson, Daffern, & Foley, 2012).

General assessment

An assessment by the health professional of what has triggered or caused the challenging behaviour will begin with a biographical and social history. Engaging with the person and encouraging them to tell their story will enable the health professional to identify their current issues, which will provide some context to the person's current issues and problems. If a clear pattern emerges of, for example, difficulty in dealing with or responding to others constructively, health professionals need to take this into account during future interactions. Such patterns also provide the health professional with the opportunity to discuss issues related to the behaviour in the health context. Alternatively, the health professional may find that the person is someone with a higher than usual need for information or an inbuilt critical approach to problems. Again, this will enable the health professional to adapt the way they respond to the person.

Another option may be that the consumer has grown into the role of a 'difficult patient' as a result of past experiences when they received poor or disappointing treatment. In this case, the health professional will be positioned by the consumer as the 'bad health professional', in a role reversal of sorts, with resultant interactions difficult. At the same time, the health professional also needs to consider the current experience of ill-health or injury and its progression. For example, a consumer with chronic illnesses or conditions, especially those that involve great pain, will have often a lower threshold for coping with additional stress.

An example of a challenging behaviour exhibited by a person who lacks skills in communicating effectively is provided in the following 'In practice' box. In this narrative, the woman's perceptions and understanding of the situation are limited by her past experiences and the way in which these experiences have shaped the person she is when she becomes unwell. She is unable to describe her emotions and acts out her feelings instead.

IN PRACTICE

Understanding the causes of challenging behaviour

Claire has been a patient in a haematology ward for several weeks, being treated for acute myeloblastic leukaemia. She is cared for in a single room. Initially chatty and cheerful, as her treatment with chemotherapy has progressed she has become more irritable, unwilling to have her observations recorded and even, on occasions, refusing treatments. She has also asked the ward staff to stop visitors coming into her room.

It emerges that, while having the treatment, Claire has been ruminating on her past, when her father psychologically and sexually abused her. He is now dead, but her mother is alive and Claire blames her mother for not being available to protect her when she was in need. Remembering this, she has re-experienced feelings of guilt, and has started having intrusive thoughts that she is not worth helping and, even if she were, the treatment will not be successful. She has begun to believe she is likely to die and fears for her two-year-old daughter's long-term welfare.

Claire feels ashamed about her anxious and negative thoughts. She believes she has no control over them or the medical condition, which has brought her into hospital, feeling her own body has 'turned against her'. Thinking that she has also lost control over what happens to her while in hospital, Claire challenges the treating team at every opportunity.

There are a series of confrontations between Claire and the frustrated staff. It is only when a nurse from the mental health liaison team meets with her that she articulates these troubled thoughts and feelings. Claire then begins to be able to challenge both her feelings and the extremely negative image of herself that she has constructed. This enables her to become more relaxed about, and accepting of, her treatment regimen and negotiating her needs with the treating team and ward staff.

Questions

1 What social and physical resources need to be put in place to support Claire in her recovery?

2 As a health professional, what strategies could you employ to help manage your feelings about Claire's behaviour?

Older people and challenging behaviours

Other causes of challenging behaviours may be associated with Alzheimer's disease and related dementias (see chapter 11). These challenging behaviours could include restlessness, pacing and wandering, and repetitive calling or questioning (see chapter 11). The individual may become emotionally labile and apathetic, and experience disturbed sleep (Enmarker, Olsen, & Hellzen, 2011). However, even in a person with dementia, the condition itself may not be the cause of the challenging behaviour (Goldberg, Whittamore, Harwood, Bradshaw, Gladman, & Jones, 2012). For example, the person may be experiencing physical pain due to a toothache. The side effects of some pain-reducing medication can also cause behavioural disturbance, including confusion and agitation. Physical discomfort can also give rise to challenging behaviours in older people; for example, constantly needing to go to the toilet. Finally, the person with a toothache may also be less inclined to drink. This could lead to dehydration, which can cause dizziness, headaches, dry skin, infection, cramps, constipation, urinary problems and increased confusion, all of which can result in disturbed behaviour.

For this reason, challenging behaviour can sometimes be the only way a person is able to communicate discomfort, pain or that there is something 'not quite right'.

This includes occasions when the person has a psychotic illness or a personality disorder. Health professionals may think they cannot respond effectively to someone who is thought disordered or has a psychosis, as the meaning of the conversation may be inaccessible. However, the health professional needs to be open to 'listening' to the expression on the person's face or their body language.

It is also important to note that anger and aggression are a response to the same physiological sensations that prompt the fight-or-flight response. For this reason, leaving any person in an anxious or frightened state may lead to an escalation of behaviour as they try to communicate their feelings through their behaviour. The following 'In practice' box describes the experience of an older male person who is exhibiting anxious and frightened behaviours.

IN PRACTICE

Communicating with the older person

Mr Crane is an 88-year-old man who lives in a nursing home and has just been admitted to hospital. He has been diagnosed with a urinary tract infection, has a high temperature, and he is nauseated and drowsy. Mr Crane is slightly unsure of his whereabouts and the time. He is also missing his hearing aid. Dozing on his bed, Mr Crane is woken by two carers who tell him they need to take him to the toilet, as it stated in his admission notes that he has problems with continence. It has been a very busy shift and the carers have many tasks to complete. They take hold of Mr Crane's arms before he is properly awake (the external stimulus) and, shocked, Mr Crane cannot make sense of what is going on. Adopting the fight-or-flight response, he tries to move away. The carers, fearful he will fall, tighten their grip. Mr Crane struggles free and pushes at one of the carers. There is an angry exchange. Mr Crane accuses them of 'doing things' to him, but still feels slightly confused and cannot articulate his thoughts clearly. The carers try to explain that he must not push them and they are only trying to help. Unable to hear properly, but embarrassed and helpless from the experience, Mr Crane falls silent and refuses to go to the toilet. Later, he has to ask the carer to urgently bring him a urinal as he does not think he can get to the toilet in time. She is delayed and he is incontinent. He shouts at her and she tells him he could have gone to the toilet earlier in the evening.

The next time the two carers approach Mr Crane, he is immediately wary, withdraws and refuses to interact with them. In recording the incident, it is noted that Mr Crane is 'confused and aggressive'.

Questions

1 Using a biopsychosocial approach, determine what Mr Crane's issues are.

2 From a risk management perspective, how could this situation be managed differently?

Challenging behaviours exhibited by health professionals

Significantly, a dysfunctional team or organisation is more likely to experience the challenging behaviours of consumers (Hegney, Tuckett, Parker, & Eley, 2010; St-Pierre, 2012). On the other hand, a supportive team environment has been found to mitigate workplace violence (Hegney et al., 2010). This provides a good basis for suggestions that health professionals must work to build and maintain cohesive relationships within the multidisciplinary team and be committed to supporting one another in the workplace.

It is a sad fact that many health professionals, despite being members of the caring professions, are not immune from workplace bullying. The phrase 'horizontal violence' is one term used to describe the bullying behaviour of a health professional towards a colleague.

Bullying has been identified as one of the most concerning forms of aggression experienced by health professionals, with reported rates of exposure comparable to high-risk occupations such as police and prison officers (Deans, 2004). Workplace bullying has been defined as the repeated and less favourable treatment of a person by a colleague(s), including behaviour that intimidates, offends, degrades or humiliates a worker (Australian Human Rights Commission, 2010).

Bullying behaviour can range from very obvious verbal or physical assault to very subtle psychological abuse. This behaviour may include:

- physical or verbal abuse
- yelling, screaming or using offensive language
- excluding or isolating
- psychological harassment
- intimidation
- assigning meaningless tasks that are unrelated to the job
- assigning tasks that are impossible to complete
- deliberately changing work rosters to inconvenience particular employees
- undermining work performance by deliberately withholding information vital for effective work performance
- eroding professional competence and reputation
- personal attack
- attack through work roles and tasks, including withholding relevant information, unnecessary disruption to work, and unfair work allocation (Australian Human Rights Commission, 2010; Hutchison, 2009).

Workplace bullying, then, is more than rudeness and incivility. Although it can include behaviours such as overt aggression or threats of violence, it more commonly involves subtle or covert acts such as belittling, blaming and public humiliation. Significantly, exposure to bullying can even begin during undergraduate education or in the initial graduate years:

> I was pretty sure it was the wrong dose — it just seemed too much for the patient — but when I tried to say something I was told 'What would you know — you're all the same straight out of university and you think you know more than the rest of us' (Chiarella & McInnes, 2008, p. 81).

Many health professionals, regardless of their discipline area or professional loyalties, will be bullied at some time in their working life, with such experience even considered to be part of the job (Huntington, Gilmour, Tuckett, Neville, Wilson, & Turner, 2011; Hutchinson, 2009).

Although some bullies may have personality characteristics that predispose them to this behaviour, bullying does not continue unless the workplace climate condones, or even rewards this kind of behaviour (Hutchison, 2009). It seems that some work environments in Australia, including health care environments, have a long way to go before the practice of bullying and workplace violence carried out by health professionals is recognised as being detrimental, not only to the victim, but to those witnessing the incidents.

Even so, there are a number of essential strategies that can be utilised by the health professional to combat bullying in the workplace. Many of these strategies relate to conflict management, and include:

- acknowledging that conflict exists
- listening
- being non-judgemental
- creating an atmosphere where health professionals are committed to working to solve problems (Cooke, 2006).

As noted at the beginning of the chapter, the development of a 'zero tolerance' approach to workplace violence is being actively promoted by the Commonwealth Department of Health of Ageing, and Departments of Health in all states and territories (e.g. Office of the Commissioner for Public Employment, 2005; Victorian Taskforce on Violence in Nursing, 2005). It is the responsibility of each and every health professional to work to support these initiatives and play a role in combating the challenging behaviour exhibited by colleagues. This is discussed in more detail in the following section.

UPON REFLECTION

Seeking help . . .

Given the prevalence of workplace bullying behaviours, it is likely that most health professionals will experience, or know someone who has experienced, some form of horizontal violence.

Questions

1. What formal reporting pathways are available to health professionals who are experiencing workplace bullying?
2. Alternatively, what informal options are available to those facing such situations?
3. From a professional perspective, how could you support a colleague who is experiencing bullying in the workplace?

Addressing challenging behaviours

This section discusses the different ways the challenging behaviours of a consumer are addressed in Australian health services. This includes a description of organisational responses, risk assessment and some practice strategies that can be used by the health professional. Consideration is also given to the use of seclusion and restraint.

Organisational responses

The Australian Commission on Safety and Quality in Health Care has developed the *Australian Charter of Healthcare Rights* that was endorsed by Australian health ministers in July 2008. The charter, which was developed after wide consultation, specifies the key rights of consumers when seeking health care services. These rights are:

- access
- safety
- respect
- communication
- participation
- privacy
- comment (Department of Health and Ageing, 2009).

All of these rights are equally important. However, the right to receive open, timely and appropriate communication about the health care being provided, and in a way the consumer can understand, is particularly relevant for health professionals who are caring for someone with challenging behaviours (Australian Commission on Safety and Quality in Health Care, 2009).

In response to the charter of rights, zero tolerance strategies have now been established in virtually every public service across Australia. As already noted, behaviours such as aggression, violence, assault, bullying or any other acts of violence are now actively discouraged in the workplace. Governments and managers alike are upholding the right of all staff to work in a violence-free workplace; and consumers, partners, carers, families and friends also have the right to receive health care or visit their partner, relative or friend in a therapeutic environment free from risks to their personal safety.

Even so, research has identified that health professionals remain the most frequent victims of violence associated with those behaviours (Gillies & O'Brien, 2006; Stewart, Bowers, Simpson, Ryan, & Tziggili, 2009). For example, findings of a number of projects researching nurses working in mainstream health, found that up to 88 per cent have experienced patient aggression on at least one occasion (e.g. Deans, 2004; McKinnon & Cross, 2008; Speedy, 2006), including verbal abuse and swearing (Stone & Francis, 2010). Although this behaviour usually results in little or no physical injury, the psychological responses can be significant. Such responses reported by health professionals include anger, anxiety, post-traumatic stress disorder symptoms, guilt, self-blame and shame (Stewart, Bowers, Simpson, Ryan, & Tziggili, 2009). Perhaps most worrying is the fact that, despite awareness of workplace violence, health professionals continue to accept that the violence they receive from consumers is a regular part of their work (Hegney et al., 2010)

Such research raises questions about the effectiveness of the zero tolerance policies and strategies being implemented nationally and across all states and territories. For example, why are these policies so difficult to enforce in practice? Another important factor is the role of the police, who are often reluctant to intervene in a hospital or other health care environment, particularly if there is any suspicion that those involved may have mental health issues. It is also important to consider workloads and the levels of stress of health professionals. Increases in expectations to meet key performance indicators and complete outcome measures have led to increases in levels of frustration, resentment and stress in health professionals. Stressed people are less able to respond to challenging behaviours or situations that involve consumers or colleagues (Hart, 2004).

Although the notion of zero tolerance is commendable, its widespread application in health settings remains complex. To be effective, anti-violence policies need to include higher levels of clinical staff, more effective training, and more appropriate facilities, with the use of restraint and a zero tolerance approach being last-resort measures (Holmes, 2006; Wand & Coulson, 2006).

UPON REFLECTION

Creating a safe working environment

Everyone has the right to work in a safe working environment. It is everyone's responsibility — not just supervisors and managers — to ensure that every workplace is safe. This means being aware of the appropriate policies, practices and procedures that apply to your particular working environment as well as the relevant Commonwealth and state or territory legislation.

Questions

1. Are there any environmental factors (e.g. bright lights at night; noises such as alarms, machinery, phones ringing, doors slamming, wet area traffic) in your workplace that contribute to consumers' challenging behaviours?
2. Does your workplace have a policy or management plan for hazards? If so, does the plan address how you identify hazards and concerns, how you assess for risk, and risk control for each identified hazard?
3. Is there a systematic process for the monitoring and review of reports? If not, how do you think you can address these issues?

Education and training

Bowers (2010) suggests that health professionals working with people who exhibit challenging behaviours, in particular, people with mental health issues, need specific training on how to respond. Bowers (2010) notes that 'particular care was recommended with aggressive and irritable patients, with a non–threatening, nonverbal stance being required and a cautious choice of the language used' (p. 25). The proposed strategies include:

- making suggestions rather than issuing orders to the individual
- being assertive and forceful
- being flexible and encouraging
- giving positive feedback.

Likewise, Beech and Leather (2006) support the use of training as a means of helping health professionals to deal with aggression and violence in the workplace. Oostrom and Mierlo (2008) suggest that such training could include improved interpersonal skills, assertiveness training, and enhanced self-esteem and self-confidence.

There are many different aggression management training programs available across Australia (Farrell & Cubit, 2005). One such program, 'PART' — Professional Assault Response Training — has been legally tested in the United States, and is one such training program recommended for all health professionals who are at a high risk of encountering a person who is aggressive or violent. Generally, the training is run over two to three days and provides health professionals with a comprehensive and systematic approach to predicting, assessing and responding to aggressive or challenging behaviour. The program emphasises problem-solving principles to defuse potentially dangerous situations, thereby avoiding the possibility of physical restraint. It works to minimise risk and increase staff confidence in responding safely and effectively to challenging situations. Health professionals across Australia are encouraged to approach their line manager about attending this training, or an equivalent program, in their local area.

One concern about the zero tolerance policies being rolled out across Australia relates to the levels of insight of the person who is exhibiting the challenging behaviour. Some consumers may not be aware that their behaviour is perceived as aggressive. In particular, the person with a mental health problem may have lost touch with reality to the point where they cannot be held responsible. In such cases, the recommended approach is to manage the behaviour of these consumers and ensure that nobody is injured, rather than taking the stand that aggression or violence will not be tolerated, regardless of the cause, triggers or context (ABC News, 2005). Indeed, although health professionals have every right to a safe work environment, they also have a duty of care to provide the best-evidence treatment to the consumer who is displaying challenging behaviours (see chapter 3). This will always include undertaking an assessment of risk.

Risk assessment

When addressing challenging behaviours, it is important to know the reasons behind the behaviours, as this can help to identify the problem that needs to be addressed (van de Sande, Nijman, Noorthoorn, Wierdsma, Hellendoorn, van der Staak, & Mulder, 2011). Table 6.2 lists some factors to consider.

TABLE 6.2 Factors to consider when assessing challenging behaviours

Factors to consider before assessment	Where will the assessment be carried out? Is it safe for those involved? If not, what steps need to be taken to ensure everyone's safety?
What has prompted the assessment at this time?	What recent event(s) precipitated or triggered this presentation or made you think an assessment was necessary now? Does the person pose an immediate (i.e. within the next few minutes or hours) risk with specific plans to self-harm or perpetrate aggression/violence towards you or others? Is there any suggestion, or does it appear likely, that the person may try to abscond?

(continued)

TABLE 6.2 *(continued)*

What is the actual problem?	Is there a clear description of the behaviour and understanding of why it is a problem? For whom is it a problem? Is there a pattern to this behaviour? Is there an underlying cause? (e.g. organic, drug and/or alcohol intoxication or withdrawal, mental illness) Has anything worked in the past to reduce or stop the behaviour?
Past history	Does the person have a history of violence? Is there a history of self-harm? Does the person have a personality disorder with a behavioural component? Does the person have a mental illness?
Perceptions	Does the person have a psychotic disorder that is contributing to the problem? (See chapter 9.) What is the person's perception of the problem? Does the person feel they have any control over the situation?
Cognition	Does the person have the capacity to consent? (i.e. can the person understand and retain information, and then make balanced judgements based on an evaluation of his or her options?)
Risk	What are the risks? How immediate is the risk? What would be the likely impact of any actions if the person were to act upon their ideas?
Formulation	What is your understanding of the issues the person has described? What is the level of risk? Is immediate action required? (e.g. action to make the situation safe, such as calling a 'threat code', rapid tranquillisation, involving security staff or contacting the police) Is a referral to the mental health liaison team necessary and, if so, how urgent is it?

It is vital to identify both the actual and potential risks of the behaviour. For this reason, a specific risk assessment is required. The risk assessment needs to be focused on the behaviour, but it must also incorporate a wider perspective. For example, although the behaviour might be occurring in the health context, if the consumer leaves that context, what could be the risk to others? The health professional must consider this as part of the assessment, and discuss options with the multidisciplinary team.

In the event that the situation escalates and it is decided to remove or relocate the individual who is displaying the challenging behaviours to ensure the safety of other consumers and also staff, local policies, procedures and legal requirements must be considered (see chapter 3). These may include liaising with police, ambulance, other emergency service personnel, other health services and various medical officers. It is likely that the consumer will require sedation to further reduce the risks. This is described in more detail in the following section.

IN PRACTICE

Using a risk assessment framework

The use of a clinical or actuarial risk assessment framework can be useful and informative for many health professionals. The use of such a tool can assist in the development of a tailored management plan to meet specific clinical and legal needs of each consumer.

In the current political climate of health care, some health professionals believe that there is an over-emphasis on risk management practices, and that some risk management strategies are really about social control measures.

Questions

1. What strategies can you put in place to ensure that you use risk assessment tools in an ethical manner?
2. Formulating a risk management plan usually results in some restrictions of autonomy and freedom for the consumer, or a legal restriction of some type. How could you balance the loss of these human rights with the consumer's wellbeing?
3. Do you see a role for intuition and tacit knowledge during a clinical risk assessment? Explain your reasons.

Working with people with challenging behaviours

empathy the ability to appreciate and validate another person's feelings

The most important aspect of managing challenging behaviours in consumers is the therapeutic alliance or relationship. As noted in chapter 2, a positive therapeutic alliance or relationship is an essential ingredient in providing high-quality health care and can be achieved only through person-centred or therapeutic communication. In particular, it is important that health professionals practise **empathy** (Stanger, Kavussanu, & Ring, 2012), which is an ability to perceive and reason as well as the ability to communicate understanding of the other person's feeling and their attached meanings. Put simply, 'knowing patients and their particular circumstances is critical and will allow health professionals to work in ways that will enhance genuine partnerships and may even reduce resistance to health care advice' (Russell, Daly, Hughes, & op't Hoog, 2003, p. 284). Indeed, while environmental, educational and organisational factors are enablers, it is the therapeutic relationship that is going to minimise the problems and disruption attributed to challenging behaviour.

For this reason, health professionals need to employ the range of skills and attributes that are integral to building and maintaining the therapeutic alliance and relationship. This includes engaging the person in a meaningful negotiation about the care and treatment they are to receive. This is not to suggest there will never be problems, but challenging behaviour can be a symptom of someone who is unsure of what is happening.

Paramedics deal with challenging behaviours.

Many of the integral skills and attributes that are required to engage with a consumer are discussed in chapter 2. The attributes listed in figure 6.3 are more specific to the issues of caring for a person who is displaying a challenging behaviour.

- Provide a consistent framework of care and treatment.
- Minimise staff splitting by keeping the same health professionals working with the person and using treatment and care plans that have been negotiated and collaboratively developed by all stakeholders.
- Explore reasons for non-adherence and address these with the consumer.
- Set clear limits, but emphasise what is available if the person stays within them.
- Give positive rewards for non-challenging behaviour, but do not react to challenging behaviour unless necessary and then do so consistently.
- Look at previous negative experiences and work with the consumer to see if he or she can identify differences from his or her current treatment and care.
- Take an unbiased look at the person's requirements and criticisms.
- Acknowledge the feelings of the consumer.
- Demonstrate empathy (see chapter 2).
- Employ anxiety management techniques (as anxiety will underlie most challenging behaviours).
- Teach new behaviours, such as assertiveness and interpersonal effectiveness.
- Provide more information, if that is what the consumer is seeking and there is information to give.
- Make use of regular clinical supervision (reflective practice) provided by a trained facilitator.

FIGURE 6.3 Key skills and approaches in providing care for the person displaying challenging behaviour

Conflict resolution

Conflict resolution has also been recognised as a key skill when working with people with challenging behaviours. The approaches chosen will depend on the skills of the health professional and the attributes of the person with the challenging behaviour. Techniques can include:

- withdrawal from the source of conflict
- suppression or 'smoothing over' of the conflict
- the use of authority to contain the situation
- compromise or negotiation
- integration or collaboration.

The last technique is usually the most successful in the health context, with the emphasis on trying to solve the problem at hand, rather than on defending particular positions or factions (Sim, Wain, & Khong, 2011). The other techniques run the risk of apparently resolving the conflict but leaving one or both parties dissatisfied, which can be grounds for further conflict in the future, even if this is unacknowledged.

The use of the 'third-person' de-escalation technique may also be useful during formal and informal conflict resolution. Su (2010) describes a **third-person intervention** as occurring when a third person is introduced into the conflict dynamic to assist resolving the situation. The third person is most often identified as a neutral person not previously involved with the conflict, and a trained mediator who can facilitate the communication between both parties to achieve the best possible outcome.

third-person intervention the practice of using a third person during formal and informal conflict resolution to de-escalate perceived or actual conflict

Planning ahead

When dealing with people who exhibit challenging behaviours, it is essential that all those involved are aware of, know or understand the notion of boundaries. The term **boundary** is often bandied around in the health context and refers to the limits of acceptability or appropriateness in a human interaction. Boundaries mark the point beyond which people are not expected to go, and are often differentiated when an individual says, 'He has just stepped over the line!' However, this differentiation can be problematic because often those involved are not aware of the where the line is or what the rules are. In the health context especially, boundaries should be clear and also clearly communicated (Bowen & Mason, 2012). One way this can be achieved is by outlining the expectations of the organisation that provides the health service to the consumer. The expectation of the health professionals involved also need to be flagged. Being informed of the boundaries or 'rules' can be an important means by which people feel safe in a new or unfamiliar context. Boundaries are also a means by which health professionals can develop trust and respect with the consumer (Geldard & Geldard, 2009).

boundary the limits of acceptability or appropriateness in a human interaction

In addition to being informed about the kind of behaviours that are and are not acceptable in a particular context, it is also necessary for health professionals to outline the consequences to the consumer when the boundaries are crossed. It needs to be noted, however, that a one-size-fits-all approach to every situation is not appropriate (see chapters 1 and 12). Indeed, such approaches assume that every situation is the same and over-simplify the complexity of human relationships and health care provision. One-size-fits-all approaches also suggest that the health professional is reacting after an incident has occurred, rather than responding in a measured way to a new situation as it occurs.

What is needed, then, is a proactive approach that addresses the person's clinical needs and the organisational needs of health professionals. Figure 6.4 outlines the three stages in the clinical management process to minimise challenging behaviours, including the proactive stage where the consumer is provided with information; the intermediate stage, where health professionals are provided with training in risk assessment and managing challenging behaviours; and the crisis stage, to ensure staff are adequately equipped to deal with challenging situations.

FIGURE 6.4 Three stages in the clinical management process to minimise challenging behaviours

Stage 1: Proactive

- Maintain an environment that is as calm and as peaceful as possible.
- Provide the consumer with information and materials to relieve boredom.
- Maintain effective systems of open communications.
- Identify health professionals and support staff as people, rather than 'anonymous' staff.
- Offer flexibility within clear boundaries.
- Take an attentive approach, both in listening and in communicating.
- Prioritise time to get to know the consumer's individual needs.
- Have ongoing training and education programs, particularly around de-escalation techniques and communication, and mental health issues in general settings.
- Hold multidisciplinary team reviews of all consumers and routinely involve consumers in collaborative decisions about their treatment and care.

(continued)

FIGURE 6.4 *(continued)*

- Provide clinical supervision (reflective practice).
- Develop and use problem-solving forums (e.g. shared governance committees).

Stage 2: Intermediate
- Provide regular training in risk assessment, de-escalation techniques and conflict transformation.
- Have access to specialist clinical management around particular consumers and/or situations (this is a service that most mental health liaison teams can deliver — see chapter 12).

Stage 3: Crisis
- Have up-to-date and effective alarm and personal duress systems.
- Have staff trained in de-escalation techniques and in safe procedures for managing violence and aggression.
- Ensure clinicians are aware of the seclusion, sedation or rapid tranquillisation policies for their context.
- Utilise security officers or the police when required.

Perhaps most important of all is the provision of workplace support to health professionals. Such support will influence the quality of the care and communication that the consumer receives. If health professionals feel confident and able to achieve their goals and have some perspective on their work, with as little organisational conflict as possible, they will be better equipped to address internal conflicts and any conflicts that occur with consumers or other stakeholders.

Contracts

Another way in which boundaries or limit setting can be utilised is through the 'contract'. A **contract**, also known as a 'voucher agreement', between a consumer and health professional can be written or verbal, and stands as an agreement between the parties that they will conform to mutually agreed-upon behaviours (Sim, Wain, & Khong, 2011). Failure to conform will give rise to consequences, which are also mutually agreed upon. Achievement in meeting the requirements of the contract will likewise generate mutually agreed-upon benefits.

contract the written or verbal agreement between the consumer and health professional or health service provider that involves both the consumer and health professional or health service provider agreeing to conform to mutually agreed-upon behaviours

Such contracts can identify specific ways to help people with challenging behaviours to stay physically and emotionally safe. The contracts are developed with the consumer during the times when the consumer is feeling calm, behaviour is appropriate, and the consumer is ready to engage, participate and negotiate. Language used in the contract must be simple, and provide clear behaviour responses to manage unsafe feelings or behaviours. For example:

> 'When I feel like hurting myself, I will . . .'
>
> 'When I feel like destroying property, I will . . .'

Contracts have been shown to create a means by which consumers are able to take responsibility for their challenging behaviour and work with health professionals to achieve positive outcomes (Wong & Tye, 2005).

Seclusion and restraint

On occasions, challenging behaviour may be considered to be so extreme that the individual is restrained, whether by the use of medication, mechanical or manual restraint, or seclusion, or a combination of one or more of these methods (Huf, Coutinho, & Adam, 2012; Stewart et al., 2009). It is interesting to note the different views of individual health professionals about seclusion and restraint. Some health professionals consider it to be an abuse of human rights, while others view it, not only as a necessity, but also as a therapeutic option (Duxbury & Whittington, 2005). Likewise, there are different cultural views (Bowers, Ross, Nijman, Muir-Cochrane, Noorthoorn, & Stewart, 2012). For example, generally health professionals in the United States view chemical restraint — that is, providing a consumer who is exhibiting challenging behaviours with a sedative — as more restrictive than physical restraint. In contrast, in Australia the physical restraint of consumers located in mental health facilities is being increasingly discouraged, with sedatives viewed as the less restrictive alternative (see chapter 3). For this reason, the seclusion method of managing challenging behaviour in the health context is less commonly used in contemporary Australia.

The practice of manual restraint has been described as 'physically holding the patient to prevent or restrict movement' usually with the individual in a prone position; that is, face towards the floor (Stewart et al., 2009, p. 750). The most commonly cited reason for manually restraining an individual is because of violent and aggressive behaviour, particularly if the behaviour has led to someone being injured. However, other less serious behaviours have also been identified in the literature, and include refusal to accept medication, attempt to abscond, refusal to comply with instructions, self-harm, and property damage (Stewart et al., 2009). This number and variety of reasons suggest the need for health professionals to consider how and when they use seclusion and restraint, and for what purpose.

Additionally, although some health professionals consider the use of restraints to be necessary, they would welcome a reduction in the use of this practice (Butterworth & Harbison, 2010). Health professionals report experiencing negative emotional responses following an episode involving the use of restraint, in particular the use of restraints on 'demented, frail older patients' (Chien & Lee, 2007, p. 67) who may have a limited opportunity to make their views, needs and dislikes known before being restrained. Other health professionals consider the use of restraints to be demeaning and stressful, and express concern about possible negative impacts on the therapeutic relationship with the person (Stewart et al., 2009).

Rapid tranquillisation

As noted in chapter 3, to protect the client, community members and health professionals from physical harm, a decision can sometimes be made to sedate a consumer who is exhibiting a challenging behaviour. This sedation may be provided very quickly, in a process called rapid tranquillisation. In some states and territories in Australia, paramedics are now involved in this process in the community. However, this would occur only in an emergency. In most cases, rapid tranquillisation would occur in a hospital context.

According to the United Kingdom's National Collaborating Centre for Nursing and Supportive Care (2005), with the National Institute for Health and Clinical Excellence

(NICE), the short-term management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments will include the use of haliperidol, lorazepam, olanzapine or risperidone. This was more recently confirmed by Choudhury, Dewsbery, Williams, & Hovey (2011). NICE also makes a number of recommendations regarding rapid tranquillisation, which are outlined in figure 6.5. Health professionals in Australia are strongly advised to obtain the policy and procedures for rapid tranquillisation that have been developed by their employer prior to participating in a rapid tranquillisation and also to undertake the relevant training.

The National Institute for Clinical Excellence (NICE) has issued guidelines for the management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments. The guideline provides a comprehensive framework for how to assess risk and prevent violence; de-escalate and calm down a potentially violent situation; and intervene safely when violence occurs. The guideline recommends the following.

- Measures to reduce disturbed/violent behaviour need to be based on comprehensive risk assessment and risk management and that mental health service providers should ensure that there is a full risk management strategy for all their services.
- All staff whose need is determined by risk assessment should receive ongoing competency training to recognise anger, potential aggression, antecedents and risk factors of disturbed/violent behaviour and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, de-escalating or coping with disturbed/violent behaviour.
- Rapid tranquillisation, physical restraint and seclusion should only be considered once de-escalation and other strategies have failed to calm the service user. The intervention selected must be a reasonable and proportionate response to the risk posed by the service user.
- Staff who may need to employ physical intervention (such as restraint) or seclusion and those involved in administering rapid tranquillisation must be trained to an appropriate level in life support techniques (such as the use of defibrillators).
- During physical restraint one team member should be responsible for protecting and supporting the head and neck, where required. The team member who is responsible for supporting the head and neck should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.
- Service users identified to be at risk of disturbed/violent behaviour should be given the opportunity to have their needs and wishes recorded in the form of an advance directive.

FIGURE 6.5 Guidelines for the short-term management of disturbed/violent behaviour

Source: National Institute for Health and Clinical Excellence (2005)

The use of restraints for older people with challenging behaviours

Turner and Snowdon (2009) have defined challenging behaviours in older people living in residential care facilities as ‘any behaviour associated with the dementing illness which causes distress or danger to the person with dementia and/or others’ (p. 262). Physical restraints are often used on older people with a dementing or mental illness who are considered to be in danger of falling or wandering, with restraints being a way of life for some residents in aged care facilities (Pulsford, Duxbury, & Hadi, 2011). The reported rates of physical restraint use in nursing homes vary considerably, with Gastmans and Milisen (2006) reporting rates of 4–85 per cent. Indeed, according to Duxbury and Whittington (2005) 'Patients and staff alike seemed to perceive that restraint was inevitable and needed in order to maintain safety' (p. 471). While much of the literature relates to the use of physical restraints in aged care facilities, these restraints are also used on older people with behavioural disturbances who are being cared for in an acute care setting.

Perhaps not surprisingly, given the negative impact coercion can have on the therapeutic relationship, there is a move away from the automatic use of restraints (Möhler, Richter, Köpke, & Meyer, 2012). For example, Turner and Snowdon (2009) support the use of case-specific causality-focused approaches, including individualised psychosocial interventions to manage challenging behaviours in nursing homes, as opposed to the regular use of physical restraint. There are a number of effective non-pharmacological interventions for behavioural disorders in dementia, including aggressive behaviour in older adults, that may have favourable outcomes in terms of reducing aggressive behaviour. These strategies include provision of suitable social activities and companionship, increased observation, and reducing noisy and over-stimulated environments for consumers (Johanna Briggs Institute, 2002; Koder, 2011). A causality-focused approach using individualised psychosocial interventions in nursing homes was also found to be as effective in reducing challenging behaviours as the more common pharmacological approach to treatment, as well as having a lower financial cost.

Regardless of the age of the consumer, restraints should be used to manage physical behaviour only as a last resort. As already noted, health professionals who focus on engaging with consumers, forging a therapeutic alliance and developing this in to a relationship, are far better placed to work effectively with consumers who exhibit challenging behaviours. Practising unconditional positive regard is likewise essential to providing high-quality health care and can be achieved only when the health professional is committed to supporting the improvement of health outcomes for all consumers, regardless of their behaviour.

THE BIG PICTURE

Supporting a restraint free environment in aged care

The Commonwealth Government has developed tool kits to guide management, health professionals and other staff to make informed decisions in relation to the use or non-use of restraint in response to behaviours of concern. The *Decision-making-tool: Supporting a restraint-free environment* resource comprises two separate documents that are relevant to both the residential and community aged care settings. Both tool kits regard

➜

a restraint-free environment as a basic human right and acknowledge that consumers are entitled to respect and protection of their basic rights and freedoms, regardless of in which setting the care is provided. They are aligned with the Ministerial endorsement of the Australian Safety and Quality Framework for Health Care, whose principles for high-quality care are focused on being:

- person-centred
- driven by information
- organised for safety.

These documents have been developed to guide staff in addressing and exhausting a myriad of environmental, clinical, pharmacological and personal consumer treatment options before they resort to using any type of restraint. Temporary and less restrictive options of restraint are then identified. The community-focused tool kit provides the following checklist to assist health professionals in determining whether those in their care are displaying concerning behaviours or facing risk of being restrained.

Physical factors
• Have there been any changes to the client's vision/hearing/sense of smell/sense of touch/sense of taste? • What toileting routine does the service user have? Have there been any changes? • Is the client unwell? Do they have uncontrolled pain? • Does the client look unwell? • Have there been any changes to the client's medicines?
Behaviour
• Have there been any changes to the client's mood/speech/thoughts? • Does the client appear to be responding to hallucinations? • Could the client be depressed? • Has the client's sleeping pattern changed? • Was the change in behaviour sudden?
Communication
• Can the client hear OK? • Is there anything in the home situation that is impacting on the client communicating? • Is anyone talking down to the client? • Can the client make clear what he/she wants to say?
Relationships
• What companionship does the client have? • Has the client met or engaged with any different people around the time their behaviour changed or escalated? • Have any different or unreasonable demands been made of the client? • Have there been any changes to the client's representative/carer or family/friends or family pets? • Has the way the service user responds to the client's representative/carer or family/friends changed? • Is the client being treated like an adult? • Have the spiritual needs of the client been met?

Tasks
• Have there been any changes to the routine of the client? • Is the behaviour happening because of a routine change or an activity of the client's representative/carer or a family member/friend/carer?
Physical environment
• Is the environment noisy or too quiet? • Is the environment too hot or too cold? • Is the environment too dark or too light? • Are there any odours? • Have there been any significant changes to the environment? • Is the client able to find their way around the house okay? • Is there a safe area in the house and outside for the client to wander? • Does the client have a private space/room in the house to go into?

Both tool kits are aimed primarily at the aged care sector; however, much of the information they contain — including the fact sheets and links to other resources — may be useful and transferable to a number of acute care areas.

Sources: Australian Commission on Safety and Quality in Healthcare (2010); Department of Health and Ageing 2012a, 2012b

SUMMARY

People exhibit challenging behaviours in the health context for many reasons. They are not necessarily the outcome of a mental health problem. Rather, challenging behaviours can be the result of the power imbalance that is inherent within the relationship between the health professional and the person they are assisting. At other times, the triggers are situational — ill-health or injury, pain, the unfamiliar health context, requiring assistance with personal care, belonging to a marginalised group, or experiencing a loss of self-determination. Feelings of vulnerability and powerlessness that lead to challenging behaviours can also arise from the health system itself or the wider social context.

This chapter discusses the nature of challenging behaviours and notes that defence mechanisms are used by everyone from time to time. They are one of the many means of coping that can help people to manage the challenging situations that make up their daily lives. The causes or triggers of challenging behaviours are considered, such as the demands being made by the health professional on the consumer, the health professional's negative attitude to the consumer, and disputes between the health professional and the consumer. The need to conduct a general and risk assessment is also identified, as well as the problem of bullying in the workplace between health professionals. The section describes health service organisational responses to bullying and other challenging behaviours in the workplace. The need for higher levels of education and training is identified and an explanation is provided of some techniques that can be used by health professionals to manage challenging behaviour in the workplace.

To be effective, health professionals must consider the many contributing factors that may lead to a person exhibiting challenging behaviours in the health context. This consideration will include identifying and practising ways and means of empowering the consumer. Such strategies can be highly specialised, but also include, quite simply, actively preserving the dignity of the consumer by practising kindness and unconditional positive regard.

Review questions

1. Name the four categories of 'difficult' behaviour as identified by Koekkoek et al. (2006).
2. What are some of the physical reasons for challenging behaviour?
3. Identify the main factors to consider when assessing challenging behaviours.
4. What steps can multidisciplinary teams take to reduce the risk of staff splitting occurring?
5. What is the definition of zero tolerance?
6. Name six examples of bullying behaviour.
7. What are four key skills that are helpful to improve engagement with people displaying challenging behaviours?
8. What are the three stages of clinical management that are determined to minimise challenging behaviours?
9. What techniques are often used in conflict resolution?
10. What is a 'third-person' intervention?

Discussion and debate

1. Think of a time when you lost your temper or became anxious (e.g. flight cancelled, long queue, lost child at shops, unhelpful staff, wallet or keys missing). How did you react to this event emotionally and behaviourally? What physiological changes did you notice in yourself? How did you treat others who were attempting to assist you during your distress? Were there other things happening that clouded your judgement? Was there anyone who was helpful during this incident? If so, what was it that person said or did that helped you? As you think about this experience, does it arouse any unresolved feelings from the past? What can you learn about yourself from this event?
2. Consider the idea of the 'contract' as a strategy for managing challenging behaviour. What do you think are the most important aspects of a contract? What factors do you think would contribute most to achieving effective outcomes of a contract?
3. What are the advantages and disadvantages of using physical restraints on older people who demonstrate challenging behaviours? Identify legal, ethical, clinical and financial considerations in your response.
4. As a health professional, what actions could you implement in your workplace to minimise bullying behaviours? What training is available in your workplace or university regarding this issue? How does your discipline-specific Professional Code of Conduct reinforce the acceptable behaviours of your profession?

5. Interpersonal skills and listening skills are fundamental communication competencies. Effective communication skills are essential to building and maintaining sound therapeutic relationships with consumers. Discuss with your peers what your strengths are in relation to communication skills, and what areas may require additional development and growth. Considerations may include verbal communication skills, non-verbal behaviour knowledge, listening skills, voice management skills, cultural awareness and gender/power issues.
6. From a professional, legal and ethical perspective, what are the advantages and disadvantages of seclusion and restraint practices? What alternatives are available to minimise the use of seclusion and restraint? How could you be actively involved in promoting these alternatives within your clinical speciality?

Project activity

Consider the following 'challenging' behaviours that consumers may exhibit in the workplace: (i) regular complaints, (ii) staff splitting, (iii) non-adherence with investigations or treatment, (iv) continued symptoms without improvement, (v) sexual disinhibition, (vi) sexist comments, (vii) racist comments, (viii) refusal to cooperate with requests, (ix) silence and/or withdrawal, (x) avoidance or denial, (xi) over-dependence on staff, (xii) constant demands for attention, (xiii) displays of anxiety and distress, (xiv) confusion, (xv) self-harm behaviours, (xvi) seemingly unresolvable grief.

1. Rank these behaviours from the least bothersome to the most bothersome.
2. What are some of the factors that influence how you rate these behaviours?
3. What personal strategies might you need to employ to manage each of these bothersome behaviours in the workplace?
4. Consider strategies the multidisciplinary team could implement to support one another when dealing with each of these behaviours.

Websites

The Anger Management website provides different approaches and strategies that can be used to help a person manage their anger: www.angermanagement.com.au

The Australian Centre for Posttraumatic Mental Health at the University of Melbourne undertakes world-class trauma-related research, policy advice, service development and education. Its innovative services help organisations and health professionals who work with people affected by traumatic events: www.acpmh.unimelb.edu.au

The Australian Nursing and Midwifery Federation (SA Branch) has an aggression management tutorial available titled 'Managing difficult or challenging behaviours in the primary health care environment': www.anmfsa-cpd.org.au

An Australian site that provides information on borderline personality disorder: www.borderlinepersonalitydisorder.com.au

The Clinical Practice Guidelines portal is an initiative of the Australian National Health and Medical Research Council (NHMRC) and is freely available to all clinicians. The site provides links to numerous health-related clinical guidelines used in Australia: www.clinicalguidelines.gov.au

The Department of Health website hosts numerous publications relevant to this chapter, including fact sheets on managing challenging child behaviours and the Healthy Kids Check program: www.health.gov.au

The Institute of Health and Nursing Australia also hosts an aggression management tutorial, titled 'Aggression management for nurses and health support workers': www.ihna.edu.au

The Mental Health Research Institute is a premier psychiatric research institute in Australia. Its researchers use laboratory and clinical research to understand the causes of psychiatric and neurodegenerative diseases, so they can be better diagnosed and treated. The ultimate aim is to prevent or cure such illnesses. The institute is formally affiliated with the University of Melbourne, Monash University and Melbourne Health: www.mhri.edu.au

The Response Ability site provides information to support the use of Response Ability multimedia packages in Australian tertiary institutions. Response Ability is an initiative of the Department of Health, implemented by the Hunter Institute of Mental Health in partnership with universities and tertiary educators: www.responseability.org

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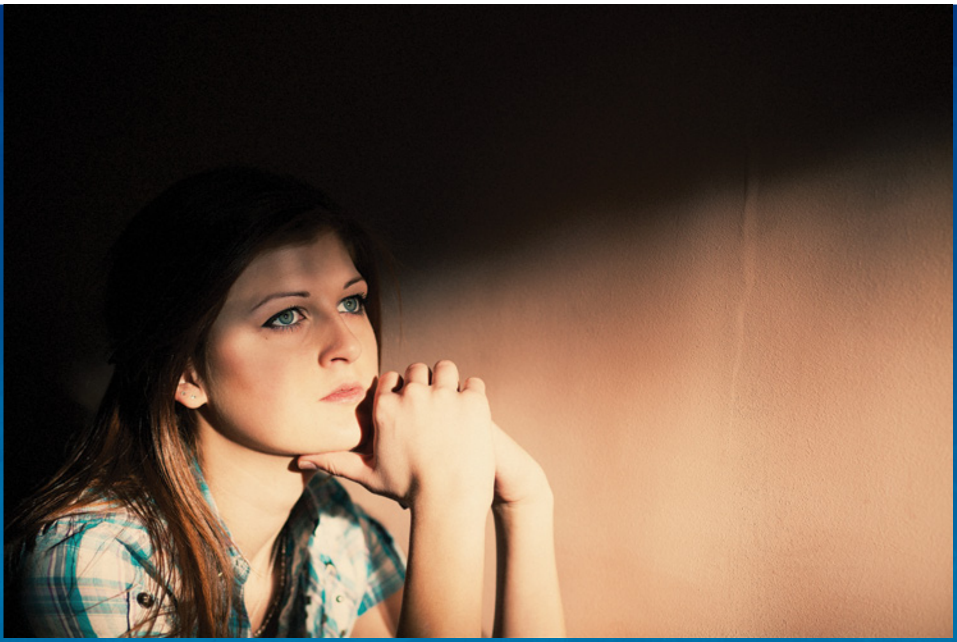
Caring for a person with depression, anxiety or perinatal mental health

7

LEARNING OBJECTIVES



This chapter will:

- discuss the factors that contribute to a person developing depression
- identify the major approaches to the care and treatment of a person with depression
- describe the main issues related to perinatal mental health
- explore the main issues related to child, adolescent and youth mental health
- outline the different types of anxiety disorder.

Introduction

In Australia, the term 'depression' is commonly used to describe a feeling of sadness. It is one of the most commonly reported mental and behavioural conditions — that is, 2.1 million people, or 9.7 per cent of the Australian population, experience affective disorders (Australian Bureau of Statistics, 2012). In the field of mental health, however, depression is a specific term used to describe a mood disorder with a clearly defined set of symptoms and criteria. These symptoms and criteria then allow mental health professionals to guide a person's recovery through comprehensive assessment and effective treatment.

Depression can be best understood as a physical illness that affects both the brain and the body. As a consequence, the brain and body do not function as well as they do in a non-depressed state. Common symptoms of depression described later in this chapter include a sustained sad or negative mood and reduced cognitive functioning, rather than a person's brief reaction to a sad or stressful situation. Depression includes behavioural (e.g. withdrawal from social groups and activities) and physical (e.g. sleep disturbance) symptoms, and these in combination with the reduced cognitive functioning can severely impair a person's overall functioning.

Anxiety disorders are characterised by clusters of persistent psychological, behavioural and physical symptoms — including angst and apprehension, emotional distress, avoidance, marked social impairment and agitation. The central symptom of all anxiety disorders is an irrational fear (perceived or real) that elicits a significant psychological and physiological response in a person when exposed. Anxiety disorders are the second most common mental and behavioural health issue in Australia (850 100 people, or 3.8 per cent of the population). They include generalised anxiety disorder, post-traumatic stress disorder (PTSD), social phobia, panic disorder and obsessive–compulsive disorder (Australian Bureau of Statistics, 2012).

This chapter focuses on depression and anxiety. The first part of the chapter encompasses the causes and types of depression, assessment of mood disorders, and treatment approaches that health professionals can take when helping a person with depression. The focus of the second part of the chapter is anxiety. The discussion includes a description of anxiety and the role of the health professional in supporting those with an anxiety. The chapter also includes a section on how these disorders manifest in children, adolescents and youth, as well as a discussion on early identification and treatment considerations. The chapter concludes with a brief explanation of the complementary and alternative medicines that are used to treat mood and anxiety disorders.

Depression

In any 12-month period, more than 4 per cent of adults in Australia will experience a depressive episode. In addition, more than 2 per cent will meet criteria for an episode of either bipolar affective disorder or **dysthymia**. This translates to almost one million Australians with a diagnosable **affective disorder** in any given year (Australian Bureau of Statistics, 2008). Women experience higher rates of affective disorders (7.1%) compared

dysthymia mild to moderate depression that occurs for most of the day, more days than not, for at least two years

affective disorder a mental health problem that is characterised by a consistent alteration in a person's mood that impacts on their thoughts, emotions and behaviours to men (5.3%). According to *beyondblue*, one in five Australians will experience depression at some stage in their life.

People can be diagnosed with depression based on a number of different signs and symptoms. Currently, the two most widely utilised classification systems for diagnosing depression are the DSM-5 and ICD-10 (American Psychiatric Association, 2013; World Health Organization, 2004; see chapter 1). Both of these systems divide the symptoms of depression along a severity continuum, including mild, moderate or severe major depression, with or without **psychotic symptoms**.

psychotic symptoms symptoms related to significant alterations to thought and perceptions, including delusions, hallucinations, loss of contact with reality and a deterioration in social functioning

Symptoms of depression

Mental health professionals are strongly encouraged to read a more detailed explanation of the symptoms of each of the different types of depression. More generally, however, a person who is depressed will experience some or all of the following:

- sad or irritable mood
- loss of interest in usual activities, including those that were once pleasurable
- unplanned weight loss
- insomnia or hypersomnia
- psychomotor disturbance
- reduced energy
- feelings of guilt
- poor concentration/indecisiveness
- recurrent thoughts of death or suicidal ideation (American Psychiatric Association, 2013).

As a consequence of these symptoms, people with depression find it difficult to undertake their usual activities of daily living. This gives rise to significant decreases in quality of life (*beyondblue*, 2011).

As with other mental health disorders, there are no laboratory tests or scans that can establish a diagnosis of depression. A diagnosis of depression is made by clinical interview, in the context of the person's history and corroborative information.

Some of the symptoms associated with depression are common experiences that most people will encounter from time to time (and some symptoms are common to a range of other disorders). It is important to note that the presence of one or two of these symptoms does not necessarily imply a diagnosis of depression.

It is worth noting that although there are no specific physical tests for depression, the general practitioner (GP) will often order various medical tests to rule out the presence of a physical illness (e.g. a thyroid condition) that can often mimic the depressive symptoms. An important aspect of any mental health assessment is the inclusion of a general and comprehensive physical assessment to ensure that what the patient is experiencing (e.g. depression) is not the result of a physical illness. Further, physical assessment should be a continuous process as poor health is often a consequence of people diagnosed with depression.

Ruby Rose, a media personality and DJ, who has been battling depression.

UPON REFLECTION

Depression and stigma

Although attitudes towards depression have changed in Australia in recent years due to the ongoing work of organisations like *beyondblue* and headspace, many people with depression still do not seek care or treatment. One reason for this is the stigma associated with any kind of mental health problem. Stigma and the associated reluctance to seek treatment may contribute to the unacceptably high suicide rate among people who suffer from depression.

Questions

1 If you began to experience the symptoms of depression, with whom would you talk?
2 What factors contribute to the stigma associated with depression?
3 What can health professionals do to reduce the stigma surrounding depression?

Causes of depression

epidemiological relating to the study of patterns of disease and treatments in defined populations

Despite many years of **epidemiological**, biological and sociological research into the causes of depression, no single factor has been identified. Proponents of the biomedical model argue that depression has a genetic basis and/or is related to biochemistry in the brain. The exact mechanisms remain uncertain, but appear to be linked to either an imbalance or a deficiency of specific neurotransmitters, particularly serotonin (5-HT) and noradrenaline.[1] Alternatively, proponents of the psychological approaches to mental health issues will argue that the causes are linked more to personality, past experiences, current lifestyle and methods of coping.

In fact, the variety of viewpoints reflects the multifactorial causes of depression. As noted by Andrews (2010), contributing factors encompass biological vulnerability, including genetic vulnerabilities and other vulnerabilities acquired early in life; environmental stressors, such as loss; substance use; and psychodynamic and personality factors. Moreover, each of these factors is interrelated and interact, adding to the possibility of the person becoming depressed.

Table 7.1 outlines some of the more common causal factors associated with depression. Health professionals are encouraged to be familiar with these factors and how they will impact on the care and options for treatment for a person with a depression.

In addition to the causal factors of depression, a range of general risk factors contributes to the person developing depression. These factors are closely related to the risk factors for all mental health issues that are outlined in chapter 12. Of particular concern in relation to depression is the risk factor of physical ill-health.

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[1] Noradrenaline and norepinephrine can be used interchangeably to refer to the same neurotransmitter.

TABLE 7.1 Overview of the aetiology of depression

Perspective	Commentary
Biological	Biochemical mechanisms underlying depression are complex, although the dominant hypothesis is that there is an imbalance of certain neurotransmitters within the brain. Two neurotransmitters in particular, serotonin (5-hydroxytryptamine) and noradrenaline, have been the focus of much research. Disturbance in these neurotransmitter systems can cause alterations in sleep, appetite, motivation and pleasure, all of which are symptoms of depression. Subsequently, medications targeting these neurotransmitter systems have been developed and are among the more commonly prescribed medications in Australia today. Endocrine disorders are also known to be associated with increased risk of depression, as are hereditary factors. Depression tends to run in families. Likewise, birth trauma, physical deprivation and physical illness have been found to play a role in the development of depression. Depression can also be the direct biological result of substance use. Substances implicated include alcohol, benzodiazepines, opioids, amphetamines, hallucinogens and inhalants (American Psychiatric Association, 2000), while cannabis has since been identified as a possible contributor to mental disorders like depression (Yap, Reavley, & Jorm, 2011).
Psychological	The concept of loss is central to the psychodynamic understanding of depression. Loss may be experienced as the result of bereavement, relationship issues or occupational redundancy. Life events, even those considered to be 'positive' events, can precipitate a depressive episode: childbirth, children leaving home and job promotions all have the potential to trigger depression in vulnerable individuals. Early life experiences and the impact of parental role models, the development of particular cognitive schema (thinking patterns) and attribution styles are thought to be influential; for example, core beliefs, low self-esteem and negative thinking patterns are likely to have evolved from childhood experiences.
Social	Impact of gender and social status; for example, depression is twice as common in women as in men, and more common in people with employment problems, housing difficulties, financial problems, and lack of supportive and confiding social networks. There are high rates of depression in individuals who consume excessive amounts of alcohol and those who use illicit drugs; although this may be due to the biological actions of substances on the brain, there are major social sequelae related to substance use that can contribute to depression.

Depression and physical illness

If a person is physically ill for any length of time, especially with a cardiac, neurological or renal problem, they are more likely to develop a depression (Scherrer et al., 2012; Kok et al., 2013). Physical illness, then, can be described as a contributing factor to the development of depression. This is because the symptoms and some treatments experienced by those with a long-term physical illness or injury are contributing factors. Symptoms can include the following.

- *Pain.* Pain can directly influence a person's mood. Both depression and anxiety can have an effect on an individual's perception and tolerance of pain. Anxiety is discussed later in this chapter.
- *Loss and grief.* As noted in chapter 5, people who experience physical ill-health very often experience a sense of loss and grief. This may be related to the loss of the way of life they enjoyed prior to becoming ill, a loss of limb or organ, loss of privacy and self-determination, and so on. Feelings of loss and grief are common reactions to stressful situations (see chapter 5). However, there may be times when a person is unable to process these feelings, which can contribute towards the development of a depression.
- *Prescription medication.* Many prescribed medications can lead to the development of depressive symptoms (e.g. steroids, digoxin, beta-blockers and benzodiazepine medications).
- *Alcohol and illicit or non-prescription medication.* Alcohol and illicit or non-prescription medications also need to be considered in determining the possible cause or complicating factors of depression. Although alcohol has a depressant effect on the central nervous system, its short-lived **anxiolytic** effect can be a factor leading to excessive consumption. A person with a physical illness needs to be asked about substance use as part of the comprehensive assessment provided by the health professional (see chapter 10).
- *Cognitive impairment.* Cognitive impairment, such as poor recall and impaired concentration, can be a symptom of depression, particularly in older people. However, it can mask other depressive symptoms. For example, people with dementia are at a higher risk of depression, but this often goes unnoticed (see chapter 11).
- *Self-perception.* It has been suggested that people prone to depression often have a negative beliefs system that adversely influences their perceptions of the self (Beck, 1970/2006). Rogers (1951) described this phenomenon as a basic mismatch between the individual's 'ideal and actual self'. Depression occurs when individuals consistently set themselves ideals and goals that they cannot hope to achieve. People with a physical illness often find themselves struggling to achieve goals that were once achievable but are no longer so. This leads to the person questioning their self-perception.
- *Coping mechanisms.* It is usual for people to experience some fluctuation in the way they feel day-to-day, sometimes hour-to-hour. This may be directly related to their physical health, and also environment, level of stress, how the person feels about themselves, as well as a variety of other social and interpersonal factors. The way in which a person responds to and deals with life's many challenges is largely determined by their level of confidence and ability to cope, problem-solve, make decisions and be supported. Sometimes it is difficult to discern the difference between someone who is not coping and the person who is depressed. This is particularly complicated if anxiety or stress is also present, as these symptoms are quite commonly seen together.

anxiolytic a treatment or approach that reduces anxiety

Health professionals who care for people who are physically unwell — especially people with a chronic physical condition — will be aware of these factors and ensure they monitor for depression. Mental illness will reduce a person's capacity to manage the physical illness, and also their overall health outcomes.

Mental illness and physical ill-health

Depression also increases the likelihood of developing a chronic physical illness, particularly heart disease, stroke and diabetes. People with a pre-existing mental illness are more likely to have a chronic physical illness (Scherrer et al., 2012; Kok et al., 2013). Indeed, it has been well established that people with severe mental illness such as major depression, schizophrenia and bipolar disorder have poorer physical health outcomes and reduced life expectancy when compared to the general population (Smith, Langan, McLean, Guthrie, & Mercer, 2013). One reason for this is that people with mental illness often have a high incidence of risk factors, such as smoking, diabetes, obesity and hypertension. Other reasons include the side effects of some psychopharmacological treatments, a reduced ability to self-care, and the tendency for health professionals to provide limited rather than comprehensive care.

According to Moussavi, Chatterji, Verdes, and Tandon (2007), depression causes the greatest decline in health outcomes when compared with other chronic diseases such as angina, arthritis, asthma and diabetes. In addition, they found that when a person has depression and one or more chronic diseases, the decline is even greater. Recovery from a depression in people with chronic physical illness is also more difficult. One reason for this is that physical illness makes it harder for the person to complete the ordinary activities of daily living — including finding the energy to exercise and eat well, to take medication regularly and access appropriate treatment options. Likewise, anxiety disorders have been shown to intensify symptoms and decrease the outcomes of some medical conditions. Indeed, there is emerging evidence to suggest that the poor physical health, disability and economic outcomes associated with anxiety may even equal that of depression (Roy-Byrne et al., 2008). As mentioned, anxiety is discussed later in this chapter.

When health professionals are aware of these various links, they can be more vigilant in assessing for signs and symptoms of depression or anxiety in those for whom they are caring. It needs to be noted, however, that a number of the symptoms of depression are similar to the symptoms of some physical illnesses and this may make it difficult to identify depression in some individuals.

Types of depression

Differentiating between the different types of depression is important so that the most appropriate care can be provided to the person. A number of approaches have been taken to the categorisation of depression. Some approaches divide depression into 'unipolar' and 'bipolar' depression. Unipolar depression refers to the presence of one aspect of mood only, and can be compared to bipolar depression, where the person cycles from feeling depressed to feeling euphoric (see chapter 9).

There is a range of other mood or affective disorders that health professionals may encounter. These include the following.

- *Bipolar affective disorder* (previously known as 'manic depression'). This is characterised by variations or 'swings' in mood, from elevation, **hypomania** and **mania** at one end, to depression at the other (see chapter 9).
- *Psychotic depression*. A severe form of depressive illness with a pervasive and unremittingly low mood. Delusional thinking may be present; for example, the

hypomania a period of elevated mood which has less impact on functioning than mania

mania an episode of highly elevated mood which interferes significantly in day-to-day life person believes they are completely worthless and deserves to be dead, or they believe they have already died. Perceptual disturbances may also be a feature of this type of depression.

- *Organic mood disorders*. These usually occur secondary to a physical or organic abnormality (e.g. brain tumour), or metabolic disturbance (e.g. electrolyte imbalance) affecting the brain. The mood changes may appear the same or similar to depression or other psychiatric illness.
- *Cyclothymia*. An illness in the bipolar spectrum of disorders characterised by sudden periods of elevated and low mood.
- *Dysthymia*. A chronic depressive disorder; less severe than major depression, though by definition lasts for at least two years and often lasts many years.

Knowledge of different types of depression and mood disorders provide a base from which health professionals can begin an assessment of the person who is exhibiting symptoms. Assessment approaches are outlined as follows.

Assessment of mood

There are a number of different approaches to the assessment of depression. Perhaps most important is that health professionals make observations and ask questions that enable them to gauge the person's mood. Ideally, this information should include details about the person's feelings, behaviour and level of functioning. This is undertaken by obtaining subjective and objective information about the mental health and overall wellbeing of the person over time. Health professionals need to be mindful that all interview questions and observations should be considered against a developmental continuum — that is, all symptoms need to be understood in relation to what is considered normal (or not) for a person's age and cultural context. Table 7.2 outlines the key information required when assessing mood, including depression and anxiety.

TABLE 7.2 Key information required when assessing mood

Aspect of assessment	Key information
Subjective	The person's description of how they feel; this information can be gathered by either asking them how they feel directly or having them describe how they feel on a scale of 0 to 10 (with 10 being the happiest and 0 being the unhappiest)
Objective	The health professional's observations of how the person feels, including note of whether the person is: • tearful • agitated • exhibiting reduced social interaction and communication not explained by physical impairment or environment
Pathological factors	Note of whether the person may be predisposed to becoming depressed or anxious because of: • side effects or consequences of medical treatments (e.g. medication, radiotherapy) cerebral damage (e.g. following stroke, head injury) • pre-existing medical or other physical health problems

Aspect of assessment	Key information
Psychological factors	Note of potential or actual impact of: • history of mood or other psychiatric disorder (particularly depression or anxiety) • recent significant life events (e.g. bereavement, childbirth, relationship problems)
Physical factors	Note of potential or actual impact of: • physical deficits or problems as a result of illness or injury (e.g. aphasia, immobility, degree of physical dependence) • reduction of or withdrawal from physical activity or recreational pursuits
Social factors	Note of potential or actual impact of: • employment (e.g. role within family unit, whether person is the main source of family income) • housing • financial worries or concerns
Interpersonal factors	Note of potential or actual impact of: • input from partner/significant other, family members, friends • pre-morbid relationship (e.g. avoid making assumptions about the role of the person's partner in providing ongoing care and support; involve significant other in discussions regarding his or her level of input and involvement in the recovery and rehabilitation process)

Screening tools

Some health professionals will support a mental health assessment (see chapter 2) with screening tools. These tools can assist health professionals to measure the level of depression the person is experiencing and, as time goes by, the way in which this improves or declines. It is important to remember that these tools are not designed as diagnostic instruments and that the data obtained is to be used to enhance the assessment, rather than act as the sole source of information (Mitchell et al., 2012).

There are many different depression scales available. For example:

- Beck Depression Inventory (Beck, 1970/2006)
- Centre for Epidemiologic Studies Depression Scale (Radloff, 1977)
- Self-Rating Depression Scale (Zung, 1965)
- Children's Depression Scale (Lang & Tisher, 1983/2004)
- Geriatric Depression Scale (Yesavage et al., 1983).
- Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987).

In Australia, a commonly used instrument is the Depression Anxiety Stress Scale or 'DASS', which measures depression, anxiety, and stress or tension. It is a useful tool because it detects a number of disorders at once, including depression. This scale is freely available and health professionals are encouraged to familiarise themselves with the different aspects of a person's mood that can be affected by depression.

Interpreting the results of a screening tool requires some expertise. Even so, health professionals who work in non-mental health settings can use the tool. Most notably, the simpler tools can be used as a means of striking up a conversation about depression or anxiety with a person who seems to be experiencing a number of symptoms.

Perhaps the most useful tool for this exercise is the Kessler 10 (K10) survey, which is used commonly in public health services across Australia. This instrument comprises ten items relating to the psychological distress experienced in the month prior to completion. Each item has a five-point scale. The items broadly focus on issues of anxiety and depression. Once the person has completed the survey, the health professional can discuss their answers and explore how their mood is impacting upon their quality of life. An example of the K10 is provided in the following 'In practice' feature.

IN PRACTICE

Screening for depression

The K10 is a self-reporting tool commonly used in mental health services across Australia. It can also be used by health professionals in other areas to aid conversation with people they think may be experiencing depression or anxiety.

Instructions

The following ten questions ask about how you have been feeling in the last four weeks. For each question, mark the circle under the option that best describes the amount of time you felt that way.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. In the last four weeks, about how often did you feel tired out for no good reason?	○	○	○	○	○
2. In the last four weeks, about how often did you feel nervous?	○	○	○	○	○
3. In the last four weeks, about how often did you feel so nervous that nothing could calm you down?	○	○	○	○	○
4. In the last four weeks, about how often did you feel hopeless?	○	○	○	○	○
5. In the last four weeks, about how often did you feel restless or fidgety?	○	○	○	○	○
6. In the last four weeks, about how often did you feel so restless you could not sit still?	○	○	○	○	○

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
7. In the last four weeks, about how often did you feel depressed?	○	○	○	○	○
8. In the last four weeks, about how often did you feel that everything was an effort?	○	○	○	○	○
9. In the last four weeks, about how often did you feel so sad that nothing could cheer you up?	○	○	○	○	○
10. In the last four weeks, about how often did you feel worthless?	○	○	○	○	○

The next few questions are about how these feelings may have affected you in the **last four weeks**.

You need not answer these questions if you answered "None of the time" to **all** of the ten questions about your feelings.

11. In the last four weeks, how many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings?	______ (Number of days)
12. [Aside from those days], in the last 4 weeks, HOW MANY DAYS were you able to work or study or manage your day to day activities, but had to CUT DOWN on what you did because of these feelings?	______ (Number of days)
13. In the last 4 weeks, how many times have you seen a doctor or any other health professional about these feelings?	______ (Number of consultations)
14. In the last 4 weeks, how often have physical health problems been the main cause of these feelings? None of the time ○ A little of the time ○ Some of the time ○ Most of the time ○ All of the time ○	

Source: Kessler Psychological Distress Scale (K10). R. Kessler, Professor of Health Care Policy, Harvard Medical School, Boston

Questions

1 What might be the some of the issues that health professionals will encounter when using a self-reporting tool like the K10?

2 How can the K10 be used in treatment other than for screening for depression?

This information provides an overview of the ways a health professional can identify a person who is experiencing a depression. Once a diagnosis has been made by an appropriate health professional, treatment options can be suggested. It is important to note that health professionals can have a significant and positive impact on the health outcomes of a person who is experiencing a depression.

Approaches to the care of depression

The provision of effective, sensitive and evidence-based care to those with depression can present a challenge to all health professionals, particularly to those working in settings dominated by the biomedical model, where numerous factors prohibit health professionals spending long periods of time with the person (see chapters 1 and 2).

When thinking about how best to support a person with depression, health professionals need to consider the following.

- *Engaging with the person*. As noted in chapter 2, skilled interpersonal care is an intervention in its own right and health professionals must not underestimate its impact. Importantly, feeling valued is likely to have a positive effect on an individual's self-esteem and mood. This is discussed in more detail in the following segment, 'Interpersonal skills'.
- *Maintaining or supporting physical health*. Poor physical health can be a precipitant for depression, but depression can also have a detrimental effect on physical wellbeing and can impair recovery and rehabilitation (Scherrer et al., 2012). Common physical problems associated with depression and also anxiety include:
  - impaired appetite — either loss of appetite (anorexia) or increased food intake as a reaction tostress
  - disturbed sleep — may present as either insomnia or hypersomnia (excessive sleeping)
  - loss of interest in appearance — leading to difficulty in washing, dressing and maintaining personal hygiene
  - increased or decreased physical activity — motor retardation may be a feature of severe depression, and increased activity, agitation and restlessness can be features of marked anxiety states.
- *Attending to other biological, psychological and social needs*. The biopsychosocial approach to care was described in chapter 2. To provide the most effective and comprehensive care, health professionals must identify the physical, emotional, social, sexual, spiritual, environmental and functional needs of the person, and seek to support the person to address these needs. This will include engaging with the person's partner or carer, family members, or others who are involved.

Each of these aspects of care requires the health professional to use interpersonal skills. These are outlined in chapter 2 and summarised in the following section.

Interpersonal skills

As noted in chapter 2, the most important intervention that can be provided to any person in need is the therapeutic relationship or alliance. This approach is supported by all the disciplines of health, including proponents of the biomedical model. For example, the Clinical Guidelines for Depression provided by the Royal Australian and New Zealand

College of Psychiatrists (2004) state that a sound alliance between the health professional and person is essential prior to the commencement of other treatment interventions.

People who are depressed are likely to experience a range of negative emotions, including feelings of hopelessness, helplessness, hurt, sadness, fear, worthlessness, aloneness and anxiety. Many health professionals find it difficult to deal with such negative emotions (see chapter 5). It is important that health professionals avoid being overtly optimistic when helping a person who is depressed. Likewise, giving overly prescriptive advice or false reassurances is not appropriate. Well-meaning statements such as, 'Don't worry; everything will be all right' or 'I'm sure you are going to be just fine' are likely to increase the person's sense of distress and disempowerment.

In addition to developing self-awareness and participating in regular clinical supervision, health professionals can also follow a number of principles to support them as they provide care. The steps to engaging with a person and building a therapeutic alliance are explained in chapter 2. The most important of these include an attitude of unconditional positive regard and active listening. Health professionals are encouraged to read chapter 2, to determine how they can implement the principles outlined to best help the person with a depression. Do not repeatedly reflect the person's affect by making statements such as, 'You're really feeling like you can't go on', because this can reinforce their negative emotional state.

Effective health professionals will be aware that depression impairs the person's ability to communicate effectively. Common difficulties include withdrawing from routine social interaction, isolation and difficulty in expressing feelings. The ability of the health professional to demonstrate empathy, warmth and optimism are core interpersonal skills that will promote engagement, which underpins all other assessment and intervention activity.

One useful technique is to use effective questions. People with depression often struggle with a lack of motivation. Techniques such as motivational interviewing are helpful (see chapter 10). However, health professionals can also learn to ask effective questions simply by reflecting on whether they are asking an 'open' or 'closed' question.

Closed and open questions

Effective questioning can assist the person to identify how they are feeling, as well as highlight specific concerns, worries and problems that may be acting as psychological reinforcements for their negative thoughts and feelings. **Closed questions** require a single-word response, and are useful for eliciting or confirming factual information. Examples of closed questions include the following.

- 'Do you feel more depressed than last week?'
- 'Has your sleep pattern been disturbed?'
- 'Are you feeling suicidal?'

closed questions questions that require a single-word response, and are useful for eliciting or confirming factual information

Although useful, such questions do not allow for the exploration of thoughts and feelings, and, if used excessively, may impart a lack of interest.

In contrast, **open questions** are a way of encouraging the person to talk. They require more than a monosyllabic response from the person being asked the question. Examples of open questions include the following.

- 'How would you describe your mood this week?'
- 'How have you been disturbed sleeping?'
- 'What are you intending to do about your suicidal thoughts?'

open questions questions that require a long explanation as a response

Open questions can create opportunities to explore what it is that may be influencing the person's current emotional state. They may also allow the health professional to identify if the person has thoughts of self-harm or suicide, the degree of pain and discomfort, and the effect of specific treatments such as the side effects of medication.

Comprehensive approach

As noted in chapter 2, effective health professionals take a comprehensive approach to providing care to people who are ill. This is no less true when caring for the person with a depression. The physical, mental, psychological, behavioural, emotional, social, sexual, environmental and functional aspects of a person should be considered.

The information obtained from a person and their partner, carer or family members will then be utilised to assist the multidisciplinary team to determine the most appropriate course of action. Health professionals are advised to seek the advice or assistance of specialist mental health professionals during this process. Various interventions that may be utilised by the health professional to support the person who is depressed are outlined in table 7.3. It is important to note that this approach can also be used when caring for a person with anxiety. Anxiety is discussed in more detail later in the chapter.

TABLE 7.3 Assessment interventions and rationale

Intervention	Rationale
Include assessment and evaluation of mood within initial health care provider assessment processes	Provides baseline against which to measure changes to mood during hospital stay
Utilise a non-judgemental approach and active listening skills when communicating with the person and their significant others	Demonstrates acceptance, value, warmth and empathy. All of these factors can have a positive therapeutic effect on the person's mood and self-esteem
Provide protected time in order to engage the person in a discussion regarding their current thoughts and feelings	Demonstrates acceptance and reinforces comprehensive care
Identify specific symptoms of depression associated with their physical illness, or as a result of current treatments (e.g. side effects of medication)	Certain depressive symptoms can be a direct consequence of the underlying physical illness/injury, or a consequence of prescribed medical treatments
Identify whether there are any pre-existing or related factors contributing to apparent depressive feelings or behaviour (e.g. interpersonal difficulties, financial worries, recent bereavement)	Assists in the screening and diagnosis of depression in people admitted to hospital
If depression is suspected, then encourage and support the person in completing an appropriate screening tool	Provides a standardised baseline against which to measure changes to mood

Intervention	Rationale
Identify whether the person has any suicidal and/or self-harming thoughts. If self-harming or suicidal thoughts are present, complete suicide risk screen (see chapter 8)	Depression is associated with an increased risk of self-harm and suicide
Explain that depressive feelings are a common consequence of physical illness and hospital admission	Utilising time to discuss thoughts and feelings can assist in normalising the individual's experience
Discuss with the multidisciplinary team any concerns regarding the person's mood	Demonstrates effective team working and collaboration. Effective communication helps ensure appropriate care and can assist in the reduction of risk
If antidepressant medication is indicated, ensure it is administered as prescribed	Ensures appropriate treatment is commenced as soon as possible
Explain that antidepressant medication can take up to three weeks before demonstrating a positive therapeutic effect	Concordance and collaboration is improved if the person is aware of all the facts and options regarding the use of antidepressants (see the following 'Psychoeducation' section)
Monitor the person's response to both therapeutic and side effects of any antidepressant medication prescribed	Provides valuable information about the person's response to treatment
Observe and record details of the person's verbal and non-verbal behaviour (e.g. anger, impulsivity, irritability, motor retardation, dietary and fluid intake)	Ensures that the appropriate level of care is initiated (e.g. recovery from depression is enhanced if adequate nutrition, hydration and physical activity are maintained)
If concerned about the person's mood or if deterioration continues, consider referral to a mental health consultation liaison clinician for specialist advice and assessment (see chapter 12)	Mental health consultation liaison clinician can assist in treatment and care (see chapter 12). Ensures specialist follow up and onward referral is arranged, if appropriate

It is also important the health professional ensures the environment in which the depressed person is located is safe. Depressed people are quite likely to have experienced thoughts of self-harm or suicide. Identification of risk and the implementation of appropriate strategies to manage specific risks are key responsibilities (see chapter 8). It is important then that health professionals conduct clinical and suicidal risk assessments on an ongoing basis to maintain the safety of the person. If restrictions are placed upon the person's access to a means of hurting themselves, they are less likely to follow through with a plan. On the other hand, health professionals must also maintain the principles of least restrictive care. This is explained in more detail in chapter 3.

Psychoeducation

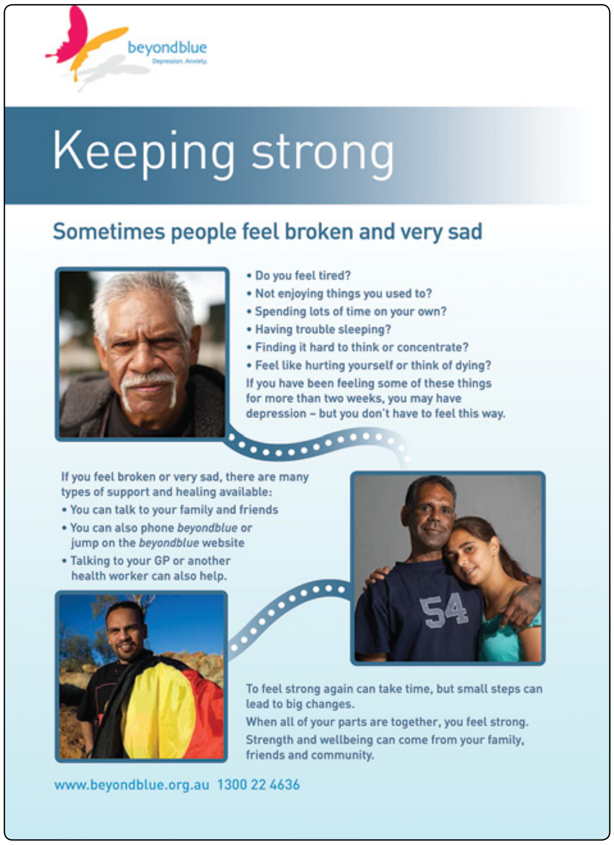
An important intervention that all health professionals can support is the provision of psychoeducation to the person, their partner or carer, and family members. **Psychoeducation** was described in chapter 1, and involves the provision of information or education to a consumer or carer about mental health issues such as:

- medical or other jargon that is often used by health professionals
- the symptoms that are affecting them, and how to manage these symptoms
- the medication that has been prescribed, including side effects and how to manage them
- the resources or support services available in the community
- how to problem-solve and develop skills that will assist the person to manage their situation.

psychoeducation an approach that involves the provision of information to consumers and their carers or significant others regarding signs, symptoms, clinical management, Recovery planning and discharge related to mental health and mental ill-health

Psychoeducation requires the health professional to have up-to-date knowledge on how to access the information needed by the person and their partner or carer. It also requires the health professional to be able to use the internet, readily access handouts or brochures, and know the services available locally for people with depression and their partners or families. Of particular importance is information on the side effects of medications for those who have commenced antidepressant medication (also, see the discussion about the side effects of medications following).

Information about depression and various treatment interventions is readily available across Australia, through public health community services and also community organisations. In addition, pharmaceutical companies provide information pamphlets to health professionals, consumers and carers about the medications they are providing and the side effects. Of particular importance in Australia are websites such as *beyondblue*, which is a high-profile national, independent, not-for-profit organisation in Australia that works to address issues associated with depression, anxiety and related substance-use disorders. Likewise, the Black Dog Institute, provides information and support. Other organisations and programs available online to support people with depression are outlined in chapter 12. Be aware that the depressed person will have an impaired capacity to take on board and remember information due to their illness. It is therefore important to repeat information for the person and their significant others.



beyondblue
Depression. Anxiety.

Keeping strong

Sometimes people feel broken and very sad

- Do you feel tired?
- Not enjoying things you used to?
- Spending lots of time on your own?
- Having trouble sleeping?
- Finding it hard to think or concentrate?
- Feel like hurting yourself or think of dying?

If you have been feeling some of these things for more than two weeks, you may have depression – but you don't have to feel this way.

If you feel broken or very sad, there are many types of support and healing available:

- You can talk to your family and friends
- You can also phone *beyondblue* or jump on the *beyondblue* website
- Talking to your GP or another health worker can also help.

To feel strong again can take time, but small steps can lead to big changes.

When all of your parts are together, you feel strong.

Strength and wellbeing can come from your family, friends and community.

www.beyondblue.org.au 1300 22 4636

beyondblue has help for Aboriginal and Torres Strait Islander peoples with depression.

Treatment options

Many of the interventions identified in table 7.3 (p. 290) include specific treatments. The next part of this section outlines a number of the options for treatment available to people who are depressed. These include psychopharmacological treatment — that is, medications specifically aimed at combating depression; the psychological therapies; and electro-convulsive therapy (ECT). The first two options are also used in the treatment of anxiety, which is described later in the chapter.

As already noted, the choice of options for the treatment of a person with a depression, and also anxiety, is made by the multidisciplinary team in collaboration with the person, and their partner, carers or family members. At this point in time, antidepressants have been cited as the most effective treatment for severe depression (Royal Australian and New Zealand College of Psychiatrists, 2004). Other researchers suggest that a combination of antidepressants and a psychological therapy has great efficacy for moderate to major depression (DeRubeis, Hollon, & Siegle, 2008). Indeed, with the causes of depression identified as multifactorial, it makes sense that treatment options will likewise combine the biological, psychological, social and functional domains.

The first treatment to be outlined is psychopharmacological treatment. This is followed by the main psychological therapies currently in use and, to finish, ECT.

Psychopharmacological treatment

Antidepressant medication has been available since the 1950s. Among the first antidepressants were the tricyclic antidepressants and monoamine oxidase inhibitors, followed by selective serotonin reuptake inhibitors. More recently, the tetracyclic antidepressants and selective serotonin-norepinephrine reuptake inhibitors have been developed. Despite their extensive use, the exact mode of action for antidepressant medication is not fully understood, although treatment is aimed at restoring the balance of neuro-regulating amines by blocking the uptake or reuptake in the brain. Alternatively, the monoamine oxidase inhibitors work by inhibiting the breakdown of neurotransmitters by enzymes such as amine oxidase (MIMS, 2013).

The following will influence the type of antidepressant chosen to be prescribed to a person:

- prescriber's experience and personal choice
- side-effect profile — groups of antidepressants have specific side-effect profiles; for example, tricyclic antidepressants are more likely to cause drowsiness than selective serotonin reuptake inhibitors
- the person's previous history of depression and treatment
- presence, or otherwise, of a physical illness
- safety profile of the medication in overdose. It is common for people with depression to contemplate suicide; individuals who are considered to be at a high risk of suicide are generally not prescribed antidepressants with a high toxicity in overdose (see chapter 8)
- the consumer's preference.

Examples of antidepressant medication used in Australia are listed as follows. Each medication can cause a range of side effects. Some side effects are listed, but, for a complete list, the health professional is advised to refer to full product information in the MIMS (Medical Information Management System) or a similar resource.

tricyclic antidepressants also known as TCAs; sedating antidepressant medications that are highly toxic in overdose

Tricyclic antidepressants (TCAs) tend to be sedating and have anticholinergic side effects such as dry mouth and blurred vision. They may also cause gastrointestinal (GIT) disturbances, sexual dysfunction, palpitations, dizziness and postural hypotension. Of some concern is their toxicity in overdose. Examples of TCAs include:

- amitriptyline (Endep®)
- clomipramine (Anafrinil®, Placil®)
- dothiepin (Dothep®, Prothiaden®)
- doxepin (Deptran®, Sinequan®)
- imipramine (Tofranil®, Tolerade®)
- nortriptyline (Allegron®)
- trimipramine (Surmontil®).

Selective serotonin reuptake inhibitors (SSRIs) tend to be less sedating than tricyclics. Some people report a stimulating effect including insomnia and nervousness or an inner tremulousness. Sexual dysfunction, nausea and headache can also occur. There are quite a number of SSRIs, including:

- Citalopram (Celapram®, Celica®, Ciazil®, Cipramil®, Citalobell®, Talam®)
- Escitalopram (Esipram®, Esitalo®, Lexam®, Lexapro®, Loxalate®)
- Fluoxetine (Auscap®, Fluohexal®, Fluoxebell®, Lovan®, Prozac®, Zactin®)
- Fluvoxamine (Faverin®, Luvox®, Movox®, Voxam®)
- Paroxetine (Aropax®, Extine®, Paxtine®)
- Sertraline (Concorz®, Eleva®, Sertra®, Setrona®, Xydep®, Zoloft®).

Serotonin noradrenaline reuptake inhibitors (SNRIs) have a side effect profile that includes gastrointestinal upset, headache and insomnia. At higher doses, SNRIs may cause hypertension. Examples include the following:

- Venlafaxine (Effexor-XR®)
- Duloxetine (Cymbalta®)
- Desvenlafaxine (Pristiq®).

Noradrenaline and specific serotonin antidepressants are less likely to cause agitation and insomnia than SSRI medications. However, they may cause a range of side effects including drowsiness, headaches, dizziness, diarrhoea, dry mouth oedema, increased appetite, postural hypotension, vivid dreams, rash, muscle aches and oedema. One example is Mirtazapine (Avanza®, Mirtazon®, Axit® Remeron®).

Noradrenaline reuptake inhibitors (NaRIs) are generally well-tolerated antidepressants, but side effects can include dry mouth, headache, nausea, sweats, tachycardia, sexual dysfunction and urinary retention. One example of an NaRI is Reboxetine (Edronax®).

Tetracyclic antidepressants can cause drowsiness, postural hypotension, tremor, headache, dry mouth, tinnitus, constipation, sexual dysfunction, weight gain, restless legs and enlarged breasts, as well as a range of more serious adverse effects including liver damage and neuroleptic malignant syndrome. An example is Mianserin (Tolvon®, Lumin®).

Melatonergic agonists are relatively well tolerated, suited to people over 55 years. An example is Agomelatine (Valdoxan®).

Monoamine oxidase inhibitors (MAOIs) are usually prescribed by psychiatrists and used for the treatment of depression that has failed to respond to first line treatments. MAOIs inhibit the metabolism of tyramine (found in certain foods, such as cheese, red meat and yeast extract). Increased tyramine can lead to hypertension, over activity and delirium; therefore, the person needs to be advised to avoid these foods. At least

selective serotonin reuptake inhibitors also known as SSRIs; non-sedating antidepressant medications which block the reuptake of serotonin at the synapse

serotonin noradrenaline reuptake inhibitors also knowns as SNRIs; antidepressant medications which increase synaptic levels of serotonin and noradrenaline by blocking reuptake

noradrenaline and specific serotonin antidepressants newer antidepressant medications which increase serotonin and noradrenergic transmission in the synapse

noradrenaline reuptake inhibitors (NaRIs) antidepressants with an action of blocking reuptake of noradrenaline at the synapse

tetracyclic antidepressants less commonly used sedating antidepressant medications

melatonergic agonists pharmaceutical agents which bind to melatonin receptors in the brain, activating them; rarely used in treatment of depression

monoamine oxidase inhibitors also known as MAOIs; type of antidepressant medications with strict dietary restrictions two weeks must elapse between discontinuing MAOIs and treatment with another antidepressant. Examples of MAOIs include:

- Phenelzine (Nardil®)
- Tranylcypromine (Parnate®).

Reversible monoamine oxidase inhibitors do not have the same dietary restrictions as the MAOIs and are generally well tolerated with no increase in sedation. Examples include Moclobemide (Amira®, Aurorix®, Clobemix®, Mohexal®)).

reversible monoamine oxidase inhibitors a form of MAOI antidepressant without the dietary restrictions usually associated with MAOIs

Antidepressant medication is likely to be prescribed for moderate to severe episodes of depression (RANZCP, 2004). It needs to be at the correct therapeutic dose and continued for a minimum of six to twelve months once the original symptoms have resolved.

There is little difference in the overall efficacy of various antidepressants, although some are better tolerated, primarily due to the presence or otherwise of specific side effects. Many individuals prefer SSRIs/SNRIs than TCAs because of the side-effect profile of the TCAs. Also, TCAs have a higher risk of toxicity in overdose, which influences many health care providers not to use them, particularly in people with suicidal ideation, which places them at risk of intentional overdose.

Side effects of medications

It is very important that the health professional help the person who is depressed to manage the side effects of their medication. The major reason people stop taking their antidepressant medication is because they are unable to manage the side effects. A number of the side effects of medications were identified in the preceding information. More generally, however, side effects are:

- dry mouth
- urinary retention
- blurred vision
- constipation
- sedation (can interfere with driving or operating machinery)
- sleep disruption
- weight gain
- headache
- nausea
- gastrointestinal disturbance/diarrhoea
- abdominal pain
- inability to achieve an erection (males)
- inability to achieve an orgasm (males and females)
- sexual dysfunction
- agitation
- anxiety.

The impact of these side effects will differ from person to person and it is crucial that the health professional identifies how the side effects are affecting an individual's lifestyle. For example, an adolescent girl who is gaining weight because she has been placed on antidepressants may find it difficult to adhere to this treatment regime in the long term. The health professional can assist people who experience unwanted side effects of medications by working with them to manage what is happening; for example, a referral to a dietitian or other allied health professional who will support the person to achieve a lifestyle change. This kind of assistance requires much more than the health professional simply informing the person about what is required or handing them a relevant brochure. Rather, close planning or additional psychological therapy may be required to support long-term behavioural change.

Another important but often unspoken side effect for the health professional to consider is the sexual issues that affect many people when placed on antidepressants. As noted earlier, these issues can include a low libido, difficulties in achieving and maintaining an erection, orgasmic difficulties and reduced penile sensitivity. Some people are embarrassed about discussing this topic and they may be unaware that medication can contribute to the sexual difficulties that they may have experienced during an episode of depression.

Sometimes health professionals are advised not to discuss sexual dysfunction with a person prior to prescribing in order to avoid increasing the likelihood of its occurrence by elevating the individual's anxiety. This approach may be interpreted as paternalistic and perhaps unrealistic in light of the information now available about medications and their side effects on the internet. However, health professionals need to assess the benefits of not providing this information on a case-by-case basis. Also, raising the subject with the person may also give them permission to talk about an otherwise embarrassing subject. Health professionals need to explain that if this becomes an issue for the person, it is not a permanent condition; although, unlike some other side effects of antidepressant medication, these side effects tend to remain for the duration of treatment (Cole, Christensen, Raju Cole, Cohen, & Feldman, 2007).

Health professionals may also suggest to the person that they discuss any sexual issues with the authorised prescriber, because there are significant differences between different antidepressants and their side effects (Schweitzer, Maguire, & Ng, 2009). Notably, Mirtazapine and Bupropion (used in smoking cessation) are known to cause less sexual dysfunction. Some authorised prescribers will also prescribe adjunctive medications to manage erectile dysfunction (Cole et al., 2007). Many people, however, will choose to remain on the same medication, once reassured that the problem will go away when their medication is ceased in the future.

Generally speaking, providing reassurance to people who are commencing antidepressant therapy is an important part of treatment. A statement used by many health professionals to raise awareness of possible issues, without increasing the risk of discontinuation of the pharmacological treatment, is 'Antidepressants usually take several weeks before you'll start to feel much better, then you're likely to feel the improvement. There are some side effects that you may notice early on in treatment, which will often reduce over a few weeks . . .' They then go on to outline the common side effects for the class of antidepressant.

Ceasing antidepressant medication

Quite often, once a person who is taking antidepressant medication starts to feel their mood improving, they are keen to stop taking the medication. One reason for this is the stigma associated with mental illness. Many people think it is somehow shameful or a sign of weakness to be taking antidepressants.

Whenever antidepressants are prescribed, treatment should be the correct therapeutic dose and should be continued for a minimum of 6 to 12 months once the original symptoms have resolved (Therapeutic Guidelines Ltd, 2008). Health professionals could pose questions such as the following.

- 'If you were taking medication for a cardiac problem, would you stop taking it when you started to feel better?'
- 'If you were taking medication for diabetes, would you stop taking it when you started to feel better?'
- 'What are the issues for you, if you continue on your antidepressants?'

Questions such as these can highlight misunderstandings the person may have about the antidepressants, and also issues of stigma. This can lead to a beneficial discussion between the health professional and the person.

When discussing any medication with people, it is recommended that health professionals advise them that they need to consult with the authorised prescriber if they choose to cease the medication. This is especially true when it comes to antidepressant medication, for two main reasons. Firstly, ceasing antidepressant medication abruptly can lead to a withdrawal syndrome termed a 'discontinuation syndrome'. The discontinuation syndrome is an unpleasant mixture of symptoms including dizziness, sensory disturbances (including paraesthesia and electric shock sensations), sleep disturbances (including intense dreams), agitation or anxiety, nausea, tremor, confusion, sweating, headache and diarrhoea (MIMS, 2013). Secondly, if a person chooses to cease antidepressant medication, the health professional may suggest increasing the frequency of monitoring the person's mood to enable an early response if the person's mood deteriorates.

Psychological therapy

A number of psychological therapies are available for use in the treatment of depression. This includes, and is not limited to, interpersonal therapy, acceptance commitment therapy, cognitive behavioural therapy, problem-solving and systemic family therapy. In order to deliver these effectively, health professionals need to undertake specific training and supervision. The therapies are summarised as follows.

- *Interpersonal therapy* is a time-limited, structured talking therapy for individuals where the onset of depression is associated with life events. The goals of treatment are to reduce depression, alleviate interpersonal distress and to assist the person to build and enhance social supports (Levenson et al., 2010).
- *Acceptance and commitment therapy (ACT)* assists the individual to accept things that seem to be out of their control, and to commit to action the things that will improve and enrich their lives. ACT teaches the person to deal with painful thoughts, memories and feelings, and to clarify what is truly important to them. There is a focus on **mindfulness**, which teaches the person to be self-aware in the present moment, to engage fully in what they are doing and the importance of letting feelings come and go without trying to control them (see chapter 1). Recent studies suggest that ACT may be effective for a variety of disorders, including anxiety disorders and depression (Forman, Shaw, Goetter, Herbert, Park, & Yuen, 2012).
- *Cognitive behavioural therapy (CBT)* is a talking therapy focusing on two elements shown to have a major influence on the development and experience of depression,

mindfulness a meditation method based on Buddhist principles; the focus is achieving a state of compassionate, non-judgemental awareness in the 'here and now' namely cognition (thoughts) and behaviour (actions). The aim of CBT is to assist the person to recognise the link between negative and unhelpful thoughts (such as irrational beliefs) and the behaviours associated with them (Corey, 2009). CBT has been evaluated positively as a treatment for depression and is a widely recommended intervention within treatment settings. Acute treatment usually takes twelve to twenty sessions and has proven to be an effective intervention for mild to moderate depression (RANZCP, 2004).

- *Internet CBT for depression and anxiety* — the long distances and isolation that challenge many people in Australia, together with the reluctance of many people to seek help, has led to the development of a number of online programs to assist people with depression. These include the online delivery of CBT. According to Andrews and Titov (2010), these programs show high levels of adherence and strong reduction in depressive and anxiety symptoms. Similar programs are described in chapter 12.
- *Problem solving therapy* (PST) is a talking therapy that assists the person to identify current stressful life events, and social, health or interpersonal problems in order of impact and priority in their life. PST promotes adaptive attitudes and behaviours, which support the person to cope effectively with stressful life events. With guidance from the therapist, the individual identifies possible solutions to the problems and works on strategies to implement these. PST has been shown to be as effective as other psychosocial therapies and medication, and significantly more effective than no treatment (Bell & D'Zurillat, 2009).
- *Systemic family therapy* aims to work with the person and their family to explore the ways that problems, illness, disability and disease affect them and others within the context of everyday life. The focus of such a therapeutic approach is to view the person, their partner or carer, and family as a unit functioning as a whole system (Corey, 2009). There is emerging evidence that family therapy assists family members to learn more about the illness in order to better support the the person with depression (Lemmens, Eisler, Buysse, Heene, & Demyttenaere, 2009). Families involved in family therapy are more likely to recognise symptoms and notice improvement in the person than those who do not engage in therapy.

Electroconvulsive therapy (ECT)

Another biological treatment for depression is electroconvulsive therapy (ECT). Movies such as *One Flew Over the Cuckoo's Nest* have presented the public with an ill-informed negative perception of ECT and its effects, at great cost. ECT is a simple but effective means by which major depression is treated (Department of Human Services, 2009). ECT involves the passing of an electrical current through the brain, following the administration of a general anaesthetic. The exact mode of action is unclear, although it is thought that the electrical current stimulates dopaminergic pathways, causing an increase in the neurotransmitter and its metabolites, resulting in a rapid antidepressant effect (Keltner & Boschini, 2009). ECT is an especially valuable treatment in people with severe depression, particularly those with psychotic features and people who have either not responded to medication or who are unable to take medication. Most

Australian states have legislation that governs ECT treatment, including minimum standards and issues of consent (see chapter 3).

Side effects of ECT include muscle aches, headache, confusion and memory loss. The type of memory loss varies between individuals and can be difficult to distinguish from memory loss associated with the depression itself and some anaesthetic-induced memory loss. For most people, the memory loss is temporary. However, for a small number, memory loss may last for months, or even years, depending on how many treatments they receive and the duration of treatment. The memory loss relates mostly to events around the period of treatment itself (Stern, 2008).

If an individual or someone close to them is to have ECT and they are apprehensive, it is best to discuss the procedure in a matter of fact way, using an analogy of a pacemaker passing an electrical current through the heart in order to keep it beating. The difference with ECT is that instead of implanting a pacemaker type device, ECT is performed in a series of sessions often over several weeks. It is not painful during or after the procedure, aside from some people reporting headaches.

Other biological treatments include vagal nerve stimulation, light therapy, transcranial magnetic stimulation and magnetic seizure therapy. These interventions are not commonly used in Australia, and, apart from light therapy for seasonal affective disorder, have achieved outcomes that fall below those achieved by ECT (Stern, 2008).

UPON REFLECTION

A less conventional path

ECT is commonly used to treat depression in older persons and those with depression that is deemed unresponsive to conventional treatments (i.e. medication and psychotherapy). Often, health professionals will be faced with patients who have requested — and been granted — this treatment, without conventional methods first being fully explored.

Questions

1. How would you deal with a situation such as this?
2. What are the factors you would consider before making a decision not to support this particular therapeutic approach?
3. In older persons, ECT is often considered early in treatment. Why might this be the case?
4. What do you think about ECT as a therapeutic approach? Upon what do you base your opinion?

This section identified the prevalence, signs and symptoms of depression. It also outlined the causes and contributing factors — which are described as multifactorial — and provided an overview of the ways in which depression is assessed and the various treatment options provided. The next section focuses on maternal depression and other perinatal mental health issues.

Perinatal mental health issues

The range of mental health issues that face women during and after pregnancy are generally the same as those faced by all people at any time in their life — with the exceptions of three conditions commonly related to the **perinatal period**: the '**baby blues**', depression and psychosis. These three conditions are the focus of the discussion in this section of the chapter.

perinatal period generally considered to cover the time from conception to 12 months following childbirth

baby blues a transient mood change that occurs about four days after the birth of a baby, and which affects most women

Childbirth and pregnancy are significant events for a woman and her family. There is a period of rapid biological change for a woman. It is also a period of social and emotional change for both the mother and father, with parenthood permanently changing their social and other statuses, and responsibilities. For most women, giving birth is a positive event. However, this is not always the case.

Women who have no history of mental health issues as well as women who have a history of mental illness may experience the 'baby blues', depression, anxiety, and psychosis. Unfortunately, mental health issues experienced in the perinatal period can often go unrecognised and untreated.

There are number of reasons for this lack of recognition and treatment. Women with no history of issues with their mental health may not seek treatment as they may think the symptoms are an indication that they are having trouble adjusting to the pregnancy and motherhood, rather than experiencing symptoms of a mental illness (*beyondblue*, 2011). Women who do have a history of mental illness may not seek treatment, as they are afraid authorities will take their baby away. Finally, many health professionals do not have the awareness or knowledge required to identify the signs and symptoms of perinatal mental health issues.

According to Bilszta, Ericksen, Buist, and Milgrom (2010), there is a growing concern in the community and also among health professionals about the mental health of new mothers. Reasons for this include the following.

- Infants are totally dependent on their carers. If an infant's carer has mental health issues, then this can place the infant at immediate physical risk as well as commence the infant on a path of increased health risks. For example, children of parents with mental health issues have an increased risk of developing health issues of their own (see chapter 12).
- Mental health issues experienced by a mother can lead to relationship problems or breakdown between the mother and partner.

Early recognition and intervention, effective treatment for the mother, and appropriate interventions for the infant and family can reduce the risk of these issues developing (see chapter 12).

Policy context

All Australian health care professionals should be aware of the *Clinical practice guidelines for depression and related disorders — anxiety, bipolar disordera puerperal psychosis — in the perinatal period. A guideline for primary care health professionals* (*beyondblue*, 2011). These guidelines are available online for all health professionals to access at www.beyondblue.org.au.

Types of perinatal mental health issues

As already noted, there are three different mental health problems that have been identified as specific to women during the perinatal period: 'baby blues', depression, and psychosis. The onset, severity, common duration, incidence and course of illness are compared in table 7.4, then explained in turn.

TABLE 7.4 Comparison of perinatal mental health problems

	Puerperal psychosis	Baby blues	Antenatal and postnatal depression
Onset	Within 24 hours of birth	3–4 days after birth	Anytime before or after birth. Peak at 5 weeks post birth
Severity	Severe	Mild	Mild to severe
Common duration	6–9 months	1–2 days	Highly variable
Incidence	1–2 per 1000 births (0.1–0.2%)	Most women	100–150 per 1000 births (10–15%)
Course of illness	Psychosis lasting weeks to months followed by a depressed phase lasting weeks to months.	Changeable mood and teary.	As per depression.

Maternity or baby blues

This is a transient mood change that occurs about four days **postpartum** and affects most women. It is a mild and self-limiting condition, usually characterised by labile mood, tearfulness, anxiety, irritability, headaches and mild forgetfulness (Laios, Rio, & Judd, 2013). The 'blues' last for two or three days and may peak on day five. Although there is no specific treatment, it is important that health professionals are aware that new mothers will often experience the 'baby blues' and that it can be a distressing and perplexing period for the mother and family. Women and partners who are affected by the 'baby blues' will require information and also reassurance that what they are experiencing is a common, possibly hormonal, reaction to an extraordinarily stressful situation.

postpartum occurring immediately after birth

Antenatal and postnatal depression

Estimates of the prevalence of antenatal and postnatal depression vary considerably. Most studies report that between 6 and 15 per cent of women experience perinatal depression. The terms **antenatal** and **postnatal** depression refer to the period in which the depression occurs. This depression is no different to the depression felt at other times in a person's life, and has the same signs and symptoms as depression generally. Likewise, the same care, treatment and support are provided to mothers with depression as is provided to other people with depression, including the provision of support to partners or carers and family members. The one exception to this may be the choice of

antenatal the period prior to the birth of a child

postnatal the period after the birth of a child medication. This will be dependent upon whether the mother is breastfeeding. This is discussed in more detail in the 'Breastfeeding and the use of psychotropic medication' section later in this chapter.

Puerperal psychosis

Puerperal or postnatal psychosis refers to a psychotic episode commencing within six weeks of birth. Between one and two women per 1000 births develop puerperal psychosis. Sixty per cent of women who develop puerperal psychosis have had a previous psychotic episode. Generally, the psychosis starts within 24 hours of birth, with symptoms becoming clearly apparent within three days of birth.

The psychotic features experienced by the mother are no different to psychosis generally (see chapter 9), although most often the content of the delusions and hallucinations in puerperal psychosis revolve around the infant and the transition to motherhood. The moods can be elated but may fluctuate rapidly to depression and suicidal thoughts. There is also a markedly disturbed sleep pattern.

The delusions, hallucinations and confusion of psychosis can have serious, even fatal, consequences for the infant, and also for the mother, if untreated. For this reason, treatment usually starts with immediate hospitalisation of the mother along with her infant. Australia has a number of tertiary-level mother and baby mental health units (e.g. Helen Mayo House, SA; King Edward Memorial Hospital, WA). These are an excellent source of information for health professionals, mothers and partners around Australia.

Caring for mothers with perinatal mental health issues

This section briefly outlines the care and treatment provided to women with perinatal mental health issues. Care and treatment includes screening, medications and providing support to fathers or partners.

Screening

The *Clinical practice guidelines for depression and related disorders — anxiety, bipolar disorder and puerperal psychosis — in the perinatal period. A guideline for primary health care professionals* (*beyondblue*, 2011) recommend using the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987).

As with the other screening tools, the EPDS can only provide a gauge of how the woman is feeling. Health professionals can 'go over' the questionnaire with the mother, which will help initiate meaningful conversation around the issues raised. If a woman scores 10, 11 or 12 on the EPDS, it should be repeated in 2 weeks time. If a person scores 13 or more on the scale, they are likely to be suffering from depression and/or anxiety and should be referred to specialist services for a detailed assessment.

Treatment

The treatment for depression or psychosis during the perinatal period has many similarities to the treatment provided for depression or psychosis outside of this period.

However, there are a number of specific issues for mothers with mental health issues that need to be considered.

- When prescribing or administering psychotropic medication, health professionals need to think about effects of the medication on the foetus or the infant.
- The safety of the infant is always a priority.
- Mental health issues have the potential to adversely affect the infant–mother relationship. This in turn can exacerbate the mental health issues in an escalating cycle. Therefore, it is important to support the mother–infant relationship as early as possible.
- Infant characteristics — such as sleep problems, or a fussy or clingy baby — may exacerbate the woman's symptoms. Therefore, it is important to ensure that the woman and her partner have the skills to manage the infant appropriately.
- The transition to parenthood is as much of a challenge for partners as it is for the new mother. Therefore, it is important to screen a woman's partner for mental health issues. It is also important to assist the partner to plan how to appropriately support the woman, and also how to support the woman to care for the infant.
- The family unit will often need assistance to function effectively. The family may need help to develop their communication, coping and problem-solving skills, as well as cope with the new family dynamic. Individual members may need help with specific skills, such as practical infant care and parenting skills. In particular, partners may need direction in obtaining additional sources of help.

It is important, then, that health professionals focus not only on the mother and her needs, but also the infant, the father or partner, and the family as a whole.

Breastfeeding and the use of psychotropic medication

Breast milk offers a number of advantages to developing infants, and the process of breastfeeding has a number of important physical, psychological and practical advantages for both the mother and the baby (Butler-Jones, 2009). However, there are important considerations for infants when the mother is taking medication.

All **psychotropic medications** enter breast milk when taken by a woman who is breastfeeding (Howland, 2009). This should not discourage breastfeeding as the benefits for the woman can outweigh the risks of the infant consuming psychotropic medication through the breast milk. However, health professionals must ensure that they discuss the risks and benefits of taking psychotropic medication while breastfeeding with the infant's parents.

psychotropic medications medication that is prescribed to alter the mental state of a person and to treat mental illness

Some psychotropic medications are considered to be safer to use with breastfeeding mothers than others (Howland, 2009; Turner, Sharp, Folkes, & Chew-Graham, 2008). However, the effects of each of the medications will vary according to the individual mother and baby. The amount of active psychotropic substance that is excreted is difficult to specify and an infant's capacity to process drugs is different to older children and adults.

If psychotropic medication is taken by the mother:

- it should be taken immediately after breastfeeding in order to limit the amount present in the milk and maximise metabolic clearance before the infant's next feed
- the infant should be routinely monitored for side effects.

It is recommended that health professionals who are unsure of the side effects refer to the information provided by pharmaceutical companies or the MIMS for information about breastfeeding.

Supporting the partner

Most mothers have partners and family members to support them. It is essential for health professionals to engage with these partners or family members, who can provide valuable support to the mother with mental health issues, the family unit, and also to the health professionals themselves.

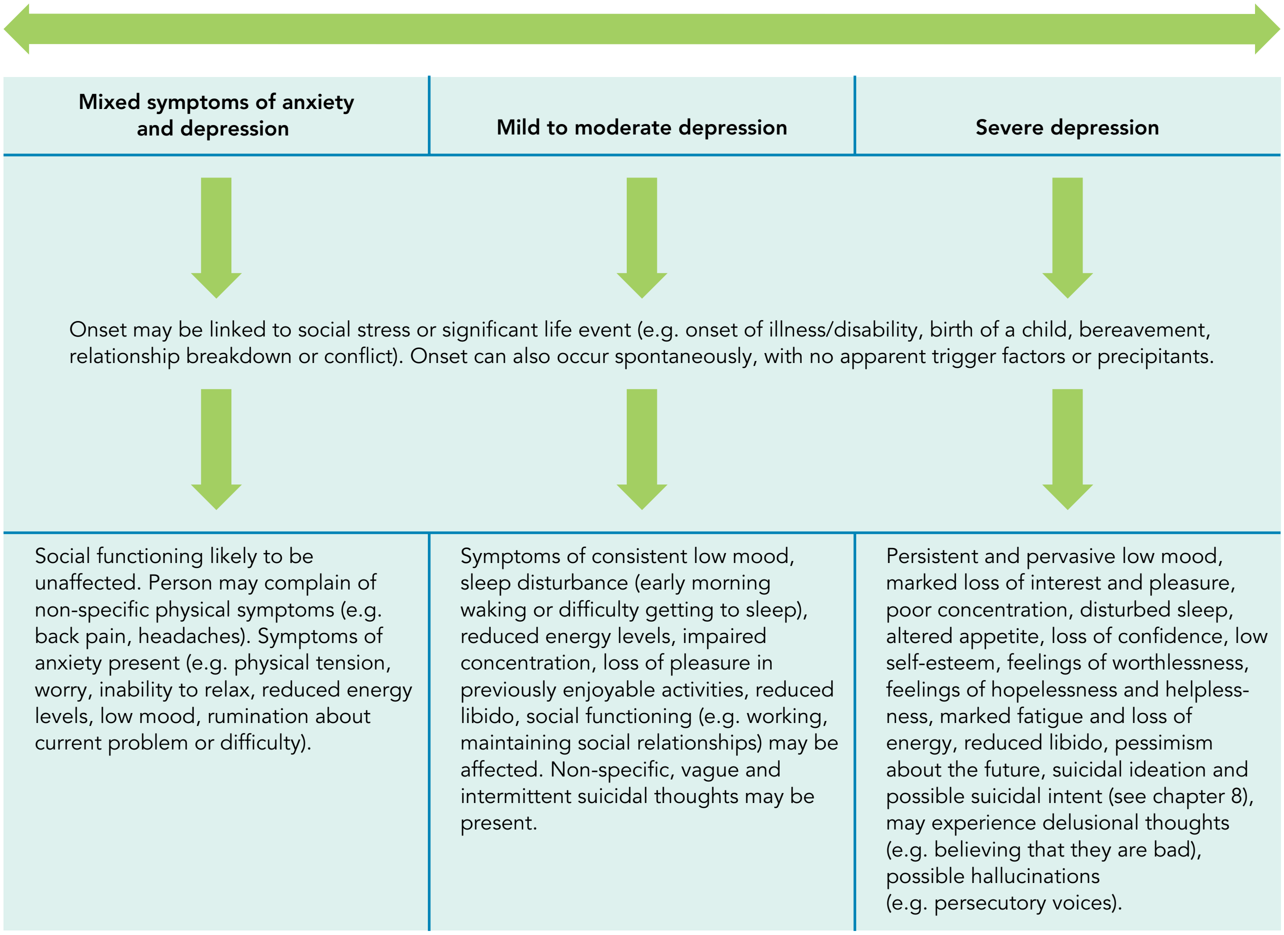
Before engaging with the partner, it is important to understand their journey. They have recently become a parent and, now that the woman has a mental health issue, they have also become a carer. Both roles are stressful and require some adjustment. To help the partner who supports a woman with perinatal mental health issues, health professionals can:

- obtain a release of information from the mother to allow discussion of her treatment with the partner
- provide psychoeducation about the mental health issue. Explain the symptoms the partner is likely to encounter, including the specific risks, and discuss strategies for dealing with these symptoms and risks
- involve the partner in discussion about the woman's care and treatment, other treatment options, and possible risks for the infant. The partner is most often responsible for the infant's safety and care along with the mother
- ascertain how the partner is coping. This could include:
  - discussing the importance of taking breaks and exploring ways they can take some time out for themselves
  - discussing communication skills and coping skills, and providing options to help develop skills where needed
  - discussing ways of strengthening relationships in the family unit, including those between the mother and partner, and parents and children
  - discussing any parenting issues, work patterns, division of tasks at home, and the organisation of other activities of daily living
- provide the partner with information on how to access support, support groups, and so on.

This section discusses issues around maternal depression and other perinatal mental health issues. A later section will focus on anxiety. Prior to moving on, however, some consideration is given to the difference between depression and anxiety.

Most people who are depressed will feel anxious. Few people, however, are diagnosed with a coexisting anxiety disorder. Significantly, some would argue that the various mood disorders, including depression and anxiety, occur across a continuum. This continuum is illustrated in figure 7.1. People may experience a mood disturbance at any point on this spectrum.

Although differentiating between depression and anxiety is important, to enable more focused and appropriate treatment, health professionals will also note a degree of similarity between the care approaches and treatment options for depression and anxiety. It is important for health professionals to differentiate between those who have difficulty coping and those with a depression, as the two quite different experiences have equally different treatment options. These interventions are described later in the chapter.



Mixed symptoms of anxiety and depression	Mild to moderate depression	Severe depression
Onset may be linked to social stress or significant life event (e.g. onset of illness/disability, birth of a child, bereavement, relationship breakdown or conflict). Onset can also occur spontaneously, with no apparent trigger factors or precipitants.		
Social functioning likely to be unaffected. Person may complain of non-specific physical symptoms (e.g. back pain, headaches). Symptoms of anxiety present (e.g. physical tension, worry, inability to relax, reduced energy levels, low mood, rumination about current problem or difficulty).	Symptoms of consistent low mood, sleep disturbance (early morning waking or difficulty getting to sleep), reduced energy levels, impaired concentration, loss of pleasure in previously enjoyable activities, reduced libido, social functioning (e.g. working, maintaining social relationships) may be affected. Non-specific, vague and intermittent suicidal thoughts may be present.	Persistent and pervasive low mood, marked loss of interest and pleasure, poor concentration, disturbed sleep, altered appetite, loss of confidence, low self-esteem, feelings of worthlessness, feelings of hopelessness and helplessness, marked fatigue and loss of energy, reduced libido, pessimism about the future, suicidal ideation and possible suicidal intent (see chapter 8), may experience delusional thoughts (e.g. believing that they are bad), possible hallucinations (e.g. persecutory voices).

FIGURE 7.1 Continuum of anxiety and depression

Caring for children, adolescents and young people with depression or psychosis

This section will briefly outline the issues relating to the diagnosis and treatment of children, adolescents and young people with depression or other mental health problems. Although primary assessment and treatment does not differ greatly from that of mental health problems in adults various considerations need to be made when caring for a patient group with specific developmental needs. It is important to recognise the importance of understanding mental health in the earlier developmental years as many adult disorders have their foundations in childhood. Trauma, family dysfunction and conflict, abuse and neglect, and homelessness can all cause deviations in healthy developmental trajectories.

There are many theorists that have provided strong foundations for how we understand, assess and diagnose mental health problems in the early years. Table 7.5 provides a selection of significant people that have influenced child and adolescent psychiatry and psychology.

TABLE 7.5 Significant influences on child and adolescent psychiatry and psychology

Theorist	Theory/influence
Sigmund Freud	Psychosexual development
Jacques Lacan	Mirror stage Three orders
Wilhelm Wundt	Father of child psychology
Jean Piaget	Theory of cognitive development
Lawrence Kohlberg	Stages of moral development
Albert Bandura	Social learning theory
John Bowlby and Mary Ainsworth	Attachment theory
Margaret Mahler	Separation–Individuation
Lev Vygotsky	Zone of proximal development
Urie Bronfenbrenner	Ecological systems theory (family theory)

Nature versus nurture

An ongoing debate continues over whether nature (genetics) or nurture (environment) has the greatest influence on childhood development. Although historically there often have been two distinct schools of thought, today most researchers and health professionals see these two concepts more as an interactive relationship that exclusively will guide the child through the various stages of development. Subsequently, both aspects are now considered in any assessment process involving children, adolescents and young people. For example, questions relating to family history of depression or illness, the pregnancy and birth processes, and early childhood (physical) illness all form a vital part in the understanding of possible genetic issues, and as such they bear equal significance to questions relating to environmental experiences (trauma), parenting style, learning and social interactions.

UPON REFLECTION

Explaining nature and nurture

As seen regularly in clinical practice, children will present to mental health services with an array of emotional and behavioural disturbances. The challenge for any health professional will be to provide an adequate explanation to the parents or carer of that child with regard to the cause of their disturbance.

Questions

1 How would you use the nature–nurture concept?
2 What elements within your assessment would you use to determine the influence of each of these?
3 How would these two concepts inform the development of a treatment plan for the child and their parents or carers?

Assessment issues to consider for children and adolescents

Although assessment of children, adolescents and young people does not differ in content to that of adults and older persons, there are some considerations relevant to the developmental phase of the person being assessed. It is vital that all health professionals assessing children, adolescents and young people have the required expertise and knowledge to ensure that their judgements are always made in the context of normal developmental behaviour and milestones. That is, they need to be able to determine that what they are seeing is in fact an illness rather than expected behaviour for the person's particular developmental phase, cognitive stage and age.

Age-appropriate interactions

When assessing a 5-year-old child for depression, the health professional would not ask the child to explain how they feel or rate their level of mood on a Likert scale. The health professional would need to utilise age-appropriate interactions and strategies that will elicit such information. For example, key people — including parents, carers and teachers — can often establish a child's mood through therapeutic drawing/painting, play and interactive games.

Flexible approaches

Health professionals need to be considerate of the fact that many adolescents and young people do not respond well to formal clinical structures and processes. The health professional will need to focus on the engagement phase with adolescents and young people, utilising some key communication strategies to be able to elicit trust and honesty. Sometimes the health professional will need to conduct interviews outside of the clinical environment — for example, youth centres, home, hostels, and public spaces (essentially somewhere where the adolescent/young person feels comfortable).

Psychometric assessments

Where appropriate, a variety of psychometric assessments can be conducted by the appropriate health professional (e.g. clinical psychologists) in order to determine the child's or adolescent's levels and types of intelligence (e.g. spatial, linguistic or logical-mathematical), processing (e.g. auditory processing disorder), developmental disorders (e.g. intellectual disability) and learning difficulties (e.g. dyslexia).

Developmental history taking

In any assessment of a child or adolescent, it is vital that the developmental history is recorded. This should include issues surrounding pregnancy, birth, early developmental milestones, physical illness and exposure to abuse and neglect.

Specialised assessments

For some disorders — for example, attention deficit hyperactive disorder (ADHD) and autism — specialised services and health professionals are required to conduct the specialised assessments due to the type of knowledge required to make an accurate and appropriate diagnosis.

Common childhood diagnoses

There are many disorders that can be diagnosed in childhood, adolescence and young adulthood; some common to all ages (e.g. depression or anxiety) and some specific to age (e.g. autism or attachment disorders). The following include some of the most common diagnostic presentations to child and adolescent mental health services.

Attachment disorders

Attachment disorders represent a broad category of disorder that describes disturbances in mood, behaviour and social functioning that are caused by the failure of the child to form appropriate and strong attachments to a primary care-giving figure. It is believed that this 'failure' often comes as a result of the child being exposed to familial environments that involve abuse and neglect, abrupt and/or unexpected separation, frequent changes in the family structure and/or environment, or lack of responsiveness or over-responsiveness of a primary carer to the child. It is generally thought that attachment disorders as a result of such disruption occur between the ages of six months and three years; beyond this age it is thought that significant disruptions, although distressing to the child, do not cause alterations in attachment (Chaffin et al., 2006).

Autism spectrum disorder

Autism spectrum disorder (ASD) is a disruption in neural development mostly characterised by impaired social interaction and communication; further, those who have this disorder often exhibit repetitive and obsessive behaviours. The diagnostic criteria require that symptoms become apparent before a child is three years old (DSM-5, 2013). Levy, Mandell and Schultz (2009) further add that autism affects information processing in the brain by altering how nerve cells and their synapses connect and organise. Autism, plus Asperger's syndrome and pervasive developmental delay not otherwise specified (PDDNOS), are the three main recognised disorders within the autism spectrum.

Oppositional defiant disorder (ODD)

Oppositional defiant disorder (ODD) is a childhood disorder that is described as a pervasive pattern of disobedience, anger and hostility, and defiant behaviour towards authority figures. These behaviours are seen as going beyond the 'normal' expected behaviour of childhood development.

Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is a neurobehavioral disorder characterised by significant difficulties of inattention or hyperactivity and impulsiveness, or a combination of the two. The DSM-5 and the ICD-10 identify that symptoms will emerge before the child is seven years of age and that they may develop one of three types of this disorder — predominantly inattentive (ADHD-PI), predominantly hyperactive-impulsive (ADHD-HI), or the combined type (ADHD-C). According to Rader, McCauley and Callen (2009), it is the most commonly studied and diagnosed mental health problem in children and adolescents, affecting approximately 3–5 per cent of children globally and is diagnosed in about 2–16 per cent of school-aged children.

Depression

Children and adolescents with this disorder will exhibit the usual symptoms of depression as seen in adults; however, they will in addition exhibit increased irritability or aggressiveness and self-destructive behaviours, rather than experience the episodic and severe sadness associated with adult forms of depression. Children who are under stress, who experience loss, or who have attentional, learning, behavioural or anxiety disorders are considered a higher risk for developing depression (Birmaher et al., 1996).

Eating disorders

Eating disorders are characterised by abnormal eating habits that usually involve insufficient or excessive food intake to the detriment of an individual's physical and emotional health. The DSM-5 and ICD-10 identify types of eating disorder, and include anorexia nervosa, bulimia nervosa, binge eating disorder, and eating disorder not otherwise specified. Each of these disorders possess distinct diagnostic traits — for example, anorexia nervosa is centred around the deprivation of food, whereas bulimia nervosa is characterised by binging and purging behaviours.

Other childhood disturbances

Other common diagnostic categories used for children and adolescents include anxiety disorders, conduct disorders, suicide and non-suicidal self-injury, emerging personality disorders, pyromania, encopresis and enuresis, and gender dysphoria. The ICD-10 is frequently used to further identify psychosocial disturbances (Z codes) in children and adolescents that, although they do not lead to definitive diagnoses (F codes), can cause serious difficulties. These disturbances include homelessness, unplanned pregnancy, domestic violence, poverty and neglect, unemployment, and problems relating to wardships, to name just a few.

Common interventions used with children and adolescents

Unlike adult health and mental health services, interventions with children and adolescents tend to focus on systems theory; more specifically, family and play therapy. Heavily influenced by Bronfenbrenner's ecological system theory (Bronfenbrenner, 1979), health professionals see childhood and adolescence as a central aspect to a larger system that includes family, community and societal influences. Children are rarely treated in isolation to their primary system (i.e. their family), given the influence that 'nurture' will have on cognitive, emotional, social and behavioural development. Medication as an intervention, even when used in combination with family and individual psychotherapy, is extremely controversial — especially when it is used with children. However, it remains an important aspect in treatment.

Family therapy

Family therapy — often referred to as family counselling — is a subtype of psychotherapy that works with families to identify how relational dynamics influence behaviour. This therapy focus its efforts on the systematic interactions between family members, emphasising that healthy interactions promote positive change and development, leading to psychological health. The different schools of family therapy all commonly believe that, regardless of whether the clients consider an issue to be of an 'individual' or 'family' nature, involving families in solutions is the strongest approach to take.

Play therapy

Play therapy is a therapeutic approach that is commonly employed with children aged 3–11 years and provides a means by which the child or adolescent can effectively express their feelings. Usually, this is encouraged through a medium or alternative source of expression — for instance, as young children often express themselves through behaviour, 'playing' with dolls, toys or drawing/painting will allow them to express how they feel in a mode familiar to their day-to-day interactions. As children's experiences are also communicated primarily through behaviour and play, this therapeutic method becomes an important medium for them to know and understand themselves, others and their environment.

Medication

Many health professionals (AACAP, 2012) consider that medication forms an effective part of treatment for several mental health problems and disorders of childhood and adolescence. A recommendation for medication often raises many concerns and questions, and so it should only be done so by an experienced medical practitioner who understands the specifics of treatment in this age cohort. It is vital that the doctor explain fully to the parents or carers the purpose and effects of the medication to be used, and ensure that appropriate use is understood and that regular monitoring and follow-up is maintained. It is clear that medication should never be used in isolation and should only ever be considered once a comprehensive assessment has been completed and when a team of health professionals is being employed to work with the child or adolescent and their family or carer.

Inpatient versus community treatment

Depending on the illness presentation, especially with regard to level of risk, children and adolescents may need to be hospitalised for a period of time. There is significant debate about the benefits of hospitalisation beyond the stabilisation of risk and medical issues and how this impacts on the recovery of the child/adolescent. Generally, one side of the debate believe that the hospital environment allows for extensive and specialist interventions to be applied under the supervision of suitable trained individuals. However, there are those who feel this level of intervention does not allow for the environmental change required for longer-term recovery (Wilson, Megel, Enenbach, & Carlson, 2010). It is thought that by not treating the presenting issue in the environment where it is occurring, recovery made in hospital will only be short term, as the child/adolescent has not learned the skills to manage the illness in their own home and community. Hospitalisation should not be mixed up with intensive residential programs (interventions provided within the child's or adolescent's environment, inclusive of family and/or carers). Residential treatment will include periods of respite to ensure that the community systems do not become overwhelmed or 'burnt out'. Most clinicians will consider all forms of treatment when assessing a child, and make treatment decisions based on risk, the ability of the home environment to provide effective care, and the nature of the presenting symptoms.

Youth mental health

Despite the advances made through the implementation of youth suicide prevention strategies in the late 1980s and early 1990s, there is still a clear gap in mental health service provision (Painter, 2010). Youth aged 15 to 24 are not only at a high risk of suicide; they are also falling through the gaps of conventional mental health service provision. Issues of homelessness, substance misuse, trauma, anti-authoritarian attitudes, self-injury and the need for flexibility traditionally make it difficult for young people to access services that would seem to not meet their needs. Further, such issues impact on accessibility, making it difficult for mental heath services to provide effective and consistent treatment. Service clinicians who lack training and awareness relating to the specifics of youth development and concerns also further impact upon the effective provision of mental health treatment.

In recent years, however, youth mental health has become a primary focus of mental health policy in Australia, with investment being allocated to initiatives across the country targeting young people aged 15 to 24 (Rickwood, Raphael, & Pilgrim, 2011). This comes as a result of focused advocacy from various aspects of the youth health industry for nearly two decades, with national mental health plans prioritising youth mental health since 1996. With the increasing burden of mental disorder in adolescence and young adulthood, targeted programs have been funded that provide not only assessment and treatment (e.g. Orygen Youth Health) but also programs that provide education, health promotion and early identification (e.g. headspace Australia).

The most recent Australian data from the National Survey of Mental Health and Wellbeing revealed that one in four young people will experience an affective, anxiety or substance-use disorder in a 12-month period (ABS, 2012). According to Rickwood, Raphael and Pilgrim (2011), this supports data from a similar study conducted in the United States that showed 75 per cent of mental disorders emerge before the age of 25 years, half of these before the age of 14. With these figures it is clear that the early identification of mental health problems and disorders is vital if health professionals and services are to reduce the impact that such illnesses have on the wider community.

Neurobiological influences

Over the past few years, the body of literature pertaining to the neurobiological processes of the brain and how they influence psychological development and thus illness has grown. Developments in biomedical technology have meant that the concept of neuroplasticity has now replaced the formerly predominant school of thought that the brain is a physiologically static organ (Pascual-Leone, Amedi, Fregni, & Merabet, 2005). Essentially, **neuroplasticity** is defined as the neural pathways and synapses that develop in response to changes in behaviour, environment, physical injury and neural processes (Pascual-Leone et al., 2011).

neuroplasticity the neural pathways and synapses that develop in response to changes in behaviour, environment, physical injury and neural processes

This approach is beginning to allow a greater understanding of how trauma, physical illness, medication and substance misuse impacts on the developing adolescent brain. Such insights will allow for improvements in both assessment and treatment of not only biological illnesses, but also psychological and social illness.

Practice principles

Engagement

Research recognises that mental health services need to have a strong and flexible approach to engagement, especially with those young people that are identifiable as high-risk (Schley, Yuen, Fletcher, & Radovini, 2012). Although engagement, as a term and principle, is frequently used within the literature and clinical practice, there is no one agreed-upon definition. Essentially, however, engagement is the process taken by which the health professional forms an appropriate relationship with the young person using strategies that will allow for age-appropriate interactions.

Comprehensive assessment

In addition to standard mental health and psychometric assessments, a risk assessment is paramount when working with high-risk young people. This will ensure that a comprehensive assessment is carried out. The health professional will need to ensure that the young person is safe and free of risk to self and others before any other intervention can be employed. Suicide and non-suicidal self-injury (NSSI) assessment (see chapter 8) comes in a variety of forms; however, generally it needs to cover the following areas:

- present thoughts and feelings (determination of whether the thoughts are of suicide or NSSI)
- thoughts, feelings and beliefs opposing suicide
- present plan, behaviour and past attempts of suicide or NSSI
- openness to other solutions and strategies
- coming events that increase risk
- available supports and willingness to access them.

Various tools exist to assess suicide — for example, the ‘no suicide contract’ and numerical rating scales; however, these should never replace clinical judgement based on comprehensive assessment and youth engagement.

Multidisciplinary approach

Given the complex nature of youth mental health problems and disorders (especially the biopsychosocial interactions), interventions should aim to involve a variety of individuals (a team) who come from different specialties and disciplines. For example, a young person experiencing depression and substance-use disorders may require support from a medical practitioner (prescription and monitoring of medication and physical illness), a clinical psychologist (to conduct the individual psychotherapy), a social worker (to assist with any social issues like housing or family conflict), a drug/alcohol service (to provide specialist inpatient treatments), a youth worker (to support access to community based services like Centrelink and recreational pursuits).

Online interventions

Given young people's affinity for technology and the present level of their interactions with social media, interventions can no longer be solely community based. Online services can provide a range of early intervention, health promotion messages and support services to young people in a form that is familiar and accessible to them. Examples of such services include:

- ReachOut (http://au.reachout.com)
- Samaritans Crisis Line (www.samaritanscrisisline.org.au/)
- headspace (www.headspace.org.au)
- Youthbeyondblue (www.youthbeyondblue.com)
- Kids Helpline (www.kidshelp.com.au).

Youth mental health services and youth-friendly GPs

Specialist mental health services can provide comprehensive assessment and treatment of mental health problems and disorders. Staffed by multidisciplinary teams — including psychiatrists, clinical psychologists, social workers, and Indigenous workers — they provide specialist mental health counselling, consultation, training and community development. Such services have a focus on enhancing the mental health and well-being of young people who are marginalised and disadvantaged, particularly those who are homeless. Services are provided in a flexible manner including outreach and community-based inreach services.

Local general practice divisions can often supply lists of GPs who provide youth-friendly medical services — for example, long consults, bulk billing, and specialist services like sexual health.

THE BIG PICTURE

The Fourth National Mental Health Plan — Priority area 2: Prevention and early intervention

The importance of promotion, prevention and early intervention (PPEI) as a mental health priority in Australia has been recognised in previous national mental health plans. *The Fourth National Mental Health Plan 2009–2014* acknowledges that there has been a development of a stronger evidence base to support models of intervention in children and young people — especially in areas such as early intervention in psychosis, and school- and family-based interventions for challenging behaviours.

➜

Outcomes relating to this priority area include the following.

1. People have a better understanding and recognition of mental health problems and mental illness.
2. They are supported to develop resilience and coping skills.
3. People are better prepared to seek help for themselves, and to support others to prevent or intervene early in the onset or recurrence of mental illness.
4. There is greater recognition and response to co-occurring alcohol and other drug problems, physical health issues and suicidal behaviour.
5. Generalist services have support and access to advice and specialist services when needed.

To achieve these outcomes, mental health services need to:

- work with schools, workplaces and communities to deliver programs to improve mental health literacy and enhance resilience
- implement targeted prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations
- expand community-based youth mental health services that are accessible and combine primary health care, mental health, and alcohol and other drug services
- implement evidence-based and cost-effective models of intervention for early psychosis in young people to provide broader national coverage
- coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them
- provide education about mental health and suicide prevention to front-line workers in emergency, welfare and associated sectors
- expand the level and range of support for families and carers of people with mental illness and mental health problems, including children of parents with mental illness
- develop tailored mental health care responses for highly vulnerable children and young people who have experienced physical, sexual or emotional abuse, or other trauma.

Source: Australian Health Ministers' Advisory Council (2010, pp. 32–33)

Anxiety

As noted in chapter 2, the most common mental health issues in Australia are anxiety disorders, including generalised anxiety disorder, post-traumatic stress disorder, social phobia, panic disorder and obsessive–compulsive disorder (Australian Bureau of Statistics, 2012). In combination, the prevalence of these anxiety disorders affects 14 per cent of the population.

Feelings of anxiety are a universal human experience, probably having evolved from the primitive 'fight-or-flight' response seen in all animals. However, anxiety can also be experienced in the absence of an apparent external threat or as a consequence of situations and events that the individual finds unfamiliar or difficult. Indeed, events such as attending a health service can trigger feelings of anxiety, which can be manifested in a variety of ways. Anxiety affects various bodily systems and functions, but consistent among these are the often distressing physical, or somatic, symptoms. Table 7.6 outlines some of the common signs and symptoms of anxiety.

TABLE 7.6 Common signs and symptoms of anxiety

Autonomic symptoms	Physical symptoms	Behavioural symptoms	Psychological symptoms
Tachycardia	Tremor	Avoidance	Excessive rumination
Sweating	Muscular aches	Ritual behaviour	Indecisiveness
Dizziness	Difficulty swallowing	Distress in social situations	Irritability
Hot/cold spells	Lump in throat	Increased use of substances	Inability to relax Feeling tense Being easily startled
Frequency of micturition	Restlessness	Appearing hostile or dismissive	Poor concentration Distractibility
Diarrhoea/nausea	Fatigue	Withdrawal from social recreational pursuits	Impatience
Paraesthesia (pins and needles)	Headaches	Repetitive seeking of reassurance	Reduced sense of humour

Types of anxiety

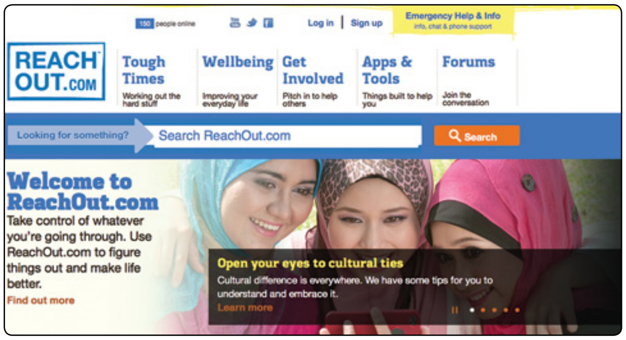
There are a number of different anxiety disorders in the DSM-5 and ICD-10. As already noted, the most common in Australia are generalised anxiety disorder, post-traumatic stress disorder, social phobia, panic disorder and obsessive–compulsive disorder. However, health professionals will also encounter acute stress reaction (chapter 5) and hypochondriasis, a **somatoform disorder** (chapter 1). In this section, an overview is provided of the different types of anxiety that a person may experience, and how health professionals can assist the person to manage the symptoms. Anxiety has been described as one of the most treatable of all mental health conditions (www.beyondblue.com.au), so health professionals are encouraged to inspire hope in those who are embarking on their recovery journey.

somatoform disorder a group of mental health disorders in which people report physical symptoms for which no medical cause is present

Generalised anxiety disorder

People experiencing a generalised anxiety disorder (GAD) tend to worry about many things. Indeed, each day can be consumed with worry over a variety of issues from social engagements to financial concerns or safety issues. People experiencing these worries will often have symptoms of muscle tension, sleep disturbance, restlessness and irritability. Sometimes these individuals will become the butt of family jokes, where people make light of their excessive and worrisome behaviour. For the person with the disorder, however, it is no laughing matter. As with most anxiety disorders, the person is usually aware that they worry far too much and wish desperately they could stop worrying.

For a person to be diagnosed with a GAD, they must experience this heightened anxious state on the majority of days for at least six months. According to Reach Out Australia, a community organisation that has been established to support young people with mental health issues, symptoms of GAD are sometimes divided into cognitive/affective, behavioural and physical symptoms.



Welcome to ReachOut.com

Take control of whatever you're going through. Use ReachOut.com to figure things out and make life better.

Open your eyes to cultural ties

Cultural difference is everywhere. We have some tips for you to understand and embrace it.

Cognitive symptoms can include:

- constant thoughts that something bad is about to happen
- constant worry that they are not doing things correctly.

Behavioural symptoms can include:

- constantly asking questions and requiring reassurance
- perfectionism
- being argumentative, especially if trying to avoid a feared situation
- ruminating over mistakes, a change in routine, or unfamiliar places.

Physical symptoms can include:

- dry mouth and/or difficulty swallowing
- nightmares
- difficulty getting to and staying asleep
- difficulty concentrating
- muscle tension and headaches
- rapid heart rate and breathing
- sweating
- trembling
- diarrhoea
- flare-up of another health problem or illness (e.g. dermatitis, asthma)
- sexual problems, such as not having any sexual feelings or being interested in sex.

GAD is more common among women than men. One in twenty people will experience GAD at some time in their life, with onset common during late teens and early twenties (White, 2013).

In order for health professionals to understand the discomfort and stress that can be felt by a person with GAD, it is useful to recall a time when they have been extremely worried and anxious about something important in their life such as a job interview or an exam. A person with GAD is likely to feel more angst than this each and every day.

Treatment for GAD can be psychological and/or pharmacological. Often, the two work best together. The most effective psychological therapy is CBT, with a focus on thoughts and behaviours, and exploring ways of changing negative patterns (see explanation in first section of this chapter). **Relaxation therapy** and **deep breathing exercises** are also useful.

relaxation therapy a range of techniques that induce the relaxation response, such as deep breathing, music and meditation; used for the reduction of stress

deep breathing exercises a relatively quick relaxation technique in which attention is focused on deep inhalation, holding the breath for a few seconds, exhaling, then repeating the process

Pharmacological treatment is usually only prescribed for GAD for short-term management, during particularly stressful times. Antidepressants are the most commonly used medications. Tranquillisers are also prescribed in the short term only, to alleviate physical symptoms.

Self-help or support groups are also useful, as people discover they are not alone and may be supported by other people with similar issues. Some people also find journaling their feelings to be a useful way of managing their symptoms. In addition, health professionals can encourage people with GAD to address any lifestyle issues and to improve their general health. This will include strategies such as eating well, exercising regularly and taking regular recreational breaks.

Panic attacks

A panic attack occurs when a person experiences episodes of sudden, severe and uncontrollable anxiety. Onset is associated with thoughts of dread and fear, which may be associated with new or previously stressful situations (e.g. going shopping or travelling on a bus). Certain objects, sounds, smells and so on, related to the health context, can also act as triggers to a panic attack — such as the sound of the dentist's drill or the smell of a hospital. According to the American Psychiatric Association (2000), a panic attack is characterised by a cluster of symptoms that include the following:

- palpitations
- chest pain
- tachycardia
- sweats
- shakes
- difficulty breathing
- nausea
- choking feeling
- dizziness
- **derealisation**
- **depersonalisation**
- fear of losing control
- weakness or tingling in the limbs
- fear of impending death or doom
- chills or hot flushes.

derealisation perceptual disturbance in which the world seems unreal

depersonalisation a feeling of being able to observe oneself, while not having control over what is happening

Most people will report different clusters of symptoms during a panic attack. Often people feel as though they are experiencing a heart attack or some serious physical problem.

If a person has never had a panic attack before, it may be impossible to distinguish between a heart attack and a panic attack. In this situation it is best that the person calls an ambulance and is taken to hospital where an accurate diagnosis may be made. If it turns out that the problem was a panic attack, the person can count himself or herself lucky. They are not to be maligned by health professionals for calling an ambulance; instead, they need to be provided with strategies to reduce the likelihood of further attacks and practical strategies to manage any future occurrences. Information regarding where to go for further support, if necessary, also needs to be provided.

A major debilitating factor in panic disorder is the fear of future panic attacks. People will often avoid a variety of life or social situations for fear of the recurrence of a panic attack. Even though a person may have experienced only a few panic attacks that were short lived, they may limit their whole lifestyle as a result of their experience (see 'agoraphobia' following).

Panic attacks are best treated with psychological therapy (Royal Australian and New Zealand College of Psychiatrists, 2003). This will include psychoeducation that encompasses information and education about anxiety. CBT is also important, and will include relaxation and slow breathing training, cognitive therapy and exposure therapy, as well as relapse prevention. Some people may also require assertiveness training, which involves teaching the person to state their preferences and maintain boundaries. The aim of this training is to manage or reduce stressors in the person's life and give the person a feeling of control over what is happening to them. Occasionally antidepressants can also be used for panic disorder; however, psychological therapies have been demonstrated to have the best effect (Royal Australian and New Zealand College of Psychiatrists, 2003).

Phobias

Phobias are irrational fears that are out of proportion to the actual threat posed to the individual and are classified as follows.

- *Agoraphobia* is characterised by avoidance of specific places or situations, triggered by the belief that the person will experience an overwhelming sense of anxiety and panic. The person may feel that escape from the situation would be difficult or that it would be difficult to gain assistance. Such feelings may lead to marked social disability and the person may avoid situations such as being in shops and supermarkets, using public transport and visiting hospital. Agoraphobia is usually preceded by panic attack. Treatment involves CBT and other non-pharmacological interventions. As above, pharmacological interventions including the use of antidepressant medication may be indicated to treat the panic disorder associated with the agoraphobia.
- *Social phobia* is characterised by excessive performance anxiety regarding situations such as talking in front of others, public speaking and ordering food in restaurants. Even bumping into people in the supermarket can cause significant discomfort. In these situations, the person may be concerned that their behaviour may cause them some humiliation or embarrassment. Again with social phobia, the person is likely to be aware that their level of anxiety in these situations is excessive. CBT and social skills training can be of use to many people who experience social phobia. If unsuccessful, first-line pharmacological interventions usually involve antidepressant medication (Stein & Stein, 2008).
- *Specific phobias* involve marked anxiety and feelings of panic triggered by discrete situations. Examples may include a phobia of certain animals or creatures such as spiders, rodents or snakes; fear of heights; fear of enclosed spaces; fear of flying; fear of attending the dentist; and fear of needles and injections.

Generally speaking, a person with any phobia will become very anxious and fearful in the situation they fear. Provided they avoid the object, situation or event that triggers the phobia, other aspects of their life remain relatively unaffected. In order to minimise feelings of anxiety, the individual avoids or limits exposure to the situation that triggers the response. For many, such avoidance has little impact on their life and social functioning, but in some cases the avoidance behaviour becomes extreme and disabling. The person will be aware that the fear or phobia is irrational, but remain unable to overcome it, despite explanation and logical persuasion.

While phobias are relatively common, specialists usually provide treatment. The most effective treatment is CBT or psychotherapy. This will include work to restructure thinking and behaviour. Some specialists may also use exposure therapy, where a person is supported to gradually face the situations they most fear. For example, if the person is fearful of lifts, the therapist may guide them through a systematic desensitisation process that involves imagining oneself in a lift, standing outside the lift, standing inside the lift, taking the lift up one floor, taking the lift up two floors, and so on. Alternatively, situations may be simulated. In so doing, the person gradually increases their confidence in the situation and is able to control their fears.

Phobias are also treated with antidepressants, in particular paroxetine, sertraline and venlafaxine. This approach is based on the suggestion that phobias are the result of an imbalance in serotonin. **Benzodiazepines** (e.g. valium) are also used, but with limitations. While acting quickly to calm a person, they are also addictive.

benzodiazepines a class of drugs that has a hypnotic and sedative action; they are used mainly as tranquilisers to control symptoms of anxiety; they are also addictive

Obsessive–compulsive disorder (OCD)

People with obsessive–compulsive disorder (OCD) experience intrusive thoughts or feelings. These thoughts or feelings induce a degree of anxiety or distress. The person will try to manage the intrusive thought by carrying out a behaviour or ritual. If the person tries to resist carrying out the behaviour, their level of anxiety will increase. The individual will invariably recognise that the rituals are excessive or inappropriate (Hyman & Pedrick, 2010).

A common presentation of OCD is a person who experiences intrusive thoughts about germs. They may constantly be thinking about germs as they handle money, shake someone's hand or turn a doorknob. In order to relieve the anxiety this produces, the person may develop some rituals regarding hand washing and cleaning their environment. The cleaning rituals may not always allay the anxiety, although they may be repeated frequently. The rituals can become very time consuming and embarrassing for the person and may end up being performed in sequences or repeated a predetermined number of times.

Some people with OCD will have concerns with checking. They may have intrusive thoughts or feelings that they have left things undone, such as not turning off electrical equipment or not locking their house or car. The discomfort caused by these persistent preoccupations will lead them to develop time-consuming rituals of checking and rechecking. For example, a person may have to switch the light switches on and off six times each time they leave a room or check the windows and doors are locked four times before leaving the house. Some people complain that they 'know' they switched the iron off, but they still have to go back and recheck to make doubly certain. The end result of this happening is that the person may feel as though they are 'going crazy'.

In the first instance, health professionals need to provide firm reassurance to the person that they are not 'going crazy'. It is also important to be clear and supportive, while being careful to be realistic regarding the support that can be offered. It is strongly recommended that treatment is provided by specialists — health professionals well trained in the assessment and management of OCD (e.g. clinical psychologists) (Hyman & Pedrick, 2010). Antidepressant medication can also be helpful in the treatment and ongoing management of the person with OCD; however, it is usually prescribed in cases where co-morbid depression is present and/or significant medical issues are present (Simpson et al., 2008).

Reactions to stressful events

People respond to stressful events differently. Most people exposed to a traumatic event will have some difficulties managing their responses. The types of events likely to cause problems for people include major stressful events such as major car accidents, serious assault, rape, torture, war and earthquake. These events and others, which put people in fear of their lives or safety, are the events that are likely to give rise to anxiety-based **sequelae**, which impact on a person's quality of life.

sequelae the consequences of a set of circumstances, particular condition or therapeutic intervention

Acute stress reaction (ASR) is discussed in chapter 5. In summary, ASR is a transient psychological or anxiety reaction that develops in response to a traumatic event. The reaction is usually self-limiting and in most cases does not require any specific physical treatments (e.g. medication). Even so, the symptoms can be severe and distressing for the person and may include the following:

- initial state of feeling dazed
- reduced levels of consciousness
- agitation or overactivity
- withdrawal
- dissociation
- anxiety symptoms (e.g. sweating, increased heart rate or flushing).

acute stress reaction a transient psychological or anxiety condition that develops in response to a traumatic event; usually begins within minutes of the event and disappears after hours or days

These symptoms can occur within a few minutes of the stressful event and usually disappear within hours or days. Some people will also experience vivid dreams related to the incident or become anxious when they recollect the event.

As also noted in chapter 5, an essential part of the care of a person who is experiencing an ASR includes treating the initial symptoms, and providing explanations and reassurance.

If symptoms of ASR persist in frequency and severity for longer than four weeks, then the condition may develop into a **post-traumatic stress disorder (PTSD)** (Giarratano, 2004). According to the Australian Bureau of Statistics, the prevalence of PTSD in the Australian population is approximately 6.4 per cent of those who experience significant trauma (ABS, 2008). Generally, the condition is diagnosed in those who have survived specific types of trauma, such as war, terrorist attacks, rape or other assault, natural disaster, refugee experiences, or the sudden unexpected death of a loved one (Silove, Steel, Bauman, Chey, & McFarlane, 2007). PTSD has ongoing lifestyle and adjustment implications and requires ongoing treatment by specialised mental health professionals.

post-traumatic stress disorder (PTSD) a diagnosed mental health condition characterised by the development of a long-lasting anxiety reaction following a traumatic or catastrophic event

PTSD is treated by mental health specialists using psychological therapies and, on occasion, pharmacological therapy. The aim of the treatment is to help the person to process the thoughts and emotions related to the trauma that was experienced. This will include exploring thoughts and feelings about the trauma, working through feelings of guilt or self-blame, learning coping strategies to manage the intrusive memories, and addressing lifestyle issues.

CBT and desensitisation are interventions also used for PTSD. Another helpful strategy is reframing, where upsetting thoughts are processed and given new meaning. Some people may participate in family therapy, as the issues experienced will affect not just the person with the disorder, but also partners and family members. Medication, such as antidepressants, is used to relieve the secondary symptoms. Another intervention that is occasionally used is eye movement desensitisation and reprocessing. This is a highly specialised form of therapy that works at restructuring the processing system of the brain.

Hypochondriasis

Hypochondriasis is a somatoform disorder in which a person has excessive health-related anxiety. There are two major factors in hypochondriasis: disease phobia and disease conviction (Noyes, 2010). The person believes they have a particular disorder as a result of misinterpreting their symptoms (Ford, 2008). Such individuals do not feel reassured when they are told they do not have the physical disorder or that the results of tests were negative. Consequently, the person continues to be excessively anxious or fearful about the disorder. This can continue for years.

It is important that health professionals do not label a person a 'hypochondriac'. There will be times when a person's symptoms actually do have a physical or biological cause but medical officers are unable to locate the source of the symptoms the person is reporting. While there have been many developments in science and diagnostics, there is still much that is unknown. Alternatively, while the symptoms may not have a biological or physical cause, this does not negate the fact that the person's concerns are very real and distressing to them. Labelling will not assist the person to address the issues.

The primary treatment intervention for the person with hypochondriasis is a supportive relationship with the health professional. It is also important that clear boundaries are implemented (see chapter 6), as people with hypochondriasis can sometimes be labelled 'challenging' and 'manipulating'. Many people with hypochondriasis are not keen to see a mental health specialist, as they see this as health professionals placing a question mark over their integrity. However, CBT can be promoted quite validly to the person as a way of managing their anxiety. If the person has anxiety or depression, they may also respond to medication.

IN PRACTICE

Screening for anxiety

The Beck Anxiety Inventory (BAI) is a self-reporting tool created by Aaron Beck and associates in the late 1980s that is widely used by mental health professionals across the United States, United Kingdom and Australia. The aim of this inventory is to establish the severity of a person's anxiety. It is not a diagnostic tool, as the 21 items used are based on common symptoms of anxiety disorders.

➜

	Not At All	MILDLY it did not bother me much	MODERATELY it was very unpleasant, but I could stand it	SEVERELY I could barely stand it
1. Frightened.				
2. Heart feels like it is skipping a beat.				
3. Legs like jelly.				

Stimulated Items similar to those in the Beck Anxiety Inventory. Copyright © 1990, 1993 by Aaron T. Beck. Reproduced with permission of the Publisher, NCS Pearson, Inc. All rights reserved.

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Questions

1 In what way would this inventory assist with diagnosis and treatment for a person experiencing problems with anxiety?
2 How could this inventory be inappropriately used in clinical practice?

Approaches to care for anxiety

There are many similarities between the approaches to care and treatment options for people with depression and/or anxiety. This can be related to the continuum between depression and anxiety, illustrated in figure 7.1, earlier in the chapter. Health professionals are advised to revisit the care and treatment options previously outlined for depression.

For health professionals working in general health contexts, the most important aspect of providing care to people with anxiety is to remember that, for the majority of people, anxiety is a transient feeling. In general, people will respond well to appropriate explanations, reassurance and sensitive communication. Only one to two people out of ten develop a problem that requires further specialist input.

Generally, strategies that health professionals can use to help people who do go on to develop an issue with feelings of anxiety, include:

- encouraging the person to relax, using music, breathing and relaxation exercises
- encouraging diversional activities (e.g. having a hot bath or listening to music)
- developing personal coping strategies that utilise some of the principles of CBT (e.g. recognising and addressing automatic negative thoughts and challenging these with more realistic alternatives) (Bourne, 2011)
- using short-term anxiolytic medications, such as a benzodiazepine, which acts by reducing emotional reactivity and **somatic** responses. These medications must not be used to treat anxiety without weighing up the risks of **iatrogenic** dependence,

somatic relating to apparent physical symptoms

iatrogenic unintended adverse effects of treatment and in any case should not be used continuously for longer than two weeks (Western Australian Psychotropic Drugs Committee, 2008)

- providing health advice and information that helps the person to address lifestyle issues, such as:
  - work–home balance (e.g. addressing the impact of excessive work, amount of time spent at work, blurred boundaries between professional and personal life caused by ‘bringing work home’)
  - addressing issues around the development of a healthier lifestyle (e.g. smoking, use of alcohol, exercise)
  - the potential benefits of developing specific strategies to manage stress (e.g. yoga, relaxation classes, aromatherapy)
- suggesting complementary or alternative approaches. These are now described in more detail.

Complementary and alternative medicines

The term complementary and alternative medicines (CAM) includes a range of medicines, supplements and approaches, such as:

- herbal remedies
- food supplements, including vitamin preparations and other organic and inorganic substances (e.g. omega-3 fatty acids)
- individual therapies, including acupuncture, aromatherapy, herbal therapy, homeopathy, iridology, naturopathy and reflexology (Bourne, 2011).

There is ongoing debate by the scientific community regarding the efficacy of these remedies, including the feasibility of using randomised controlled trials and difficulties in identifying suitable placebos (Jorm et al., 2004). Even so, interest in CAM continues to grow across the western world, including Australia.

St John’s Wort has been shown to be an effective alternative treatment for mild non-melancholic depression (van der Watt, Laugharne, & Janca, 2008). It works as a serotonin, noradrenaline and dopamine reuptake inhibitor. Many people prefer the idea of taking a herbal medication, rather than the antidepressants prescribed by medical officers. It is important, however, that the health professional informs the person that they are not to combine prescribed antidepressants with St John’s Wort due to the risk of serotonin syndrome (Lawvere & Mahoney, 2005).

CAM have also been found to have some effectiveness for the treatment of anxiety (Jorm et al., 2004). Kava has been investigated as an alternative treatment for generalised anxiety disorder, with some evidence of an anxiolytic effect (Sarris & Kavanagh, 2009). However, there is concern about its association with hepatotoxicity (van der Watt et al., 2008). Valerian and passiflora are also used, but there is still some debate as to their efficacy.

As already noted, anxiety is one of the most treatable of all the mental health problems. A variety of treatment interventions can be used to good effect. However, most importantly, by utilising the same principles of unconditional positive regard and active listening, all health professionals are able to work toward making a difference for people with an anxiety disorder.

SUMMARY

This chapter provides an overview of the major issues related to the care of a person with depression or anxiety, and includes a discussion of the factors that contribute to a person developing depression and anxiety. Information is provided about the role of the health professional in assessing a person's mood, and the use of screening tools are suggested as a useful means by which health professionals can strike up a conversation with a consumer, and also their partners or family members, about the symptoms they are experiencing. Depression and anxiety are experienced by a large number of Australians; these conditions have the potential to impact significantly upon their quality of life. Ways of caring for the person who is depressed are specified, including pharmacological interventions, psychological interventions and also physical interventions, including electroconvulsive therapy.

Following this is an explanation of the major mental health issues faced by women who are pregnant and for 12 months after the birth of their baby. These issues include the 'baby blues', depression, and puerperal or postnatal psychosis. The ways in which health professionals can support the woman, her partner, and also the family unit are outlined.

Child, adolescent and youth mental health are explored with an explanation given about the specifics characteristics that distinguish it from adult and older persons mental health services. Further description is provided of the various types of disorders that are experienced in the age related cohorts. Assessment and treatment options and issues are considered and further placed into the current Australian political context.

Finally, the symptoms of anxiety are identified. Generalised anxiety disorder, panic attacks, phobias, obsessive–compulsive disorder, post-traumatic stress disorder, and the more common reactions to stress such as acute stress reaction are described. Many of the treatments for anxiety are similar to those recommended for depression. In addition, the benefits of complementary and alternative medicines are outlined.

According to *beyondblue*, over a million people in Australia live with depression and over two million have an anxiety disorder. With the right treatment, most people recover. Both of these conditions respond well to care and treatment that is empathic and evidence-based. Health professionals are encouraged to read more about the effects of depression and anxiety on people's lives, and learn how they can support the individual to achieve the best possible health outcomes.

Depression and anxiety can be complications of a range of physical illnesses. For this reason, they are often not recognised nor adequately treated despite the availability of evidence-based treatment options. Untreated depression and anxiety are responsible for a significant burden of disease in the community and cause considerable individual distress.

The multifactorial causes of depression mean they are problems that require health professionals to adopt a comprehensive or holistic perspective when assessing and caring for people experiencing a low mood.

All health professionals have a responsibility to be aware of issues related to depression and anxiety. They also have a responsibility to address the needs of people with depression and anxiety who present for treatment for any condition.

Review questions

1 What are the common symptoms of depression?
2 What is obsessive–compulsive disorder?
3 Name four SSRI antidepressants in use in Australia.
4 Describe the primary therapeutic focus of child and adolescent services.
5 List three types of childhood mental illnesses.
6 What are some of the types of online services for young people? How do such services form part of their treatment?
7 What class of medication is prescribed to treat a variety of anxiety disorders?
8 Is depression more common in people with a medical illness? Why?
9 How do internet-delivered CBT programs fare for people with anxiety and depression?
10 During a panic attack (particularly the first one), a person may feel as though they are having a heart attack. How should they respond in this situation?
11 What are some tips in the chapter around discussing antidepressants with people who have had them prescribed?

Discussion and debate

1 Think of someone you know (of) who may have had depression. What signs and symptoms did they experience? What was the hardest aspect of the experience for them? What was the hardest aspect of the experience for you?

2 Depression is more common among females than males in Australia. What are some possible reasons for this?

3 The use of medication to treat depression in children remains a controversial issue both in Australia and internationally. Research clearly indicates that it can provide some benefit so long as it is prescribed alongside psychotherapeutic interventions. What are the pros and cons of using antidepressant medication in children under the age of 12? What are your own views on this issue? Describe how your own opinion may influence your treatment practices.

4 Advocates of ECT say it is an effective treatment for depression. Many members of the community believe that ECT is a barbaric practice. Compare the perception of ECT with the perception of heart transplant surgery. Heart transplant surgery involves slicing open the human chest with a scalpel, cutting through the bone of the chest wall, removing the human heart and inserting the heart of a dead person into a living person, using electrical stimulation to restart the 'dead heart' before sealing up the chest cavity. Discuss why many do not see ECT, which saves people's lives and gives them a life worth living, in a similar light to heart transplant surgery.

5 Youth mental health services provided a vital adjunct to conventional child, adolescent and adult mental health services. They have arisen out of the need to provide comprehensive assessment and interventions to persons aged 15 to 24 years. What are the key differences between youth mental health and adult

services? How do you think social media and the internet influence services provided to young people?

6. Specific phobias are very common and usually people manage to avoid the triggers. What specific phobias are you happy to share about yourself? Have you found any strategies helpful in managing the phobia?

Project activity

Access a variety of articles and fact sheets that discuss the use of SSRIs to treat depression in young people. (Australian mental health websites www.headspace.org.au and www.beyondblue.org.au are good starting points.) What do you think are the pros and cons of using medication to treat depression in young people? How would you present this aspect of treatment to a young person?

Websites

Anxiety Treatment Australia provides information about anxiety disorders, the treatment options, psychologists around Australia who treat anxiety disorders, group therapy and workshops, support groups, articles, resources and links to other sites: www.anxietyaustralia.com.au

Australian Natural Therapists Association is the largest national democratic association of 'recognised professional' traditional medicine and natural therapy [complementary medicine] practitioners who work in the areas of health care and preventative medicine: www.australiannaturaltherapistsassociation.com.au

beyondblue is a national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related disorders in Australia: www.beyondblue.org.au

The Black Dog Institute is a not-for-profit, educational, research, clinical and community-oriented facility offering specialist expertise in depression and bipolar disorder: www.blackdoginstitute.org.au

Centre for Clinical Interventions (CCI) is a specialist program that conducts clinically-applied psychosocial research, training and supervision for various psychological interventions. CCI offers a clinical service for adults suffering from anxiety, mood and eating disorders. Its website contains comprehensive resources (research and clinical) for both health professionals and community members: www.cci.health.wa.gov.au

Clinical Research Unit for Anxiety and Depression is a series of internet-based cognitive behavioural therapy courses designed to treat people with anxiety and/or depression: www.crufad.org

headspace Australia is a national initiative that provides both internet- and community-based resources for young people. This service provides information about the various issues faced by youth and provides an opportunity to locate and easily access appropriate support services: headspace.org.au

The Hunter Institute of Mental Health is a business unit of the Hunter New England Local Health Network. The mission of the Hunter Institute of Mental Health is to promote mental health and to improve the outcomes for people with mental illnesses: www.himh.org.au

Kids Helpline is a companion web service for children, adolescents and young people to access support including chat forums and telephone counselling: www.kidshelp.com.au

Phobias: phobias, fear and stress — solutions to overcome phobias. How our fears create phobias and how to overcome them. Practical techniques to create a stress free life: www.phobias.com.au

ReachOut is a national site specifically designed for young people to access information on a variety of topics and available sources of help. The site also provides opportunities for young people to openly discuss their own issues in a safe and secure way: reachout.com.au

The Samaritans Crisis Line is a site that offers both information and telephone support for persons experiencing mental health problems, illness and crises: thesamaritans.org.au

Social Phobia/Social Anxiety Association (SP/SAA) is a non-profit organisation, formed to meet the growing needs of people throughout the world who have social phobia/social anxiety: www.socialphobia.org

Therapuetic Guidelines is an independent not-for-profit organisation dedicated to deriving guidelines for therapy from the latest world literature, interpreted and distilled by Australia's most eminent and respected experts: www.tg.org.au

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Caring for a person who has self-harmed

8

LEARNING OBJECTIVES

This chapter will:

- define deliberate self-harm, suicide and suicidal ideation
- outline the incidence of self-harm and suicide in Australia
- describe factors that may contribute to self-harming behaviours
- describe attitudes to self-harming
- outline the National Suicide Prevention Strategy
- discuss suicide risk assessment
- outline the care of the person who has self-harmed.

Introduction

Self-harming and suicidal behaviours are major issues for the community, government, health services and professionals across Australia. The annual Australian suicide rate, averaged over the past five years, is 2320 — equating to more deaths per year by suicide than by road or traffic accidents (Mindframe, 2012; Australian Bureau of Statistics [ABS], 2013; Bureau of Infrastructure, Transport and Regional Economics, 2012). Outcomes of self-harming behaviour include hospitalisation and death (headspace, n.d.; National Institute for Clinical Excellence [NICE], 2012). In addition, family and friends of people who suicide or self-harm are at risk of being profoundly affected — emotionally, socially and economically (SANE, 2012).

This chapter provides definitions for self-harm, suicide and suicidal ideation. It also outlines the incidence of self-harm and suicide in Australia, and the methods by which people choose to self-harm or suicide. The attitudes of the community and health professionals towards people who self-harm or attempt suicide are discussed, as well as the impact of these attitudes upon health care providers. The major components of a suicide risk assessment are outlined. In addition, a description is provided of the ways in which the health professional can provide effective care and treatment to the person with self-harming behaviours, their partner or carer and family members. The chapter concludes by considering how health professionals can support a person who has been bereaved by suicide.

Definitions

The terms **deliberate self-harm (DSH)** or deliberate self-injury (DSI) are generic phrases used to describe a wide range of self-injurious behaviours. These behaviours can include:

- deliberately cutting the body
- scratching
- hitting
- head banging
- burning and scalding
- hair pulling
- excessive use of substances such as alcohol and illicit drugs
- self-poisoning (overdose)
- jumping from a height or in front of a moving vehicle.

deliberate self-harm (DSH) the intentional injuring of body tissue without suicidal intent

Self-harming behaviours are generally defined as the intentional, direct injuring of body tissue without suicidal intent. Although people who self-harm do not necessarily have suicidal intent (NICE, 2012), there is a very real possibility that self-harming behaviours could lead to death.

Suicide is the act of a person intentionally causing their own death, while **suicidal ideation** describes the thoughts, ideas or plans a person has about causing their own death. Suicidal behaviours are usually more lethal than self-harming behaviours, and could include:

- self-poisoning (overdose)
- jumping from a height or in front of a moving vehicle
- driving a car into a tree at a high speed
- poisoning from gases and vapours (including motor vehicle exhaust)

suicide the act of a person intentionally causing their own death

suicidal ideation the thought, ideas or plans of a person about causing his or her own death

- use of a lethal weapon
- hanging.

It is interesting to note that a number of self-harming behaviours are also suicidal behaviours. This explains why many people are confused about the difference between self-harm and suicide. The factor that differentiates the two is the motivation behind the act or behaviour.

A person who self-harms does not necessarily wish to die. Rather, people who self-harm are generally trying to express their great emotional pain. By hurting themselves, they are expressing physically what they are feeling, but are unable to express in other more constructive ways. In a large 2010 Australian community telephone study of over 12 000 people, it was also found that people used DSH in order to punish themselves (Martin, Swannell, Hazell, Harrison, & Taylor, 2010).

Likewise, people who intentionally plan for or cause their own death do not necessarily want to die. Most suicide attempts occur in crisis situations; that is, they are impulsive reactions to personal crises of one form or another. A number of people who have survived suicide attempts have gone on to say their prime motivation was to escape the pain they were feeling at that time, rather than bringing about their own death. Their pain — physical or emotional — and feelings of hopelessness or helplessness were so great that they were unable to see a future for themselves. Escape from the present was the only option they could see at that moment in time. This suggests why it is important for health professionals to support a person through difficult periods or situations. Once a person has developed the skills to deal or cope with the situation and see that there are indeed other options, they can move on with hope into the future.

To clarify the difference between DSH and suicidal behaviour, it is helpful to consider self-harm as an umbrella term for three distinct but overlapping subgroups of self-injurious behaviours. These subgroups are physical self-injury, impulsive self-harm and attempted suicide. Table 8.1 provides a list of the most common forms of self-harming behaviour and also their presentation.

TABLE 8.1 Common forms of self-harming behaviours and their presentation

Physical self-injury	Impulsive self-harm	Suicide attempt
Common motivating factors	Common motivating factors	Common motivating factors
• Feelings of frustration, anger, low self-esteem • Means of communicating distress • Means of managing and coping with negative feelings, often those produced as a result of difficult or problematic interpersonal communication • Response to underlying beliefs and a habitual negative coping strategy • Rarely are actions motivated by suicidal intent	• Overwhelming sense of ambivalence — simultaneous beliefs about two opposing actions. For example, on the one hand, wanting to die, but on the other, wanting to live, as long as the emotional pain disappears • Impulsive action often linked to use of alcohol immediately beforehand • Short-lived perception that death is the only solution to current crisis • Often precipitated by some form of interpersonal crisis (e.g. argument with partner/significant other)	• Suicidal thoughts consistently present over a period of weeks, months or years • Well thought through and considered plan to end life • Unable to contemplate life continuing • Unshakable belief that others 'will be better off without me' • Feelings of ongoing hopelessness present

(continued)

TABLE 8.1 *(continued)*

Physical self-injury	Impulsive self-harm	Suicide attempt
Typical behaviours and presentation	Typical behaviours and presentation	Typical behaviours and presentation
• Cutting, scratching and burning the skin — most frequently arms and legs • May present as withdrawn, uncommunicative and passive following injury	• Overdose of medication the most common form of self-harm • Impulsive decision to end life • Likely to seek help after taking the overdose (e.g. calling an ambulance) • Expressions of subsequent regret and embarrassment at actions afterwards	• Likely to have taken precautions against discovery — may only have come to the attention of others due to miscalculation or unenvisaged interruption by another person • More likely to have used a violent method to harm self (e.g. hanging and firearms) • Likely to express regret that actions failed to result in death

It is important to remember that motivations will often overlap and individuals can present with characteristics from each subcategory. For example, a person may regularly self-harm to help them cope with stress. However, one day they may experience a particularly difficult situation, such as the breakdown of a relationship, and they are unable to manage their feelings by self-harming. On impulse, they take an overdose of medication that results in their death.

Incidence of self-harming

The nature of self-harm suggests some difficulty in precisely identifying its frequency. For example, many episodes of self-harm take place in private and do not come to the attention of health professionals or other record keepers. Likewise, identifying the frequency of death by suicide presents many challenges. For example, unexplained single-car road accidents may be the result of suicide — however, when there is no proof, the cause or manner of death cannot be ascertained. This is particularly relevant when considering that 44 per cent of all fatal crashes in the 2009–10 period were single car crashes (Bureau of Infrastructure, Transport and Regional Economics, 2012).

Suicide rates

For each day during 2011, more than six Australians took their own lives, resulting in 2273 completed suicides, which accounted for 1.5 per cent of all deaths across the nation. Suicide was the fifteenth most common cause of death in Australia for that year (ABS, 2013). However, the level changes according to gender and age groups. For example, suicide is the leading cause of male death in the 15–44-year-old age group, with just over one-quarter (27.8%) of all male deaths within the 15–24-year-old age group due to suicide. These high age-specific prevalence rates contribute to suicide being ranked as the tenth highest cause of death within the male population.

Indeed, suicide rates across all age groups were higher for males (76%) than females (24%) in 2011; that is, males suicided at approximately three times the rate of females. The highest number of male age-specific suicides occurred in the 85-plus age group, with a rate of 32.1 per 100 000 deaths. The next highest age group was the 80–84-year-old group who recorded 24.4 per 100 000 deaths, closely followed by the 45–49-year-old age group with 23.8 per 100 000 deaths. This is in comparison to the lowest age-specific male suicide rate of 10.4 per 100 000, being the 15–19-year-old age group.

For women, the highest age-specific suicide rate occurred in the 85-plus age group with 7.8 per 100 000 deaths, followed by the 40–44-year-old age group recording 7.7 per 100 000 deaths and then the 30–39-year-old age group with 7.4 per 100 000 deaths. The lowest recorded age-specific female suicide rate occurred in the 65–69-year-old age range at 3.5 per 100 000 deaths (ABS, 2013; Mindframe, 2012). The standardised suicide incidence rate for all Australians in 2011 was 9.9 per 100 000 deaths. Of the people who completed suicide, the average median age was 43.1 years old; the average median age for males being 43.2 years old and 42.6 years old for females. This is in comparison to the average age of death related to all causes, being 81.5 years on average — specifically, 78.4 years for males and 84.5 years for females. Suicide was the cause of death for 2.3 per cent of all male deaths, and 0.8 per cent of all female deaths in 2011(ABS, 2013).

Suicide is an outcome that is preventable. This suggests an important reason why communities, the government, health professionals, and family and friends who have been affected by suicide are so concerned by these statistics. Much is made of deaths on the roads in Australia — and rightly so. If a person is killed in a car accident, their death is announced on the news across Australia, and an annual road toll is published at the end of each year. Significantly, however, the number of people killed on the roads in 2011 was 1291 — a death toll 43 per cent lower than the number of people who died by suicide (ABS, 2013; Bureau of Infrastructure, Transport and Regional Economics, 2012). The Australian public was not made aware of this in the same way by the media.

Even so, it is heartening to know that the overall suicide rate for the past 10 years has fallen, with males having a larger overall suicide reduction rate than females. This is a positive result, especially when considering that the suicide rates in the United States for the 1999–2009 decade increased by 12 per cent (Schmitz et al., 2012). One reason for the Australian suicide rate reduction is the **National Suicide Prevention Strategy** and the significant fiscal resources the Commonwealth government has committed to fund the various programs it administers. More information about the National Suicide Prevention Strategy is provided later in this chapter.

National Suicide Prevention Strategy provides the platform for Australia's national policy on suicide prevention with an emphasis on promotion, prevention and early intervention for mental health

THE BIG PICTURE

Suicide — A look at the global picture

The World Health Organization (WHO) estimates that, worldwide, one person intentionally kills themselves every 40 seconds — that is, almost one million people per year (WHO, 2012a). Self-inflicted injuries are the third leading cause of death and the sixth leading cause of ill-health and disability for the global age group of 15–44 years (WHO, 2012b).

Globally, the statistics demonstrate that suicide risk increases with age and that, generally speaking, those aged 75 years or older complete suicide at a rate three

➜

times higher than the 15–24-year-old age group (WHO 2012b). This age-related statistic is representative of both genders. However, using demographic age distribution ratios, one-third of all countries that provide data to the WHO record that there is a higher suicide rate for those under the age of 45 (WHO, 2012b).

Age-adjusted suicide rates for countries illustrate that the highest suicide rates are in Eastern Europe. Lithuania has the highest recorded rate with a suicide mortality rate of 34.1 : 100 000, followed by Korea with a suicide mortality rate of 31 : 100 000. Russia and Belarus are the next two highest ranking countries for suicide. Korea has the highest rate in the Asian geographical region (WHO, 2013).

Egypt and Jordan share the lowest recorded mortality of 0.1 : 100 000. Kuwait was the next lowest ranking country, with a mortality rate of 1.8 : 100 000 (WHO, 2013).

In 2011, Australia fell below the global average mortality rate of 16 : 100 000 with an average mortality rate of 9.9 : 100 000. New Zealand recorded a slightly higher mortality rate of 11.7 : 100 000 in 2007 and the United States reached a mortality rate of 11.0 : 100 000 in 2005 (WHO, 2013).

Men kill themselves more often than women. The global average male-to-female suicide ratio is 3 : 1 — a statistic which is reflected in Australia. The highest worldwide male-to-female suicide ratios of 6 : 1 are recorded in Romania, Greece and Lithuania, whereas the Eastern Mediterranean and South Eastern Asian regions are reported as having the most narrow suicide margins between the sexes (WHO, 2013).

The results of the *National survey of mental health and wellbeing* (ABS, 2007) highlighted that 13.3 per cent of Australians aged 16–85 years have, at least once in their lives, experienced some form of suicidal ideation. The report illustrated that 4 per cent of the population in this age group had made a suicide plan, and 3.3 per cent disclosed that they had attempted suicide at least once.

In terms of numbers, this alarming statistic equates to just over 2.1 million Australians having had at least one moment in their life when they considered killing themselves, slightly more than 600 000 people then making a suicide plan and over 500 000 people then making an attempt to kill themselves during their lifetime.

When asked what people had experienced in the 12 months prior to the survey being conducted, rather than across the life span, 2.3 per cent of the total population (i.e. just over 370 000 people) reported having experienced suicidal ideation, 0.6 per cent or 91 000 people made a suicide plan, and 0.4 per cent or 65 000 people attempted suicide.

Rates of self-harm

The incidence of self-harm is currently measured by the number of people who present to an emergency department or other health setting and seek assistance from a health professional. Currently, self-harm is one of the most common reasons for presentation to an emergency department (Australian Institute of Health and Welfare [AIHW], 2013). During 2011–12, there were 33 502 hospital presentations for DSH. This represents 20 per cent more presentations than for assault, and is equivalent to 47 per cent of all traffic accident presentations. DSH presentations across the country account for 12 per cent of all emergency department presentations, excluding complications from medical and surgical care, falls and traffic accidents (AIHW, 2013).

People who were admitted to hospitals in Australia with a primary diagnosis of intentional self-harm during the 2009–10 period accounted for 6 per cent of all injury hospitalisations in Australia. These admissions included people who had **attempted suicide** and those who intentionally hurt themselves but did not intend to kill themselves (Tovell, Mckenna, Bradley & Pointer, 2012).

attempted suicide an action that involves a person endeavouring to intentionally cause his or her own death, but death does not result

Other significant Australian statistics related to DSH include the following.

- DSH was the third most commonly reported cause of community injury resulting in hospitalisation during 2009–10.
- DSH accounts for 10 per cent of injury admissions to hospital for the 15–24-year-old age group, and 11 per cent for the 25–44-year-old age group.
- DSH is a significant risk factor for repeated DSH and suicide (Olfson, Marcus, & Bridge, 2011).
- Females are admitted to hospital at almost double the rate of males for DSH, with a male to female ratio of 0.6:1.0. The incidence of DSH is higher in every age group for females, except the 80-plus age groups, where the incidence for males is significantly higher than females.
- The highest prevalence of DSH for females occurred in the 15–19-year-old age group bracket, at a rate of 371.4 per 100 000 population.
- The highest prevalence of DSH for males occurred in the in the 30–34-year-old age group, with a ratio of 163.4 per 100 000 population (Tovell et al., 2012).
- Intentional self-poisoning represents 82 per cent of all DSH presentations, followed by 13 per cent presenting for injury with a sharp object. Handgun discharge was the least common and only reported for males.
- Forty-six per cent of poisoning cases involved ingesting sedative-hypnotic, antiepileptic, antiparkinsonism and psychotropic drugs including benzodiazepines and unspecified antidepressant medications.
- The mean length of stay for a hospital admission caused by DSH was 3.4 days.
- Eighty-one per cent of DSH injuries took place in the person's home, and 8.4 per cent occurred in a health service area (Tovell et al., 2012).

There is clearly a need for research to identify the predisposing factors for these age groups. These factors are discussed in more detail in the following sections of this chapter.

Alarmingly, a systematic literature review identifying 74 papers related to health professional attitudes and knowledge toward people who self-harm, found that a large number of health professionals felt negative and pessimistic toward people who present for self-harming behaviours, especially those who have repeat presentations (Saunders, Hawton, Fortune, & Farrell, 2011). The interventions and strategies a health professional can use to effectively care for and support people who have self-harming behaviours are outlined later in this chapter.

Indigenous populations

As noted in chapter 4, the suicide rate of Australia's Indigenous peoples is much higher than that of non-Indigenous Australians (ABS, 2013).

- The suicide rate for Indigenous males and females is twice that for non-Indigenous males and females.
- For Indigenous males aged 25–29 years, the death by suicide rate was four times that for non-Indigenous males — that is, 90.8 deaths per 100 000 people.
- For Indigenous females aged 20–24 years, the suicide death rate was five times that for non-Indigenous females — that is, 21.8 per 100 000 people.
- On average, there are 100 Aboriginal and Torres Strait Islander suicides recorded annually (Commonwealth of Australia, 2013b).

This trend is of great concern to health professionals, health services, governments and communities. The Australian government is committed to reducing suicide rates within Aboriginal and Torres Strait Islander communities through increased resourcing and suicide prevention activities that are specific to these communities. In May 2013, the Commonwealth Government released the first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, supported by $17.8 million over four years from 2012–13 to 2016–17 (Australian Government, 2013b). The Strategy identifies six broad action areas, which are:

- building strengths and capacity in Aboriginal and Torres Strait Islander communities
- building strengths and resilience in individuals and families
- targeted suicide prevention services
- coordination approaches to prevention
- building the evidence base and disseminating information
- standards and quality in suicide prevention (Commonwealth of Australia, 2013b).

Methods of self-harm

From a clinical perspective, injuries sustained from self-harming behaviours may be minor, moderate, serious or potentially life threatening. Self-harming behaviours include poisoning by drugs, poisoning by other methods (including alcohol, gases and vapours, and motor vehicle exhaust), hanging, strangulation and suffocation, drowning and submersion behaviours, firearm presentations, contact with sharp objects, and falls and jumping from a high place. Other causes that are not separately identified by the ABS include explosives, smoke/fire/flames, blunt objects, jumping or lying before a moving object, crashing of a motor vehicle, and other unspecified means.

As can be seen in table 8.2, hanging is the most common method of suicide for both genders and it accounts for more than half of all suicide deaths. Intentional hanging has contributed to the largest proportion of both male and female deaths by suicide for more than a decade. For males, poisoning by a non-drug method has been the second highest cause of suicide death every consecutive year since 1999, closely followed by poisoning by drugs. For females, the second leading cause of suicide death during this time frame is attributed every year to poisoning by drugs. The third leading method of suicide over the past decade for females has consistently been identified as 'poisoning by other' (ABS, 2013).

TABLE 8.2 Methods of self-harm leading to death for the year 2011, by gender

	Males		Females		Total	
Method	**%**	**number**	**%**	**number**	**%**	**number**
Poisoning by drugs	6.8	(154)	6.3	(144)	13.1	(298)
Poisoning by other	7.7	(175)	2.0	(45)	9.7	(220)
Hanging, strangulation, suffocation	44.5	(1012)	11.5	(261)	56	(1273)
Firearms	5.7	(130)	0.2	(5)	5.9	(135)
Contact with sharp object	2.2	(49)	0.6	(13)	2.7	(62)
Drowning and submersion	1.5	(35)	0.6	(14)	2.2	(49)
Falls	3.1	(71)	1.45	(33)	4.6	(104)
Not specified from the following: explosives, smoke/fire/flames, blunt objects, jumping or lying before a moving object, crashing car and other unspecified means.	4.4	(101)	1.4	(31)	5.8	(132)
Total gender distribution	76	(1727)	24	(546)	100	(2273)

Source: ABS (2013)

The methods by which people self-harm are significant to health professionals because they affect whether or not the person presents to a health service for assistance. For example, health professionals who work in intensive care units will often have to care for or treat a person who has deliberately taken an overdose of medication. Likewise, people who use more violent or high-impact methods, such as those that involve vehicles, weapons or hanging, may require critical care in the first instance, then long-term rehabilitative care. It is also important to identify the preferred method of the person with self-harming behaviours, as this will impact on their level of risk.

'Causes' of self-harming behaviour

According to the Australian governm0ent (2013), the causes of suicide and self-harming behaviours appear to be a complex mix of:

- adverse life events
- mental and physical ill-health
- social and geographical isolation
- cultural and family background
- socio-economic disadvantage
- genetic makeup
- the extent of support of family and friends
- the ability of a person to manage life events and bounce back from adversity.

In short, it would seem that there is no single cause of self-harm or suicide.

Although it is important that health professionals work within a framework of person-centred care that will assess each person as an individual and according to that person's own unique set of circumstances, it can also be helpful to identify general trends. These trends are called **predisposing causes**, **precipitating influences** and **perpetuating factors**.

Predisposing causes are the factors that render the person liable or more prone to a particular behaviour. They are usually a part of the person's background or previous experiences, and so cannot be changed. For example, past childhood sexual assault is a common predisposing factor in people who self-harm (Cashmore & Shackel, 2013). Even so, the way in which the person responds to these predisposing causes can be changed or managed. Precipitating influences are the catalysts of the behaviour. They are not the underlying causes, but rather the influences or triggers that elicit or provoke the behaviour in the 'here and now'. They are difficult to predict and will often just happen; however, like predisposing causes, they can usually be managed. Finally, perpetuating factors are those that promote or support a continuation of the behaviour. These are the factors that a person has the potential to both manage or control and change.

The major predisposing, precipitating and perpetuating factors related to self-harm and suicide are listed in table 8.3. They have been categorised according to the social, psychological and interpersonal aspects of a person's life. Mental health and physical risk factors are discussed further on in this section.

predisposing causes factors that render the person liable or more prone to the behaviour

precipitating influences the influences or triggers that elicit or provoke a behaviour in the present or 'here and now'

perpetuating factors the factors that prolong or support the continuation of a behaviour

TABLE 8.3 Predisposing, precipitating and perpetuating factors relating to self-harm and suicide

	Predisposing	Precipitating	Perpetuating
Social	Family history of self-harm and suicide Abuse as a child, particularly sexual abuse Homelessness Physical illness	Entering care Parents divorcing Bereavement Rape and sexual assault Unplanned/unwanted pregnancy Significant financial problems Lack of availability of specialist help for high-risk individuals	Being bullied Unresolved housing, employment and financial problems Ready availability of potentially lethal means of self-harm (e.g. over-the-counter analgesics)
Psychological	Family history of mental illness Reduced ability to regulate emotions Poor impulse control Low self-esteem	Mental illness (e.g. depression, psychosis) Excessive alcohol Illicit drug use	Intoxication with alcohol and/or illicit drugs Cognitive problems (e.g. negative thinking, thoughts of worthlessness, hopelessness about the future) Believing that their distress or problems are not being taken seriously by others
Interpersonal	Conflict between parents Lack of supportive, close relationship(s) Poor interpersonal problem solving	Perceived stressful situations involving others Relationship breakdown Argument/verbal conflict with partner or significant other	Unresolved conflict with parents Continuing negative experiences of care Ongoing difficulty in communicating feelings

Consideration of the different factors listed in table 8.3 can assist the health professional to understand how a person may reach the point of choosing self-harm or suicide as a way of dealing with a situation. For example, a person may belong to a family where there is a history of suicide; that is, suicide has been modelled to the person as a way of dealing with a difficult situation. This modelling predisposes the person to view suicide as an option when they feel unable to cope with a problem. The person in this example may also have poor impulse control — another factor that will predispose them to behaving in a certain way.

At the same time, these predisposing causes do not mean that the behaviour is inevitable. The person has choices that can enable him or her to manage these predisposing factors. However, to use the same example, one day the person consumes excessive amounts of alcohol. At the same time they have an argument with their partner. These two factors precipitate a crisis that leads to self-harming behaviour. Although the person does not die on this occasion, the perpetuating factors of the excessive drinking of alcohol and ongoing relationship problems perpetuate the issues involved. This may lead the person to make an even more serious attempt to self-harm sometime in the future — a choice they may not otherwise have made if the predisposing, precipitating and perpetuating factors had been different.

It is significant that a large proportion of people who self-harm are intoxicated with alcohol or a combination of alcohol and other substances. As is noted in chapter 11, substance misuse has been linked to an increased risk of psychosis and depression, accidents and injuries, overdose, impaired judgement and decision making, as well as increasing levels of impulsiveness (Collins & Lapsley, 2008). All of these factors have been linked to suicide. At the same time, and as has already been noted, self-harming behaviour is also the result of a complex interplay of many different interpersonal, psychological and social factors that trigger a particular reaction. Alcohol does not always play a role in self-harming behaviour.

Perhaps what is most important to remember is that the trigger to an episode of self-harm can often be a relatively minor or insignificant incident. The challenge is to identify ways of managing the situation so that the person's reactions to the trigger can be minimised and so the self-harming behaviour is less likely to occur.

Other risk factors

The risk of suicide is higher in people who have previously self-harmed (NICE, 2012; Elisei, Verdolini, & Anastasi, 2012). Certainly, it cannot be assumed that everyone who attempts suicide will make further attempts or even complete a suicide. Even so, prior suicidal behaviour is a major risk factor for completed suicide (SANE, 2013; Hayashi et al., 2012). Suicide risk assessment is discussed in more detail later in the chapter. At this point, risk is discussed as it relates to the major predisposing, precipitating and perpetuating factors, mental illness and chronic physical illness.

Mental illness

The experience of a mental illness increases the person's risk of suicide by up to seven times when compared to the general population (SANE, 2010). An extensive meta-analysis conducted in 2012 determined that the lifetime risk of suicide for a person diagnosed with major depression or bipolar disorder is 6–10 per cent, 10 times higher than in the non-psychiatric population (Cipriani, Hawton, Stockton, & Geddes, 2013). Nordentoft, Mortensen, and Pedersen (2011) found that, specifically, men admitted to psychiatric hospital with bipolar disorder and a history of deliberate self-harm represented the highest lifetime risk for suicide — at 26 per cent. In a study of over 1200 school-based adolescents aged 13–16 years, Kelleher and colleagues (2013) found a nearly 70-fold increase of odds of acute suicide attempts in a twelve month period between those adolescents who screened positive for psychotic symptoms at baseline screening and those who did not.

In 2010, the Australian government released a report titled *The hidden toll: Suicide in Australia* that reiterates the strong association of suicide and the following diagnoses:

- major depression
- bipolar disorder
- schizophrenia
- alcohol and other substance-use disorders
- borderline personality disorder
- behavioural disorders in children
- depression in adolescents (Commonwealth of Australia, 2010).

Gvion and Apter (2012) report that the diagnostic criteria for a psychiatric disorder, particularly major depression, substance use disorders, cluster B personality disorders and schizophrenia, is met in approximately 90 percent of all people who suicide. These links suggest that mental illness predisposes a person to suicide. Mental illness can also precipitate suicidal behaviour; for example, a major depressive episode or a psychotic episode could be a trigger that causes the person to react in a way they otherwise may not. Finally, mental illness may work to perpetuate certain behaviours; for example, alcohol and substance-use disorders may lead to ongoing behaviours that are risky.

Eating disorders

Anorexia nervosa (AN), Bulimia nervosa (BN), Binge-eating disorder (BED), Other specified feeding or eating disorder, Unspecified feeding disorder, Pica, Rumination disorder and Avoidant/restrictive food intake disorder (ARFID) are all classified under Feeding and eating disorders in the DSM-5. The first five disorders are most likely to be treated in adolescence and adulthood (American Psychiatric Association, 2013a). Eating disorders are primarily characterised by distorted or obsessive thoughts about food and a preoccupation with body shape and weight. Eating disorders are serious and potentially life threatening.

Eating disorders are mental illnesses, and are associated with significant psychological distress, major physical complications and increased mortality. One in 10 people with anorexia nervosa do not live more than 10 years after the onset of the disorder (Deloitte Access Economics, 2012). AN primarily affects girls and young women (American Psychiatric Association, 2013b). Arcelus, Mitchell, Wales and Nielsen (2011) conducted a meta-analysis study spanning 45 years and found that people with eating disorders have significantly elevated mortality rates of up to twelve times higher compared to the general population, with the highest rates occurring in those with AN. Furthermore, this study reported that 20 per cent of the deaths related to AN was attributable to suicide.

In 2012, the Butterfly Foundation commissioned Deloitte Access Economics to examine the social and economic costs of eating disorders in Australia. The report estimated that there were almost 914 000 people in Australia with an eating disorder — roughly 4 per cent of the population. From this group, 3 per cent had AN, 12 per cent were diagnosed with BN, 47 per cent had BED and 38 per cent were affected by other eating disorders. Females comprised around 64 per cent of the total sample (Deloitte Access Economics, 2012). However, a study involving a much smaller combined Hong Kong and Sydney outpatient eating disorders unit sample group of 16- to 50-year-old people diagnosed with AN or BN found that 98 per cent of participants were female, and almost 70 per cent of the entire cohort were single (Leung, Ma, & Russell, 2013). The National Eating Disorders Collaboration (NEDC) states that many people who have eating disorders also develop depression, anxiety disorders and substance abuse problems; and approximately 58 per cent of people with eating disorders present with personality disorders (2013).

Treatments for eating disorders are diverse and include specialist inpatient, specialist outpatient or routine general outpatient services. The recommended multidisciplinary approach may consist of nutritional supplementation; psychosocial interventions including interpersonal psychotherapy, motivational interviewing, and cognitive behaviour therapy; medication and family counselling and other somatic treatment as indicated (American Psychiatric Association, 2012). Treatment in Australia is most commonly provided in an outpatient setting, with some people requiring medical stabilisation in hospital (Deloitte Access Economics, 2012).

Hospitalisation usually occurs when a person's body mass index (BMI) falls below 14. The BMI is a simple and common tool used to estimate a person's total percentage of body fat, and assists in determining a person's healthy weight range. Based on height and weight, the BMI helps classify people as being underweight, in a healthy weight range, overweight or obese. This tool is used for both adults and children; however, in the childhood population, care needs to be taken as the BMI in children changes significantly with age and gender, and a specific BMI sex and age chart must be used (Royal Children's Hospital Melbourne, 2012). There are also some exceptions to the usefulness of BMI gauging body fat percentage for some groups in the population — for example, pregnant women, body builders, older people, people with disabilities and some specific cultural groups, and people who are very short or very tall (State Government of Victoria, 2013).

BMI is defined as weight in kilograms divided by the square of the person's height in metres ($\text{kg}/(\text{height (m)})^2$). For example, the BMI calculation for a person who is 1.71 m tall and weighs 72 kg is:

$$\frac{72}{(1.71 \times 1.71)} = \frac{72}{2.92} = 24.66.$$

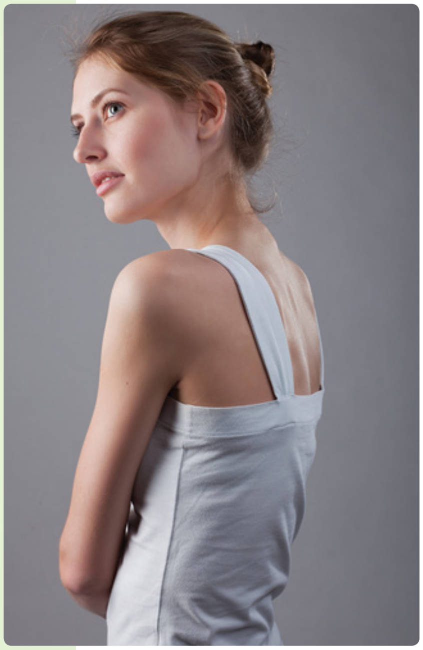
The following BMI ranges are used to determine whether a person's BMI value is considered healthy:

- <18.5 (underweight and possibly malnourished)
- 18.6–24.9 (healthy weight range (for young and middle-aged adults))
- 25.0–29.9 (overweight)
- >30 (obese).

However, a person's general health status may be of greater significance than being mildly overweight, if they are over 74 years of age. Some research has indicated a 22–26 BMI range as acceptable for this age group (State Government of Victoria, 2013).

THE BIG PICTURE

The NSW service plan for people with eating disorders



In September 2013, the NSW Minister for Health and the NSW Minister for Mental Health launched the NSW Service Plan for Eating Disorders 2013–2018. The plan is the first of its kind stating that eating disorders and the provision of a range of appropriate evidence-based treatments for them is now part of the core business of every local health district in New South Wales.

While NSW Local Health Districts and Networks (LHDs) have responsibility for assessing and delivering treatment to people with eating disorders, they are at different stages of readiness to provide more than short-term non-specialist responses, delivered through general services.

The NSW Service Plan for People with Eating Disorders establishes a clear service goal for LHD mental health services to establish models of care that support a significant degree of clinical expertise and self-sufficiency. The aim is to ensure timely access to developmentally appropriate services that respond to all levels of clinical need.

To support clinicians, the Service Plan includes a focus on strong governance, linkages and structures to support clinicians and service access across the state.

Over the past ten years, several treatment models delivered in various settings have been demonstrated to deliver significant rates of full remission from eating disorders. Other models have proven effective in supporting improvement or stabilisation of symptoms and bringing about improvements in quality of life even where recovery is significantly delayed. Services should be developmentally appropriate, flexible and reflect the difficulties associated with early engagement, ongoing treatment and fluctuations in risk. The range of eating disorder service options that are therefore needed across the health system can be conceptualised in four main delivery areas:

1. community-based interventions
2. specialist outpatient treatment
3. hospital-based interventions
4. tertiary specialist inpatient treatment.

The Service Plan focuses on:

1. prevention by working with the wider community to promote positive self-image and healthy behaviours
2. early recognition of risk behaviours and signs of physical and psychological distress related to eating and body image, as well as access to appropriate interventions
3. responses to different levels of need with evidence-based interventions to promote recovery
4. early access to acute intensive and integrated care (including psychological, psychiatric and medical treatments) in order to minimise harm.

Sources: Centre for Eating and Dieting Disorders (2013); NSW Ministry of Health (2013)

Physical illness

The suicide rate may be higher among people who experience specific ongoing or chronic physical illnesses. The prevalence of long-term physical conditions — for example, diabetes, heart conditions, chronic pain, severe headaches or migraines and epilepsy — were found to be higher in people living with a mental illness than Australia's general population, with the exception of cancer (Commonwealth of Australia, 2011). Furthermore, those who live with a long-term health condition are also at higher risk of developing depression (*beyondblue*, n.d.). Indeed, side effects experienced from prescribed psychotropic medication may also exacerbate physical ill-health and emotional distress (Suicide Prevention Australia, 2012). Webb and colleagues (2012) reported that after reviewing almost 900 suicide reports over eight years, they determined that the following physical illnesses were associated with an increased risk of suicide:

- coronary heart disease
- stroke
- cancer
- chronic obstructive pulmonary disease
- osteoporosis.

Additionally, Ceretta and colleagues (2012) found that there was an association between type 2 diabetes and depressive episodes, recurrent depressive episodes, dysthymia, psychotic symptoms and suicidal ideation. Of interest, recurrent depression and psychotic symptoms correlated with higher blood glucose levels. This research is particularly relevant, given that there is a strong bidirectional link between diabetes and depression (Chen, Chan, Chen, Ko, & Li, 2013). Other physical conditions where research has proven an association with increased risk of suicide include low levels of total serum cholesterol (Olié, Picot, Guillaume, Abbar, & Courtet, 2011), asthma in young people (Kuo et al., 2010), and traumatic brain injury in veterans (Bryan & Clemans, 2013). Furthermore, an online study by Australian authors concluded that people with a mental illness were significantly more likely to have a long-term illness than the general population, including obesity (Scott, Burke, Williams, Happell, Canoy, & Ronan, 2012).

Health professionals who provide services to people with a chronic physical illness need to be aware of these risk factors and work proactively to provide appropriate support. This is especially important for people with a long-term physical condition and also a mental illness, who account for 12 per cent of Australians aged 16–85 years (AIHW, 2012). This means that around one in nine Australians in this age group have both a mental illness and physical condition, and these people are statistically more likely to be female and in their early forties. People with a mental illness and physical condition have higher hospitalisation rates than those without comorbidity, and they are also more than 10 times as likely to report high levels of psychological distress compared with the cohorts with no mental disorder (AIHW, 2012).

It is also recommended that health professionals ensure each person who presents to a health service with self-harming behaviour is assessed and treated as an individual. This will enable the health professional to reach some understanding of the person's unique reasons for engaging in the self-harming behaviour.

Person-centred care is discussed in more detail later in the chapter. Prior to this discussion, consideration is given to the attitudes of people, communities and health professionals towards people who self-harm.

IN PRACTICE

Voluntary euthanasia

69-year-old Martin Burgess has terminal cancer and is going to Switzerland to use a euthanasia system.

The Northern Territory became the first jurisdiction to legalise voluntary euthanasia in the world. The controversial legislation, which came into force in July 1996, was revoked by the federal government just eight months later. Currently in Australia, suicide is legal, but assisting suicide is not legal and is a criminal offence in all States and Territories. Voluntary euthanasia is also illegal in Australia. This is in contrast to figures released in September 2013 by the ABC, declaring that 75 per cent of the almost 1.4 million Australians — who participated in an online poll leading into and just after the 2013 Federal election — supported legalising voluntary euthanasia for the terminally ill. The Northern Territory and Tasmania are both in the process of attempting to introduce legislation supporting assisted dying laws. To overcome this legal obstacle, every year a small number of Australians with incurable and intolerable physical conditions or unbearable pain travel overseas to kill themselves. Many more acquire and conceal chemical or mechanical devices that would assist them to kill themselves should they decide to end their lives.

Sources: Liddy (2013); World Federation of Right to Die Societies (n.d.)

Questions

1. Has the law kept up to date with bioethics, given that we have a growing ageing population who are living a prolonged life due to advances in medical technology, and who are likely to experience a deterioration in their physical status in their retirement years?
2. In the absence of cognitive distortions, should an individual with an incurable disease have the right to decide when they can end their own life, or should the morality of this be decided by politicians? Explain your reasons.
3. Many individuals in the community are compassionate toward animal welfare, and agree with the euthanisation of animals in distress. How are the principles underpinning legally-assisted suicide different to ‘putting animals to sleep’?
4. When people want to kill themselves, their mental state and competency to make decisions is usually questioned. How could this be proactively addressed?

Attitudes towards self-harm

The attitudes of health professionals often reflect the attitudes of the community. Many health professionals have negative attitudes or perceptions of people who self-harm because this behaviour is stigmatised by the wider community, and often viewed as 'self-destructive' or 'wrong'. At the same time, there is no doubt that providing care to a person who has self-harmed or attempted suicide can be emotionally challenging for health professionals. Self-harming behaviours can evoke strong personal feelings in people — with many of these feelings arising from the person's beliefs and values.

For example, health professionals may perceive self-harming behaviour as a form of 'attention-seeking' or 'manipulative' behaviour (National Collaborating Centre for Mental Health [NCCMH], UK, 2012). The health professional may think it is appropriate to distance themselves from the consumer to avoid reinforcing the behaviour. This is often demonstrated by limiting communication, keeping the person waiting, avoiding the person, or adopting a sarcastic or patronising manner (Commonwealth of Australia, 2010). Alternatively, some health professionals may feel unsure about what they should say or how they should provide care to someone who has self-harmed; for example, the health professional may think that talking about the self-harming behaviour will only encourage the person to want to do it again and thus avoid the topic. Indeed, researchers have identified that health professionals consistently feel a lack of confidence when it comes to caring for the person who has self-harmed and additionally, many health professionals perceive that they have not received the education or training they need and lack the skills to care for people who have self-harmed (NCCMH, UK, 2012; SANE, 2013). Negative attitudes from health professionals toward people presenting with eating disorders has also been reported. A literature review of twenty studies published over the past twenty-five years found that inexperienced health professionals held the strongest negative views towards those with eating disorders, with self-reported high levels of frustration, hopelessness, lack of competence, and worry. Of critical importance, negative staff attitudes towards individuals with eating disorders was associated with clinical lack of improvement (Thompson-Brenner, Satir, Franko, & Herzog, 2012).

UPON REFLECTION

Keeping people safe

All organisations have policies and procedures that determine how body and personal belonging searches should be conducted when a person states they are going to harm themselves. These policies and procedures are aligned with human rights legislation.

Questions

1. What search provisions and limitations are described within the policy of an organisation you have worked within or are familiar with?
2. Considering the consumer's perspective, how might you broach the issue of personal belonging searches with a consumer?
3. What legal considerations underpin your practice?

In particular, health professionals who work in the emergency context and deal on a day-to-day basis with people who are highly distressed because of accidental injury or unwanted illness or loss, often find it difficult to be non-judgemental towards people who self-harm. These health professionals may find themselves feeling resentful towards the person they perceive as a 'time-waster' — they may feel that if the person chose to hurt themselves, they do not deserve treatment and should be made to bear the consequences. Many of these views are also shared by the Australian public (National Mental Health Commission, 2013a). Indeed, Saunders and colleagues (2011) found that people who presented after abusing alcohol or drugs were the only group of patients who generated higher negative feelings in health professionals, than those who presented for self-harm. Of the 74 studies reviewed in this systematic review, overall, doctors were found to have the most negative attitudes of all health professionals towards those who have self-harmed.

The person who has self-harmed is often aware of these negative perceptions. Significantly, both health professionals and consumers report high levels of dissatisfaction with their experience of care when self-harm is involved (NCCMH, 2012). This dissatisfaction, in turn, can impact upon the consumer's willingness to receive timely and necessary treatment. Negative attitudes are also a motivating factor for people leaving a health context prematurely, before the necessary assessments, interventions or referrals have been completed. This is a significant issue in light of the fact that a person who has self-harmed only once may go on to suicide within a year (Large, Smith, Shamra, Nielssen, & Singh, 2011).

In summary, the negative attitudes of health professionals towards people who have self-harmed:

- reinforce stereotypical and misinformed beliefs about the nature of self-harm and those who exhibit self-harming behaviours
- maintain a spiral of negative feelings and expectations towards people who self-harm
- reduce the ability of the health professional to view the person as an individual in need of care and treatment for their own particular health issues
- interfere with the ability of health professionals to make effective judgements regarding the assessment of risk, identification of ongoing needs, and the implementation of care
- increase the likelihood of consumers feeling frustrated and dissatisfied with their care and treatment.

For these reasons, it is important that health professionals are aware of their personal values and feelings about people who self-harm and develop strategies to manage their reactions. These may include a guided practice reflection, such as that which is utilised in clinical supervision sessions and peer support groups. For example, the NCCMH (2012) reports that the literature provides good evidence that positive attitudinal changes occur post suicidal behaviour training for both health professionals and non-clinical staff, and both groups identified feeling more confident and capable of managing the needs of those who self harm. Negative attitudes towards consumers who self-harm will have a negative effect on both health professionals' ability to plan person-focused care and also the consumer's experience of seeking help and treatment. By challenging these attitudes, the health professional will be more able to respond in a considered way, rather than react to the person with self-harming behaviours, and thereby support the improvement of health outcomes.

National Suicide Prevention Strategy

In 1999, Australia launched the National Suicide Prevention Strategy (NSPS) in response to a growing body of evidence which reflected concern for the risk of suicidal behaviours developing across the whole-of-life span. Using government allocated funds for new and expanded mental health reforms, the NSPS provides the platform for Australia's national policy on suicide prevention with an emphasis on promotion, prevention and early intervention (Department of Health [DoH], 2013). The total funding attached to the NSPS was $2.2 billion over five years from 2011–16 (Australian Government, 2013).

In addition to the NSPS, the National Mental Health Commission (NMHC) was established as an independent body in 2012. The NMHC reports directly to the prime minister and is tasked with reporting and advising on the mental health needs of the community; increasing accountability and transparency in government, non-government and private mental health and suicide prevention sectors across the country; and giving mental health reform national prominence (National Mental Health Commission, 2103b; Australian Government, 2013). The fundamental aim of the NMHC is to support all people in Australia to achieve the best possible mental health and wellbeing, as individuals and as groups within the community. This broad aim is underpinned and further supported by the main objectives of the NSPS which are to (DoH, 2013):

- build individual resilience and the capacity for self-help
- improve community strength, resilience and capacity in suicide prevention
- provide targeted suicide prevention activities
- implement standards and quality in suicide prevention.
- take a coordinated approach to suicide prevention
- improve the evidence base and understanding of suicide prevention.

These objectives have a primary health care focus, with health promotion, suicide prevention and early intervention for early warning signs viewed as essential (see chapter 12).

The NSPS also has four key interrelated components:

1. Living Is For Everyone (LIFE) Framework (www.livingisforeveryone.com.au)
2. National Suicide Prevention Strategy Action Framework
3. National Suicide Prevention Program (NSPP)
4. mechanisms to promote alignment with and enhance state and territory suicide prevention activities.

Each of these four components has enabled the implementation of community-based projects that have impacted on issues related to suicide and self-harm at a local level across Australia and support population health infrastructure and research. These components appear to be contributing to a positive reduction in suicide — the suicide rate in Australia has decreased by 17 per cent over the past decade, from 12.7 to 10.5 deaths per 100 000 people (ABS, 2012).

Groups 'at risk'

The NSPS provides a population based, universal suicide prevention framework. Additionally, the NSPS targets a number of population groups that have been identified as being at particular risk of suicide. These include people in rural and remote areas, Indigenous peoples across Australia, men, young people, people who are bereaved by suicide and people who have previously attempted self-harm or suicide. In response to *The hidden toll* report, the Commonwealth Government introduced the Taking Action to Tackle Suicide (TATS) initiative, and provided funding of $292.4 million for the five-year period 2011–16. This package comprises four streams of activity to provide more services on the ground for those at risk of suicide, including all the aforementioned vulnerable groups. The four streams are:

- boosting frontline services to support those at risk
- taking action to prevent suicide and boost crisis intervention services
- providing more services and support for men
- promoting good mental health and resilience in young people (Commonwealth of Australia, 2013a).

People in rural and remote areas

People who live in rural and remote areas are at a higher risk of suicide than those who live in urban or metropolitan areas. This is due to the economic and financial hardship, social isolation and reduced access to health, community and support services in rural and remote areas. The regular but distressing cycles of droughts, floods, fire and cyclones that are an integral part of life in rural and remote areas are also contributing factors (Royal Australian and New Zealand College of Psychiatrists, 2009). Finally, people in rural areas are less likely to seek help than people in urban or metropolitan areas because of a fear of social stigma, lack of confidentiality or because seeking or accepting help is seen as 'a sign of weakness' (Commonwealth of Australia, 2010, p. 73). The government has established arrangements with telecommunication service providers to ensure that crisis calls made to the majority of crisis lines in Australia, are charged at the 'cost of a local call' from a landline, regardless of the caller's location (Commonwealth of Australia, 2010). For people living in a rural or remote area, this improves the affordability of contacting a telephone crisis centre in the absence of a face-to-face option, and addresses potential confidentiality issues. Ways and means of providing more effective care and treatment to people in rural and remote areas, including those with mental health issues, are discussed in chapter 4.

Indigenous Australians

Suicide rates for Indigenous peoples of Australia — in particular, youths in the 15–24 year age group — are four times higher than the general population. In their study on Koori youths living in Melbourne, Luke and colleagues (2013) found that approximately one quarter of the Indigenous people in the 12–26 year age group had made at least one suicide attempt in their lifetime, correlating with negative emotional, social, cultural and behavioural factors. From a rural and remote perspective, the Northern Territory has an alarming and disproportionately high Indigenous suicide cluster rate (Hanssens, 2011). As discussed in chapter 4, higher suicide rates in the Indigenous population is related to a number of factors. Indigenous people often live in poverty and have a lower socioeconomic status; poorer levels of education and employment; reduced access to social, community and health services; higher rates of domestic violence or abuse and alcohol and other drug abuse; and lower levels of health generally. In addition, many Indigenous people have been affected by the suicide of another family or community member, and trauma and grief issues are also ever-present within Indigenous communities.

As mentioned earlier in this chapter, in 2013 the Commonwealth Government released the first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy to address the self-harm and suicide rates of this cohort of the population (Commonwealth of Australia, 2013b). Further issues around suicide and self-harm and the programs that are being implemented by the Indigenous communities themselves to raise the social and emotional wellbeing of Indigenous people are discussed in detail in chapter 4.

Males

In 2011, nearly 80 per cent of people who took their own lives in Australia were male. As mentioned, the TATS package has a focus on developing and implementing more services and support for men. Specifically, $33.7 million funding has been provided to develop the three branches to this stream:

- expansion of the *beyondblue* National Workplace Program
- increased helpline capacity which targets men using online advertising across Facebook, LinkedIn, Google and other major web publishers
- targeted campaigns for high risk male groups on reducing depression and stigma (Commonwealth of Australia, 2013a).

The *beyondblue* Man Therapy website, www.mantherapy.org.au, specifically targets males and further supports these initiatives. Additionally, under the community prevention programs for high risk groups, a further $5.2 million has been provided to develop suicide prevention services targeting men in the building industry, through the Mates in Construction program (www.matesinconstruction.com.au). Many men make the decision to suicide impulsively and show few warning signs. For this reason, it is essential to respond quickly and effectively to those who seek help. Men of all ages and backgrounds can be at risk. Contributing factors include social isolation, unemployment, ill-health, old age, being part of the forensic system, work-related pressure, relationship breakdown, legal or financial problems, chronic illness or pain, suicide by a family member or close friend, substance-use disorders and mental illness. Significantly, many men do not recognise symptoms of emotional distress or may prefer to try to work things out for themselves so they don't appear 'weak'. The generally lower health status of men in Australia is now receiving much deserved attention as governments target the key areas that are in need of improvement.

Youth

Youth suicide appears to have declined as a proportion of total suicides over recent years. Even so, suicide is the leading cause of death for young Australians aged 15–34 years, claiming the lives of 321 young people aged 15–24 years in 2011 (ABS, 2012; ABS 2013). Although suicide is a tragedy at any age, youth suicide generates extreme levels of distress and loss in Australian communities. There are a number of organisations that are currently working hard to address the youth suicide rate in Australia, including Suicide Prevention Australia, Inspire Foundation, Youthbeyondblue, Principals Australia, Black Dog Institute, headspace, the Australian Institute for Suicide Research and Prevention, Carers Australia, Youth Focus, and Lifeline. The strategies of these organisations generally are to:

- remove structural barriers to youth wellbeing
- target risk factors and increase protective factors for suicide prevention
- involve young people in the design and implementation of youth suicide prevention programs

- increase research and access to online services
- focus on early intervention in youth mental illness
- reduce the stigma of asking for help
- provide gatekeeper training for adults
- include suicide prevention mechanisms in the school curriculum.

Again, the TATS package has quarantined $90.9 million for five years to implement programs to promote mental health and resilience in young people. The three-pronged approach for youth is to:

- expand the KidsMatter Primary initiative, for the Medicare Local system, with support from the Australian Psychological Society
- implement additional services for around 26 000 children who have or are at significant risk of developing a mental, emotional or childhood behavioural disorder
- develop a 'virtual clinic' as a mental health and counselling service to provide online (via the Mindspot website, www.mindspot.org.au) and telephone (phone: 1800 614 434) cognitive behavioural therapy counselling to people with mild to moderate depression. Access is free of charge and available with or without referral from a health professional. Health professionals are encouraged to familiarise themselves with the excellent work being done in this area by accessing the Mindspot website and other relevant websites (e.g. http://suicidepreventionaust.org).

IN PRACTICE

Reporting self-harm

Danielle is an only child. Both her parents work in professional roles: her father is an accountant, and her mother works as a lawyer. Both parents are high achievers, and rarely work less than ten hours per day, six days per week. Danielle is a bright and bubbly 17-year-old, and she is a well-liked Year 11 student at the nearby private school. Danielle has had a part-time job for the past two years, working most weekends in a kitchen shop. She saved enough money to buy a little car, and now drives herself to work and school. Some months ago, Danielle broke up with Ryder, her boyfriend of five months. Since that time, Danielle has found it difficult to manage her feelings, and finds it hard to concentrate at school. Her academic work has steadily declined over the past term. She is often tearful and irritable, and has begun taking regular doses of paracetamol for her stress headaches. Sometimes she takes large doses of paracetamol when she doesn't have a headache. She hasn't bothered to tell her parents about her problems because she knows how busy they are.

On her way to school one day, Danielle failed to give way to an oncoming car at a roundabout. A low-speed collision occurred, and Danielle was transported to hospital via ambulance with a suspected broken arm. Danielle is overwhelmed by the noise and the lights of the hospital, and sits quietly in a corner waiting for her parents to arrive. You recognise Danielle from the kitchen shop that you often visit, and so you approach her. You strike up a conversation, and during the conversation with her, you notice a large number of scratches and cut marks on both of her arms. This is especially evident where her jumper has been pulled high above her elbow. A few of the scars look old, but many appear to be recent wounds, and some look like they may have been significant injuries.

As a health professional, you are aware that you have a professional obligation and responsibility, underpinned by a legislative basis, to protect children and young people aged 0 to 18 years from any form of child abuse or neglect. You do not have to prove that abuse or neglect has occurred, only form a reasonable belief that it has occurred. Danielle starts to cry because you're being so nice to her, and she tells you that she has been feeling lousy lately and her boyfriend left her. She also says that she's fat and ugly, her parents don't have any time for her, and she feels like hurting herself with a razor blade. That's what she usually does when she feels emotionally overwhelmed. At that point, Danielle is called to the triage desk, and you part ways. You're bothered by this conversation, and you speak to a more senior colleague, and relay the story. Your colleague suggests that perhaps you need to make a Child Protection Report.

Questions

1. What framework do you use to underpin your clinical decision about what to do in this situation?
2. What are the legal considerations that you need to factor in your decision?
3. Explain the ethical issues that need to be addressed in this situation.
4. What other options could you employ to manage this situation?

People bereaved by suicide

Individuals and families bereaved by suicide are at higher risk of suicide themselves. This is because people bereaved by suicide often experience a very complicated form of grief. The sudden shock and denial of losing someone through a preventable event often generates a feeling of guilt and plays on a person's mind through unanswered questions such as 'Why?' and 'What could I have done?' The person bereaved by suicide may also experience anger, numbness, searching, self-blame, despair, shame, anxiety, depression, or a sense of rejection, or be traumatised following the discovery of the person who has taken their own life (South Australia. Attorney-General's Dept., 2011). The unique needs of people bereaved by suicide, also sometimes referred to as **suicide survivors** (Andriessen & Krysinska, 2012), has been addressed as a major component of the second stream of the TATS program, in community prevention activities for high risk groups. Ways of supporting the person who has been bereaved by suicide are discussed later in this chapter.

suicide survivor someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person

People who have self-harmed or attempted suicide

A significant number of people who complete a suicide have previously attempted suicide or self-harmed (NICE, 2012; Elisei, Verdolini, & Anastasi, 2012). It cannot be assumed that everyone who attempts suicide will make further attempts at or complete a suicide in the future; however, prior suicidal behaviour is a major risk for completed suicide (SANE, 2013; Hayashi et al., 2012).

Identifying those who are at risk presents some challenges. For example, self-cutting is considered common in adolescents (Rissanen et al., 2013) and if a person of any age chooses not to inform the health professional that their injury was due to self-harm, they will not be identified as 'at risk' and so will not be followed up (NICE, 2012; Elisei, Verdolini, & Anastasi, 2012; SANE, 2013). In a Finnish study involving over 440 teenagers who self-cut, 67 per cent of these teenagers cut on their upper arms only. The study found that teenagers who also cut elsewhere on their bodies presented with higher rates of psychopathology including suicidal ideation, and were predominantly female (Laukkanen, Rissanen, Tolmunen, & Hintikka, 2013). For this reason, it is important for health professionals to be aware of this risk and ensure that they talk to people who have unexplained injuries. Health professionals are encouraged to read more about the NSPS and also about the population groups who are at risk of suicide on the Department of Health website, www.health.gov.au. There are also many opportunities to be involved in one or more of the programs or access information from organisations that have been developed as part of the NSPS. For example, Suicide Prevention Australia (http://suicidepreventionaust.org) provides online information about suicide — including information about the resources and supports for those who have been affected by suicide across Australia.

In addition to the group described above, a number of other groups have been identified as at risk of suicide. According to the *The hidden toll* report, older people are also at risk of suicide. Likewise, people who are lesbian, gay, bisexual, transgender or intersex are more likely to suicide than people who are heterosexual. These two groups are now discussed.

Older people in the community

In 2011, the highest number of age specific suicide deaths per population for both men and women in Australia occurred in the aged 85-plus age group (ABS, 2013). There are a number of factors that contribute to suicide in older people, including declining physical health and chronic pain, economic dependency, lack of social support and social isolation, and evolving grief, loneliness and depression (Suicide Prevention Australia, 2012). Despite a reduction in overall suicide rates, men aged 80 years and over remain a high-risk group and suicide statistics for men aged over 85 years reached a national peak in 2011. There is also some concern that the rates of suicide for older men are under-reported because of stigma issues; for example, medical officers are more likely to record a physical condition as the cause of death of older people, rather than suicide.

The needs of older people generally are often overlooked by health professionals. Older people are stigmatised and the provision of health care to older people is often viewed as somehow less important or glamorous than the provision of care to younger people. There is also a lack of choices for older people in relation to end-of-life care (Commonwealth of Australia, 2010).

Lesbian, gay, bisexual, transgender and intersex groups

Another group often overlooked in the community, with a high risk of suicide, is gay, lesbian, bisexual, transgender and intersex (LGBTI) people (Living is for Everyone [LIFE], 2012; *beyondblue*, 2011). This collective of community members may also include people who self-identify as queer and questioning (LIFE, 2012). The complex and multifaceted reasons for this identified increased risk of suicide can be largely related to the effects of negative health determinants such as social marginalisation and stigma (Dysart-Gale, 2010; Fish, 2010; Hatzenbuehler, 2011). Effects of the social marginalisation include an acute sense of isolation, worthlessness and hopelessness, poor social support structures, internalised **homophobia** and **transphobia**, avoidance of health services and poor mental health outcomes — including a higher incidence of depression, anxiety disorders and psychological distress (Rosenstreich, 2011). According to the Mental Health Council of Australia (2009) most suicide attempts within this group occur while people are 'coming to terms' (p. 25) with their sexual orientation and identity.

It is difficult to establish accurate LGBTI suicide rates because, firstly, LGBTI people are treated as one group in mental health and suicide research and, secondly, there is limited evidence regarding gender identity and sexuality collected at the time of death (additionally, each diverse subgroup is not clearly reported). This may be the result of deliberate or unintentional omission by partners, family members and friends or due to the fact that questions about gender and/or sexual identity may not be asked by investigating authorities. Thus, it is likely that suicides for LGBTI people are under-reported. A number of submissions to the Senate Inquiry into suicide in Australia highlighted a lack of community and health services and resources for LGBTI people, particularly for those living in rural and remote areas; and for older LGBTI Australians, particularly those entering care facilities (Commonwealth of Australia, 2010). In response to this report, the government provided funding to the National LGBTI Health Alliance for strategic mental health and suicide prevention activities under the community prevention activities program. Further funding of $1.1 million was also provided to the National LGBTI Health Alliance for the MindOUT! national mental health and suicide prevention project, available at www.lgbthealth.org.au/mindout (Commonwealth of Australia, 2013a). It is clear that further research into this situation (including subgroups), inclusive of developing policy and evidence-based practice to support the needs of LGBTI members of the Australian community, is needed in order to enable social equity and inform the development of inclusive support and health services.

homophobia an individual's or society's misunderstanding, fear, ignorance of, or prejudice against gay, lesbian and/or bisexual people

transphobia an individual's or society's misunderstanding, fear, ignorance of, or prejudice against transgender people

Assessment of risk

All people who are seen by a health professional in health services across Australia after an episode of self-harm must receive a comprehensive **suicide risk assessment** or **clinical risk assessment** from a mental health professional (headspace, 2013; Department of Health, Victoria, 2010; Government of South Australia, 2012). A suicide risk assessment is a process by which health professionals gauge or estimate a person's short-term, medium-term and long-term risk for suicide. The assessment will include the development of interventions to assure the person's safety, address the major issues and promote better health for the person.

Clinical risk assessment is a formal process by which health professionals gauge or estimate a person's short-term, medium-term and long-term risk for a variety of issues, including but not limited to self-harm, self-neglect, aggression or violence, vulnerability/exploitation, poor adherence to treatment, child protection issues, domestic violence, homelessness, loss of income, and so on. Each or any of these factors can impact on a person's level of health, and also increase their risk of suicide and self-harm.

suicide risk assessment the formal process by which a health professional gauges or estimates a person's short-term, medium-term and long-term risk for suicide

clinical risk assessment the formal process by which health professionals gauge or estimate risk for a person in relation to factors such as self-harm, self-neglect, violence or aggression, vulnerability, poor adherence to treatment and homelessness

All health professionals are required to undertake risk assessments of consumers. The type of risk assessment undertaken will depend upon the nature of the risk that is being assessed. Significantly, however, many health professionals state that they lack the confidence and skills to undertake risk assessments, and training in this area is considered inadequate (Vail, Adams, Gilbert, Nettleingham, & Buckingham, 2012; Schmitz et al., 2012). A number of Australian states and territories have developed comprehensive training packages and guides for health professionals in light of the call by the Commonwealth government for a 'documented system [in all states and territories] for prioritising referrals according to risk, urgency, distress, dysfunction and disability with timely advice and/or response to all those referred, at the time of assessment' (Commonwealth of Australia, 2010, p. 23).

The 'why' of risk assessment

Suicide and clinical risk assessments are a major component of the comprehensive biopsychosocial care that is provided to all consumers. While specialist mental health professionals will undertake a more detailed or specific risk assessment for people who have been identified as a high risk, health professionals in any setting will be required to undertake risk assessments to:

- clarify whether the person is at risk of self-harm or suicide in the short term
- identify if other people (e.g. staff or community members) are at risk of harm
- identify risk factors that will inform the person's immediate care and treatment
- ascertain whether a more detailed suicide risk assessment is indicated.

Risk assessments such as these are quite preliminary in nature and allow health professionals to identify the priorities for immediate intervention, manage any risk issues or behaviours that are being displayed at the time, and develop ongoing care.

Health professionals who work in emergency settings may also be required to undertake a suicide risk assessment because a significant number of individuals who present to a health service for assistance may not be prepared to wait or may refuse to be assessed for risk of suicide or self-harm by a mental health professional (Department of Health, Victoria, 2010; Department of Health, 2012). Reasons for leaving may include excessive waiting times, stigma, embarrassment, and the negative attitudes of staff. In instances such as these, the initial or preliminary risk assessment will be used to determine whether or not the police should be notified to find the person and bring them back to the health service for treatment.

The 'who' of risk assessment

Many health professionals are uncertain as to whom they need to assess for risk. The most obvious answer is: if a person has expressed suicidal ideation, has attempted suicide, or has self-harmed, a suicide risk assessment is required.

Other people who may require a risk assessment are those who fall into the groups most at risk. A number of these groups have been already identified in a previous section. In addition, figure 8.1 lists the factors, situations and symptoms associated with an increased risk of suicide and self-harm. This table can be used by the health professional to help identify those people who may be in need of a risk assessment. In general, if the health professional is unsure, they are advised to go ahead with a risk assessment.

Even if the person is found to have a low risk, the assessment will have provided an opportunity for the health professional to engage with the person and discuss other health issues.

Individual
- Single, divorced, widowed or separated
- Access to potentially lethal means of harm/further harm (e.g. large amounts of medication, firearms)
- Physical illness — especially chronic, painful, debilitating and terminal conditions
- Family history of suicide
- Bereavement — especially loss of spouse/partner

Social
- Living alone
- Social isolation
- Prisoners and those in custody

Mental health related
- Depression
- Psychotic illness
- Personality disorders
- Substance misuse
- History of self-harm
- Depressed thinking
- Suicidal ideas
- Suicidal plans
- Expressions of hopelessness
- Extreme variations in mood (labile mood) within relatively short periods of time ('mood swings')
- Displays of hostility and aggression
- Perceptual disturbance — particularly auditory hallucinations instructing the person to harm themselves

High-risk situations
- Recent major stress (e.g. relationship breakdown, loss of employment, disruption to usual living arrangements)
- Recent self-harm
- Currently receiving psychiatric inpatient care — especially if on 'leave' from a mental health unit
- Recent discharge from psychiatric inpatient care — especially during the first week following discharge
- Anniversary of previously stressful or traumatic life event(s)
- Ready access to potentially lethal means

Indications of suicide risk following an episode of self-harm
- Evidence of pre-planning
- Well thought through and considered decision to choose a violent method
- Fully expects or expected to die
- Took steps to avoid discovery or intervention

Lack of appropriate ongoing care
- Consciously isolated at the time of the act
- Suicide note
- Regret at survival

FIGURE 8.1 Factors, situations and symptoms associated with increased risk of suicide and self-harm

The 'how' of risk assessment

It is crucial the health professional considers how to approach risk assessments. The decisions made will be informed by:

- the type of self-harming behaviour with which the person presents
- the attitude and behaviour of the person on arrival or admission; for example, the degree of cooperativeness, level of consciousness, degree of intoxication
- the information available from other sources; for example, written information brought in by the person, information from partner, friends or significant others, and access to the person's medical and general health history.

Information that will inform risk assessment can be obtained through observation, the use of questions and, as previously noted, reference to sources of written information from significant others.

Reliance on a risk assessment tool does not substitute the need for therapeutic engagement with people in order to determine a person's mental state (SANE, 2013). When using a suicide risk assessment tool, it is necessary to consider the assessment in the context of the individual, their personal circumstances, the predisposing and precipitating factors that have led them to act or to think about acting, their current thoughts and feelings, and whether the person has any mental health issues. It is important not to avoid direct questions concerning the person's thoughts or plans regarding further self-harm. In fact, direct questioning allows the risk to be assessed and managed more effectively. In addition, the person may experience relief that previously distressing feelings can be discussed openly and honestly.

Questions the health professional may find helpful to use are provided in figure 8.2. In addition, many health professionals make use of the variety of risk assessment tools that are available from health services across Australia or on the web.

- What things have led up to you harming yourself?
- What did you want to happen, or what did you think would happen, as a result of you harming yourself?
- Do you still have any thoughts or plans to harm yourself?
- How likely do you think you are to act on these thoughts? (It is often helpful to suggest that the person uses a 0–10 scale to rate the likelihood of further self-harm; that is, 0 = will definitely not harm myself; 10 = will definitely harm myself.)
- How do you feel now about having harmed yourself?
- Do you have anything on you right now that you could use to harm yourself with?

FIGURE 8.2 Possible questions to ask following self-harm or a suicide attempt

Risk assessment tools

Currently, some states and territories have standardised assessment tools for health professionals to use across all settings. Health professionals are advised to familiarise themselves with the risk assessment policy, procedures and forms that are used in their place of work. The suicide risk assessment and clinical risk assessment tools that are available across Australia are not identical, but will almost always contain the same elements, such as those identified in figure 8.3. Like all assessment tools, these instruments are meant to provide only a gauge or estimation of the person's risk of suicide. As noted, these tools can be used by non-specialist health professionals to strike up a conversation with the person, rather than to develop a diagnosis.

FIGURE 8.3 Overview of the risk assessment process

Assessment categories		
1. Background history and general observations	**Yes**	**No**
• Does the person pose an immediate risk to self, you or others?		
• Does the person have any *immediate* (i.e. within the next few minutes or hours) plans to harm self or others?		
• Is the person aggressive and/or threatening?		
• Is there any suggestion or does it appear likely that the person may try to abscond?		
• Does the person have a history of self-harm?		
• Does the person have a history of mental health problems or psychiatric illness?		
If yes to any of the above, record details below:		
2. Appearance and behaviour	**Yes**	**No**
• Is the person obviously distressed, markedly anxious or highly aroused?		
• Is the person behaving inappropriately to the situation?		
• Is the person quiet and withdrawn?		
• Is the person inattentive and uncooperative?		
If yes to any of the above, record details below:		
3. Issues to be explored through brief questioning		
• Why is the person presenting now? What recent event(s) precipitated or triggered this presentation?		
• What is the person's level of social support (i.e. partner/significant other, family members, friends)?		

(continued)

FIGURE 8.3 *(continued)*

4. Suicide risk screen — greater number of positive responses suggests greater level of overall risk

	Yes	No	Don't know		Yes	No	Don't know
Previous self-harm	☐	☐	☐	Family history of suicide	☐	☐	☐
Previous use of violent methods	☐	☐	☐	Unemployed/retired	☐	☐	☐
Suicide plan/expressed intent	☐	☐	☐	Male gender	☐	☐	☐
Current suicidal thoughts/ideation	☐	☐	☐	Separated/widowed/divorced	☐	☐	☐
Hopelessness/helplessness	☐	☐	☐	Lack of social support	☐	☐	☐
Depression	☐	☐	☐	Family concerned about risk	☐	☐	☐
Evidence of psychosis	☐	☐	☐	Disengaged from services	☐	☐	☐
Alcohol and/or drug misuse	☐	☐	☐	Poor adherence to psychiatric treatment	☐	☐	☐
Chronic physical illness/pain	☐	☐	☐				
				Access to lethal means of harm	☐	☐	☐

Management or action plan and outcomes following initial risk screen:
Describe all actions and interventions following assessment. Include details of referral to other team(s), telephone calls/advice and discharge/transfer or follow-up plans.

Two of the most important things to note about any suicide risk assessment are, firstly, the process should not be undertaken by a health professional in isolation; and secondly, it is a dynamic process. Assessment of people at risk of suicide is a complex and demanding task. Wherever possible, health professionals need to discuss findings with the multidisciplinary team. Decisions made about the consumer must be collaborative — involving the consumer, partner or carer, and other health professionals, including a mental health specialist.

In addition, suicide risk assessments, and also clinical risk assessments, are not static. Indeed, the 'changeability' of risk status, especially in the period immediately after an experience of DSH or a suicide attempt, needs to be identified. If a person seems ambivalent and there is a level of **high changeability** in the way they present themselves to the health professional, the health professional needs to recommend reassessment (e.g. every eight hours) and closely monitor the person. Various factors will influence the person's level of risk and for this reason it is helpful to consider such an assessment in relation to the short-, medium- and long-term risk. These different levels of risk are considered in turn as follows.

high changeability
a state of being that is demonstrated by a person who is quite ambivalent about suicide or self-harm

Short-term risk

The most important factors in assessing a person's imminent suicide risk arise from their current personal or lived experience. Factors of concern include:

- 'at risk' mental state; for example, feelings of hopelessness, despair, agitation, shame, guilt, anger, psychosis, or psychotic thought processes (see chapter 9)

- recent interpersonal crisis, especially rejection or humiliation
- recent suicide attempt
- recent major loss, trauma, or anniversary of loss or trauma
- alcohol intoxication
- drug withdrawal state
- chronic pain or illness
- financial difficulties, unemployment
- impending legal prosecution and/or child custody issues
- cultural or religious conflicts
- lack of social support network
- unwillingness to accept help
- difficulty accessing help due to language barriers and stigma for some culturally and linguistically diverse groups (Department of Health, Victoria, 2010; South Australia. Attorney-General's Dept., 2011).

This information is best obtained by directly questioning the person and encouraging them to be as specific as possible about the likelihood of acting on their suicidal thoughts. Health professionals also need to be familiar with the criteria for using mental health legislation to protect the person or others from further harm. Information about mental health legislation, such as Australian state and territory Mental Health Acts, can be found in chapter 3.

Medium-term risk assessment

Some people retain suicidal thoughts, but deny any plans to act on them in the short term. These people may or may not be concurrently managing an ongoing mental illness that requires specialist mental health assessment or treatment. Some people may also describe ongoing suicidal thoughts, but, despite this, may have no plans to act on them in the short term. For a number of people, self-harm may be the culmination of a long period of distressing symptoms and difficulties. To manage and reduce the associated risks, it is important to ensure that people with medium-term risks are referred to a mental health service to receive appropriate and ongoing specialist care.

Long-term risk assessment

Statistically, all individuals who have self-harmed have an increased risk of suicide in the longer term. For a number of people, the act of self-harm is 'a one-off', an out-of-character action that they find difficult to explain and does not reflect how he or she is currently thinking and feeling. However, many of these individuals may also have longstanding difficulties with communication or in maintaining effective interpersonal relationships that predispose them to the risk of further self-harm or suicide in the long term. Again, to manage and reduce the associated risks, it is important to ensure people with long-term risks are referred to their general practitioner (GP) for regular checkups or suitable community services to provide ongoing support.

UPON REFLECTION

Caring for long-term high-risk consumers

A small number of consumers are at a high risk of suiciding over a long period of time. These consumers are viewed as 'long-term high-risk' consumers. Constraining them for months, even years, under mental health legislation in an acute mental health unit is not an option. A large percentage of people who make repeated suicide gestures have a borderline personality disorder diagnosis.

Questions

1. How do you think that a person who is assessed as having a long-term high-risk of suicide could be managed in the community?
2. When caring for a person who has a long-term high risk of suicide, what factors does a health professional need to be mindful of that may increase immediate risk?
3. How would you clinically determine the importance of protective factors versus the intensity of perpetuating risk factors for people who are at long-term high risk of suicide?

Caring for the person who has self-harmed

Just as the causes of self-harm and suicide are complex and multi-factorial, so is the provision of care to those with self-harming or suicidal behaviours. The decisions that are negotiated around the care and treatment provided will depend upon the level of risk of the person at the time of assessment, including the person's risk and protective factors; and the 'here and now' situation of the person.

In the first instance, the health professional who is providing care to a person who has self-harmed or attempted suicide needs to follow a number of important steps:

- treat any urgent complications of the self-harm or attempted suicide to prevent or minimise the risk of future self-harm, severity of injury, or disability or death
- undertake an initial assessment of risk as part of the comprehensive biopsychosocial assessment
- provide a safe environment
- consult with specialist mental health professionals
- in consultation with the consumer, their partner, carer or family members, and also the mental health professional, develop an immediate management plan
- in consultation with the consumer, their partner, carer or family members, and also the mental health professional, develop a Recovery plan
- refer the person on for specialist treatment
- follow up and check that the person is receiving this specialist treatment.

Each of these steps is framed by person-centred approaches. This means that the health professional must first and foremost engage with and listen to the person (Michel et al., n.d.). The importance of the therapeutic communication relationship is discussed in chapters 2, 5 and 6. Additional suggestions that relate specifically to the person who has self-harmed are outlined as follows.

Effective interpersonal communication

Many people will feel ashamed, guilty or embarrassed because they have self-harmed and it is important that health professionals are aware of this distress, accept what has happened without judgement and provide a degree of emotional support by validating the person's feelings and displaying empathy (Government of South Australia, 2012). This will involve the use of effective interpersonal communication. Strategies include the following.

- Adopt a non-judgemental and non-critical attitude. Overt or implied criticism usually only reinforces the person's sense of guilt and shame.
- Observe and note details of the person's emotional state and behaviour, in particular whether they are angry, impulsive, irritable, withdrawn or tearful.
- Use active listening techniques. This will assist in engaging the person in the processes of assessment and care.
- Use minimal responses. Reflecting the content and emotion of the person's story back to them will demonstrate attentive listening.
- Use open questions as a means of gaining a more detailed understanding of the person's emotional state; for example, 'How are you feeling right at this moment?', 'What would help you deal with your current difficulties?'
- Acknowledge the person's underlying distress by using empathic responses such as 'I can see you are very upset', 'You look distressed', or 'You must have found it very hard coping with these feelings of depression'.
- Avoid the use of overly reassuring or patronising statements, such as promising things that may be difficult to deliver (e.g. 'Everything will be all right', 'Don't you worry; we'll sort out all your problems').

Health professionals are also advised to stay in the present or 'here and now' with the person as much as possible, rather than going over past problems or old ground. Discussions about old problems are best left for specialist mental health professionals. On occasion, and once engagement has been achieved, the health professional may decide to make the person aware of the inconsistencies and discrepancies in their thinking, but this must be undertaken in a way that does not arouse antagonism or defensiveness.

Finally, if there comes a time when the health professional does not know what to say or how to say it, the use of empathy is always productive. Health professionals cannot 'fix' or 'cure' a person's self-harming behaviour overnight. However, by imagining what it could be like to be in the other person's shoes and sharing these thoughts with the person, the health professional will be supporting the person emotionally. It is with such support that a person can often find hope enough to move on slowly but surely into the future.

IN PRACTICE

Why do people decide to suicide?

Sometimes living can become very painful and problems can seem overwhelming. At some point, many people think about suicide, but do not make a plan or act on it. However, for others, the thought of suicide might begin to seem like a real alternative to a problem or situation that appears hopeless or as if there is no solution.

Situations that might contribute to a feeling of hopelessness include:

- relationship break-ups
- family problems
- sexual, physical or mental abuse
- drug or alcohol problems
- mental illness, including schizophrenia, bipolar and depression
- major loss and grief such as a death
- school, university or work problems
- unemployment or being unemployed for a long time
- feeling like you don't belong anywhere
- any problem that you can't see a solution for and is ongoing.

Is deliberate self-harm the same as wanting to suicide?

Wanting to end your life, or suicide, is not necessarily the same as deliberate self-harm. Deliberate self-harm, such as cutting or burning oneself, is often used to cope with difficult or painful feelings. When someone can not express in words or make sense of their feelings or emotions, they may choose to hurt themselves physically.

However, most people who engage in deliberate self-harm do not wish to die.

Source: Reach Out, http://au.reachout.com

Questions

1 How important is it to differentiate between feelings of suicide and self-harm?
2 Choose one of the situations listed above that contribute to a feeling of hopelessness. What could be some predisposing, precipitating and perpetuating factors? What could be some protective factors?

Managing short-term high risk

A small number of individuals may retain suicidal thoughts and plans to such an extent that they need hospitalisation. When this occurs, health professionals need to follow certain steps.

Firstly, if the person describes ongoing suicidal thoughts, health professionals need to ask the person directly if they have any means of harming themselves, such as medication or sharp objects. If this is the case, the person needs to hand these over for safe keeping while they are in the health setting. Health professionals are encouraged to refer to the policies and procedures of their workplace for guidance on the removal of personal items and/or body searches.

Observation

The person then needs to be cared for in an area that allows for easy observation and regular eye contact by health professionals. However, a balance must be struck between ensuring that health professionals know the whereabouts of the consumer to uphold their duty of care, and upholding the consumer's need for privacy. If specific risks of repetitive self-harm or suicide behaviour have been identified, then a further assessment and updated advice from mental health professionals need to be sought. If the person needs to remain in the general part of the hospital, then sedation, partial environmental confinement, or one-on-one observation may need to be instigated. It may also be useful to refer to the relevant mental health legislation for additional measures that can be taken to ensure the safety of the person, health professionals, other staff members, consumers and the general public.

Discharge planning

Planning for discharge occurs as soon as the person has been admitted to hospital. After an episode of self-harm, discharge planning is one of the most important aspects of the person's care.

For many individuals, the act of self-harm may be a means of communicating distress relating to underlying interpersonal, family or social difficulties. It would not be realistic to expect to deal with all such difficulties while the person is in hospital, but these may require referral, advice and specialist assessment by other members of the multidisciplinary team.

abscond when a person leaves a health service setting without informing health professionals and against a medical officer's advice

If the person **absconds** or discharges themselves from hospital before a plan for future treatment has been negotiated, or before a mental health assessment has taken place, the multidisciplinary team will need to consider what actions to take to ensure that follow-up care can be arranged and is communicated to the person. Such actions will also demonstrate how the multidisciplinary team as representatives of the health service provider, will address appropriate legal and ethical duty of care towards the person. Deciding the most appropriate action to take in such a situation will be informed by the risk assessment that was undertaken on arrival to the health service or admission to the hospital. Figure 8.4 (overleaf) outlines the general steps that need to be taken if a person who has been assessed as having a high risk of suicide leaves the health setting without informing health professionals or against the medical officer's advice.

A person who has been hospitalised for self-harm or a suicide attempt will be ready for discharge when they are physically well enough and also when their risk of suicide is at a level that can be managed in the community. All individuals who have self-harmed need to be assessed by a specialist mental health professional prior to discharge. They must also be referred to a community mental health specialist for follow-up after discharge. A list of key clinical tasks prior to discharge is provided in figure 8.5 (overleaf).

1. Check the preliminary risk assessment that was undertaken and recorded in the clinical records.
2. Follow the health service's 'Missing patient/person policy'.
3. Inform the nominated next of kin, guardian or nearest relative or significant other/family member (as per your policy).
4. Inform the person's general practitioner (GP) and other professional carers (e.g. community clinical manager or key worker), if appropriate.
5. If the preliminary risk assessment identified a high risk of suicide, health professionals must seek advice from a senior colleague about whether there is a need to inform the authorities that the person is missing. If the person was under the care provisions of mental health legislation, it is important to contact the police, health service managers and the mental health crisis assessment team (or equivalent) promptly, along with any other necessary stakeholders, as per your legislative requirements under your State or Territory Mental Health Act, and your local policy.

FIGURE 8.4 Actions to be taken when a person leaves hospital prematurely

1. Complete all relevant documentation (e.g. risk assessment, baseline assessment tools).
2. Ensure that the person has been assessed as medically and physically well enough to leave hospital.
3. Organise a referral to mental health professionals for a comprehensive assessment.
4. Inform next of kin, guardian or relative/significant other of discharge plans.
5. Provide written information and advice to the person and next of kin, guardian or relative/significant other.
6. Inform the person's general practitioner (GP) in writing.
7. Contact the person's clinical/case or care coordinator if the person is already known to health services.
8. Document the reason why the multidisciplinary team is discharging the person without the person being assessed by a specialist mental health professional.

FIGURE 8.5 Clinical tasks required before discharging a person who has self-harmed

While the immediate care and treatment provided in a hospital will relate to the person's level of risk, the longer term Recovery plan and specialist treatment will involve:

- exploring underlying psychological or mental health issues
- improving coping skills
- reducing stress
- providing education
- restricting access to means of self-harm
- extending time between episodes of self-harm
- developing social networks
- supporting family (NCCMH, UK, 2012).

To assist with this treatment, many consumers will participate in one or more of the psychological therapies. These are now identified.

Psychological therapies

One of the major aims of the use of the psychological therapies for people with self-harming behaviours is to help the person to manage their stress and distress. It is also important to support the development of the person's ability to problem-solve. For short-term psychological therapies, the Royal Australian and New Zealand College of Psychiatrists (2009) recommends cognitive behavioural therapy (CBT), problem solving therapy (PST) and interpersonal therapy (IPT).

Brief interpersonal psychodynamic or person-centred therapies for people who have been admitted to a mental health unit after DSH were also found to have benefits, especially transference-focused psychotherapy (TFP) and mentalisation-based therapy (MBT) (Rossouw & Fonagy, 2012; Kerr, Muehlenkamp, & Turner, 2010). Perhaps the most effective psychological therapy is **dialectical behaviour therapy (DBT)** which has been demonstrated to be effective for women with borderline personality disorder and multiple DSH episodes (Kerr, Muehlenkamp, & Turner, 2010).

dialectical behavioural therapy a type of cognitive and behavioural therapy used with positive outcomes for people with a borderline personality disorder and self-harming behaviours

DBT was developed as therapy for women with borderline personality disorder who engaged in repeated DSH (including suicide attempts) (Linehan, 1993). DBT uses cognitive and behavioural techniques to enhance interpersonal communication, develop skills to cope with emotional distress, regulate emotions and improve self-help. It is an intense and long-term form of therapy that comprises four modules: mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness.

Perhaps one of the reasons DBT has been found to be so effective for people with self-harming and suicidal behaviours is that it provides them with new and more constructive ways of **self-soothing** and expressing their emotions. It also provides a means by which people are taught the skills to problem-solve and relate more effectively to others. In particular, those who self-harm often feel unable to work effectively through their problems or life experiences. The psychological therapies provide one means by which these skills can be learned.

self-soothing the processes or internal resources used by an individual to lower their personal stress and distress level

Medication

There are no pharmacological preparations that are approved solely for the specific treatment of self-harm. There is some limited data regarding the use of Naltrexone with encouraging results, albeit with small consumer sample sizes. A reduction in self-harm episodes has also been reported with both Clozapine and Topiramate, but these are yet to be duplicated in an approved clinical trial (Kerr, Muehlenkamp & Turner, 2010). Despite evidence which does not support the use of medication, antidepressants and mood stabilisers are often prescribed. This is because the person with the self-harming behaviour is looking to the authorising prescriber to 'do something' and medication is a concrete or tangible option. People with a depression or psychosis may show some improvement if their DSH is related to their symptoms of mental illness. The main role of the health professional in psychopharmacological interventions is to provide the person with information about the medication and help the person to manage side effects.

The role of family and carer(s)

The NSPS has provided information for partners, carers and families on how to support the person who has self-harming behaviours. This is available through the Living Is For Everyone (LIFE) framework, which is part of the National Suicide Prevention Initiative (Department of Health and Ageing, 2012; www.livingisforeveryone.com.au). Health professionals can suggest to the partner, carer or family the following steps.

- *Always take self-injury seriously* and pay particular attention if the person talks of feeling depressed, hopeless or anxious, as these feelings may also be associated with suicidal thinking.
- *Don't panic, become angry, reject the person or ignore the problem*. Don't take the self-injury personally by thinking that the person is doing it to hurt you. These reactions may increase the person's feelings of guilt and shame. Remain calm and focus on supporting the person and helping them to find better ways to cope.
- *Don't condone the self-injury*. Be non-judgemental, and let the person know that you will continue to support them throughout their recovery and that you will be there for them no matter what they do.
- *Don't give ultimatums*. It can be tempting to demand that the person stop their self-injury immediately. This may drive the person away, make them feel more rejected, decrease their trust in you, and make them believe you are not listening.
- *Listen to the person* so they feel heard and supported and reassure them that the conversation will be treated confidentially.
- *Provide the support the person needs*. Self-injury is more likely to stop if the person can learn other ways to cope with their feelings and emotions. For example:
  - Help the person to find other coping strategies.
  - Encourage the person to seek further help. There are many people and organisations that can help the person find better ways of coping and dealing with the issues underlying their self-injury.
  - Suggest options for support (e.g. seeing their general practitioner or other health professional) and offer to accompany the person to their appointment.
- *Do not pressure the person* into any treatment with which they are not comfortable.

Many partners or carers may feel that they do not have the skills to help or support the person who self-harms. Effective health professionals will direct the partner or carer on to relevant support services that will provide them with the education and training they may need. A number of the different services available are outlined in chapter 12.

Postvention

Postvention refers to activities and strategies undertaken after a suicide death to reduce associated trauma. Postvention Australia was launched in June 2013, and is the national association for the bereaved by suicide. Postvention responses aim to:

- provide bereavement support and advocacy for those affected by the suicide
- prevent further suicide events including **contagion suicides** and **suicide clusters** (Swanson & Colman, 2013).

postvention activities and strategies undertaken after a suicide death to reduce associated trauma

contagion suicides the effect whereby one suicide death seems to stimulate other people to likewise suicide; often linked to a series of events or media reports that apparently transmit the message

suicide clusters a number of suicides that are proximal but not usually simultaneous and grouped by association in a community

While the prevention of further suicide events is a role for those working in primary health care, individual health professionals also play an important role in supporting the partners, carers or families of those who suicide. This is because a completed suicide gives rise to a complex grief in those left behind. Indeed, those bereaved by suicide will need ongoing and personal support.

According to Andriessen and Krysinska (2012), postvention will involve providing support to individuals, communities and service providers, from both a clinical and public health perspective. Key points to remember are as follows.

Clinical perspective:

- use the lived experiences of bereaved people to participate in developing appropriate supportive services.
- observe for potential risk factors and emerging mental health problems in people bereaved by suicide, especially children and siblings bereaved by suicide.
- postvention programs should offer assistance in the social, financial, practical and spiritual domains.
- provide ongoing training for health professionals to reduce the personal and professional psychological burden of consumer suicide.

Public Health perspective:

- develop and implement a nationally consistent suicide prevention program.
- the public and private health sector to actively contribute to raising awareness by promoting and supporting postvention related activates.
- postvention programs should be evaluated for effectiveness (Andriessen and Krysinska, 2012).

Grief counselling and follow-up will generally be provided by a specialist health professional; however, all health professionals can help those affected by being aware that grieving a suicide is a long and complex process. As already noted, people who are bereaved by suicide may have unanswered questions that will never be answered. They may also experience anger or a sense of rejection or be traumatised following the discovery of the person who has taken their own life. In addition, there is still some stigma associated with death by suicide in Australian society, and the person left behind must learn to deal with this. This can be a long and tortuous journey for the person, and the effective health professional will understand this and demonstrate empathy regardless of the amount of time that has passed since the suicide (Suicide Prevention Australia, 2009; Government of South Australia, 2012).

The NSPS has funded each state and territory to provide an information and support pack for those who have been bereaved by suicide and other sudden death. It is recommended that health professionals obtain the information pack relevant to their location for ready access to provide to those in need in a timely way. Additionally, there are specific population-targeted postvention packages available for secondary schools (headspace, 2012) and those recommended for Indigenous people (Hanssens, 2011). Information on postvention is also available through Lifeline, via its website or by phoning 13 11 14. The Suicide Call Back Service (SCBS), the Salvation Army National Hope Line and the StandBy Response Service are all nation-wide 24-hour telephone counselling services that also offer immediate online support for families, friends and communities who have been bereaved by suicide.

SUMMARY

People will often attend a health service after they have self-harmed, yet many health professionals find it challenging to maintain a positive approach to their assessment and the care they provide. To develop professional confidence and skills in this area, it is necessary for health professionals to become aware of the reasons why people engage in self-harming behaviour, and actively participate in ongoing training.

This chapter focuses on the ways the health professional can provide care to the person who self-harms. The chapter commences by explaining the difference between self-harm and suicide, and the incidence of suicide and rate of deliberate self-harm are discussed. Methods people use to self-harm are identified, as well as the predisposing, precipitating and perpetuating contributors and risk factors. The effects of the attitudes of health professionals towards the person who has self-harmed are also considered. This is followed by an overview of the National Suicide Prevention Strategy and the major population groups in Australia that have a higher risk of suicide.

The chapter then moves on to explain risk assessment, including the 'why', 'when' and 'how' of risk assessment. A suicide risk assessment tool is provided and the major principles of negotiating and implementing care and treatment to the person with self-harming behaviours are considered. The role of partners or carers is summarised. Finally, the concept of postvention is described, including a description of how health professionals can support those who are bereaved by suicide. Further information about carers and the role they play in supporting consumers is provided in the next chapter.

Review questions

1. What are the differences between self-harm, suicide and suicidal ideation?
2. Describe the main objectives of the National Suicide Prevention Strategy, including the main action areas of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.
3. Outline what is meant by the terms predisposing causes, precipitating influences and perpetuating factors of suicide.
4. Name at least six risk factors for suicide.
5. What are the defining characteristics of eating disorders? List the five most common types of eating disorder.
6. Describe the link between mental illness, physical illness and suicide.
7. Identify the key strategies that support the population groups in Australia that are most vulnerable to suicide.
8. List the essential components of a suicide risk assessment.
9. What are the key factors for effective interpersonal communication when speaking with a person who has self-harmed, or is a suicide survivor?
10. What is dialectical behavioural therapy?
11. What are the key points to remember about 'postvention'?

Discussion and debate

1. What self-harming activities (not necessarily life-threatening behaviours) have you observed or experienced in others? What environmental and psychological factors do you think sustain these behaviours?
2. List three personal considerations from your background that might consciously or unconsciously limit your ability to care for people in a non-judgemental way.
3. Discuss whether talking about suicide with people will increase or decrease the risk of a person considering suicide, or acting upon suicidal thoughts.
4. How might important ethical considerations guide and assist your interactions when working with people who may self-harm?
5. Discuss how health professionals can help to develop coping skills in people who have recurring self-harm behaviours.
6. What behaviours constitute self-harm in the younger population? For example, do you consider risk taking behaviours — for example, unprotected sex, self-cutting, self-inflicted cigarette and match burns, body piercings, eating disorders, alcohol use, dangerous driving and tattoos — as self-harm, or just typical younger generation behaviour? Discuss your reasons using a clinical, legal and ethical framework.
7. Discuss whether social media contributes to either perpetuating or reducing self-harm rates in adolescents. Provide evidence for your responses.

Project activity

Via the Rural Health Education Foundation website (www.rhef.com.au), access the one-hour tutorial titled *Self-harming behaviour: Management in adolescence* (dated 16 April, 2013 under the subject 'mental health'). Complete the learning objectives and submit the evaluation form to obtain certificate of participation as a professional development activity. What have you learned that you can now incorporate into your practice?

Websites

The Butterfly Foundation is a non-government organisation that represents all people affected by eating disorders — including individuals, their families and friends. As a leading national voice in supporting these people's needs, the Butterfly Foundation highlights the realities of seeking treatment for recovery, and advocates for improved services from both government and independent sources: http://thebutterflyfoundation.org.au

The Centre for Rural and Remote Mental Health is based in Orange. It is a major rural initiative of the University of Newcastle, Faculty of Health and the NSW Department of Health. The Centre aims to bring quality education and research programs to all rural areas of New South Wales through effective partnerships. It also seeks to improve the mental health of rural and remote communities through academic leadership, collaboration and achievements in research, education, service development and information services: www.crrmh.com.au

Conversations Matter is an online resource managed by the Hunter Institute of Mental Health, New South Wales. The site provides information and fact sheets for both health professionals and members of the public, in relation to understanding, preventing and responding to suicidal behaviours from a talking/understanding perspective, rather than a treatment or intervention perspective: www.conversationsmatter.com.au

headspace provides mental and health wellbeing support, information and services to young people and their families across Australia: www.headspace.org.au

The Living Is For Everyone (LIFE) website is a world-class suicide and self-harm prevention resource. Dedicated to providing the best available evidence and resources to guide activities aimed at reducing the rate at which people take their lives in Australia, the LIFE website is designed for people across the community who are involved in suicide and self-harm prevention activities: www.livingisforeveryone.com.au

Mindframe provides access to up-to-date, evidence-based information to support the reporting, portrayal and communication about suicide and mental illness: www.mindframe-media.info

The Royal Australian and New Zealand College of Psychiatrist's Consumer and Carer Clinical Practice Guidelines have recently been updated to ensure continued supply of this valued resource. These booklets are provided free of charge and are a valuable resource to support consumers and their carers, families and friends in learning more about mental illness and the treatments that are available: www.ranzcp.org/resources/clinical-practice-guidelines.html

The South Australian Government's *Information booklet for people bereaved by suicide*, comprises an important resource for those bereaved by suicide. It is freely accessible at: www.voc.sa.gov.au/Publications/BereavedBySuicide/Victims%20of%20Crime%20book%20web.pdf

square (suicide, questions, answers and resources) is an integrated suicide prevention resource — part of the National Suicide Prevention Strategy — developed by General Practice SA and Relationships Australia (SA) in conjunction with the Federal and State Governments : www.square.org.au

Suicide Prevention Australia is a not-for-profit, non-government organisation working as a public health advocate in suicide prevention. It is the only national umbrella body active in suicide prevention throughout Australia: http://suicidepreventionaust.org

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9

Caring for a person with a serious mental illness

LEARNING OBJECTIVES

This chapter will:

- define the terms 'serious mental illness', 'schizophrenia' and 'bipolar disorder'
- understand the incidence of physical comorbidities in people with a serious mental illness
- clarify the role of carers in the health context
- describe the major interventions for schizophrenia and bipolar disorder
- consider the notions of Recovery for people with a serious mental illness.

Introduction

As with anyone else in the community, people with serious mental illness access health services for treatment of comorbid physical disorders; therefore, it stands to reason that all health professionals will work with many people who have a serious mental illness in the course of their professional lives. Comorbid physical illness and mental illness is common and those with an existing serious mental illness receive less-than-adequate care when it comes to addressing their physical health care needs. This group of individuals is heterogeneous — some people will cope relatively well with the experience of being unwell and receiving treatment; however, others will require additional support and enhanced levels of care. This chapter will identify the core elements of effective care for this group of people.

The chapter begins by providing a description of two major mental illnesses: schizophrenia and bipolar disorder. An overview is also provided of the physical comorbidities that a person with a major mental illness may develop. The principles of caring for a person with a serious mental illness are outlined, together with the main treatment options for schizophrenia and bipolar disorder. Consideration is also given to the role of the carer of a person with a serious mental illness. The carer plays an essential role in the Recovery journey of the person with a mental illness and health professionals are advised to utilise and support carers in their roles. Finally, the Recovery journey of the person with a serious mental illness is described, with emphasis placed upon the hope and optimism that enables the person to live a full and meaningful life.

Definitions

Defining the term 'serious mental illness' is problematic and can be open to different interpretations in different settings. It is generally accepted that the vast majority of individuals with a serious mental illness will experience long-term and pervasive symptoms. The illnesses most commonly defined as 'serious' are schizophrenia and bipolar disorder. It is important to remember, however, that other mental health disorders such as depression, anxiety and personality disorder can also be severely debilitating for some individuals, and have a major impact upon the person's lifestyle, relationships and **social functioning**.

social functioning the ability of a person to interact in a group or as part of society

Whether or not such disorders are classified as 'serious' will be influenced by the nature and severity of symptoms, the duration of the disorder and the extent to which it has impacted on the person's life and ability to function independently. A serious mental illness will usually follow a long-term course, with fluctuating symptom severity at different times. A person with a serious mental illness may receive treatment from their general practitioner (GP) or specialist mental health service, either periodically or on an ongoing basis.

In order to dispel some of society's misunderstandings around mental illness it is helpful to understand the relationship between commonly misunderstood terms such as schizophrenia, psychosis and bipolar disorder.

In broad terms, schizophrenia is described as a psychotic disorder, specifically belonging to the Schizophrenia spectrum and other psychotic disorders DSM-5 category. Bipolar disorders, on the other hand, are described as disorders that sit between the

Schizophrenia spectrum and other psychotic disorders and Depressive disorders categories 'in recognition of their place as a bridge between the two diagnostic classes in terms of symptomatology, family history, and genetics (American Psychiatric Association [APA], 2013, p. 123).

Another term that tends to generate some confusion is **psychosis**. One reason for this confusion is that the word can describe a single event and also a long-term illness. In essence, a 'psychosis' is a state of being experienced by a person who has lost touch with reality. The symptoms experienced by the person may include hallucinations, delusions, disorganised thinking, and grossly disorganised or abnormal motor behaviour (positive symptoms) or diminished emotional expression, avolition, alogia, and anhedonia (negative symptoms). People who experience the symptoms of psychosis may have one **psychotic episode** or many episodes. An episode of psychosis may be of short duration — from hours to days. A small number of people will experience symptoms of psychosis that persist.

psychosis a state of being in which a person loses touch with reality and experiences hallucinations, delusions or disorganised thinking

psychotic episode a temporary event in which a person experiences symptoms of psychosis

prodrome a symptom, or group of symptoms, that appears shortly before the development of an illness; most often indicates the period before the appearance of the first symptoms of schizophrenia

The term **prodrome** or prodromal phase is often used when describing the time just prior to a person developing symptoms severe enough to meet the criteria for a diagnosis. During the prodromal phase, the person (most often a young person) will experience changes in the way they feel, think and behave. These changes are sometimes difficult to identify due to either their gradual onset or subtle presentation. Indeed, prodromal symptoms are often only identified retrospectively, after the person has developed a more pronounced symptom set or diagnosed mental illness; the symptoms are experienced as something that is 'not quite right' (Addington, 2013; Correll, Hauser, Auther, & Cornblatt, 2010; Woods, Addington, Cadenhead, Cannon, Cornblatt et al., 2009). The phase is also called 'psychosis risk syndrome' or the 'early warning signs', which are described in more detail in chapter 12. In particular, table 12.2 provides a list of the early warning signs of serious mental illness.

It is important to note that the early warning signs are not a definite marker of the onset of a serious mental illness. A person who experiences the early warning signs of a serious mental illness will not necessarily go on to develop the illness (Addington, 2013). Even so, identification of the early warning signs will enable early treatment and lead to better health outcomes for the person who is experiencing the event (McGorry, 2013).

Another condition health professionals may encounter is **schizoaffective disorder**. This is a major mental illness that can be difficult to identify accurately. This is because it involves psychotic symptoms together with severe, enduring symptoms of a mood disorder. The cluster of symptoms experienced by persons with schizoaffective disorder can resemble bipolar disorder, major depressive episode with psychotic features, or schizophrenia. Schizoaffective disorder is not described in this chapter because it is a specialised diagnosis. The care and treatment for schizoaffective disorder is similar to that which is provided for a person with schizophrenia and bipolar disorder; that is, pharmacological interventions, psychological interventions and psychoeducation. This is described in a later section of this chapter.

schizoaffective disorder a diagnosis that includes symptoms resembling a mood disorder, together with symptoms of schizophrenia, particularly psychosis and social withdrawal

In the next sections, the diagnoses of schizophrenia and bipolar disorder are described. This includes an overview of the prevalence and causes of these disorders. An outline is also provided of the major symptoms of these conditions and the principles by which health professionals provide effective care to those who experience these symptoms.

Schizophrenia

Descriptions of psychotic behaviour date back to early written history. However, schizophrenia was not described until the late 1800s by Emil Kraepelin (1856–1926) and Eugen Bleuler (1857–1939). Kraeplin described the syndrome as a dementia praecox or decline in functioning with an early onset. The term 'schizophrenia' was first coined by Bleuler. The term itself is derived from two Greek words meaning 'to split' and 'mind' — a derivative that most likely contributes to the common misunderstanding that schizophrenia relates to split personality. Schizophrenia is not a split personality; it more closely resembles a split between a dream-state and reality. A person who has been diagnosed with schizophrenia will experience episodes of psychosis, including disturbances in perceptions and thinking. This in turn gives rise to unusual behaviour.

There are a number of different types of schizophrenia; for example, paranoid, undifferentiated, catatonic and disorganised. Health professionals with an interest in this area are encouraged to seek out a specialist text on the different types of schizophrenia and what it is that differentiates them. Note that the term 'schizophrenic' is no longer used to describe a person who has schizophrenia due to the term's pejorative connotations.

Prevalence

Schizophrenia is a disorder that typically develops in late adolescence or early adulthood. It affects both genders equally, but tends to be more severe and develop at an earlier age in males. Schizophrenia appears in about 0.3–0.7 per cent of the population of most countries, including Australia.

While the course of the illness varies, 20–30 per cent of people diagnosed with schizophrenia will not have their lives severely impaired by the illness over the longer term. Another 20–30 per cent, however, will experience symptoms that will intermittently or otherwise cause moderate disruption to their lives. Unfortunately, 40–60 per cent of people diagnosed with the illness will experience significant impairment (Sadock & Sadock, 2008). The risk of suicide is greatly elevated in people diagnosed with schizophrenia, with the lifetime risk often quoted as high as 10 per cent (or higher). The highest risk period for suicide is the first year after the first psychotic episode (Gale, Skegg, Mullen, Patterson, & Gray, 2012). Meta-analysis of suicide data for people diagnosed with schizophrenia shows a suicide rate of 5.6 per cent (Palmer, Pankratz, & Bostwick, 2005).

Development and course

As stated in the DSM-5, the psychotic features of schizophrenia typically emerge between the late teens and the mid 30s; onset prior to adolescence is rare. The peak age of onset for the first psychotic episode is in the early to mid 20s for males and in the late 20s for females. The onset of the symptoms and episode may be abrupt; however, the majority of persons usually develop symptoms over a gradual period, with the severity of symptoms increasing with time (APA, 2013, p. 102). Psychotic symptoms tend to diminish over the course of an individual's life, and this appears to be related to the reductions in dopamine observed in the normal aging process (APA, 2013, p. 102).

Paediatric schizophrenia, otherwise known as childhood schizophrenia, is a type of mental disorder that is characterised by degeneration in thinking, behaviour and emotional processes in children and early adolescence. This disorder remains a controversial diagnostic category, primarily due to the difficulties in establishing the presence of psychotic symptoms (i.e. hallucinations and delusions) in the context of developmental processes and the use of medication in children. The criteria for paediatric schizophrenia are the same as for the adult version and is based on behaviour as observed by parents, carers and significant others (e.g. teachers).

Causes

The causes of schizophrenia are not well understood. There appears to be genetic, biochemical and environmental factors involved.

In relation to genetics, studies have shown that people who have a close relative with schizophrenia have a higher chance of developing it themselves. Theories underpinning the understanding of schizophrenia also arise from irregularities that have been noted in the brain structure and neural transmission, particularly dopamine transmission. The **dopamine hypothesis** underpins the use of antipsychotic medication in the treatment of schizophrenia (Madras, 2013) and is explained later in the chapter.

dopamine hypothesis a theory that attributes the cause of schizophrenia or psychosis symptoms to excess dopamine transmission in the brain

Environmental factors, such as drug use and stress, have also shown to be linked to the development of schizophrenia. In particular, a link has now been confirmed between cannabis and psychosis. Many consumers will use cannabis to assist with managing their symptoms. For this reason, there is some difficulty in determining if cannabis use caused the psychosis or if the person began taking the substance to help them to manage the early warning symptoms of their illness.

In the past, a number of people thought that schizophrenia was caused by the way in which families, in particular mothers, related to their children (Mental Health Association NSW, 2008). Today, this view is thought to be counterproductive. While family dynamics may affect the course of schizophrenia, they are in no way to be blamed for its initial development.

Symptoms of schizophrenia

Early descriptions of schizophrenia focused on the decline in drive and motivation of a person. More recent definitions have focused on the psychotic phenomena experienced by those with schizophrenia (APA, 2013). This focus has given rise to some misunderstanding about the difference between a psychotic episode and schizophrenia. It is important that health professionals understand that it is possible for a person to experience a psychosis but not to have schizophrenia.

There is currently no test that can absolutely diagnose schizophrenia — although physical tests will help to exclude other conditions that may be causing the psychosis, including metabolic disorder, thyroid dysfunction, brain tumour, and so on. As already noted, some people only ever experience a single episode of psychosis. Others may experience a number of psychotic episodes — but infrequently and without these episodes significantly impacting their life. No single symptom is definitive for a diagnosis of schizophrenia; instead, the diagnosis is made based upon a pattern of signs and symptoms together with impaired occupational or social functioning. For this reason, a diagnosis of schizophrenia takes time. Also, it is best determined by a psychiatrist. Health professionals who have not undertaken specialised training in the field should avoid making such a diagnosis. This is because of the stigma that is still attached to the condition and the potential for a misdiagnosis to cause great distress to the person.

A useful framework for understanding schizophrenia involves separating the symptoms into **positive symptoms** and **negative symptoms**. Positive symptoms are those that seem to be in excess or distortions of common or ordinary experiences; that is, where an experience or phenomenon is added to the person's ordinary or usual experiences. An example of a positive symptom is a hallucination as this involves a person experiencing a sensation (such as hearing something) that others do not.

Negative symptoms are those that seem to take away from or suggest a deficit in relation to common or ordinary experiences; that is, where there is an absence or lack in the person's ordinary or usual experiences. Examples of negative symptoms include lack of motivation, initiative or emotion; cognitive deficits; and apathy. The positive and negative symptoms of schizophrenia are now described in more detail.

positive symptoms psychotic symptoms that seem to be excesses or distortions of ordinary thinking processes — where phenomena are added to the person's experience

negative symptoms psychotic symptoms that seem to be a deficit of ordinary thinking processes — where there is an absence or lack in the person's experience

Positive symptoms

Health professionals are more likely to recognise the positive symptoms of schizophrenia. This is because they are most often overt and observable, unusual and extraordinary. The positive symptoms of schizophrenia include hallucinations, delusions and disorganised thinking.

Hallucinations

Hallucinations are usually described as false sensory perceptions, or perceptual phenomena arising without any external stimulus; for example, hearing (most common), seeing, smelling, feeling or tasting things that others do not. For people with a serious mental illness, the voices will often be persecutory and critical in nature, or may command the person to behave in a certain way. Hallucinations are described according to the sensory modality they affect and are referred to as follows.

- *Auditory* — hearing things that are not there (often taking the form of voices), which may be unpleasant. For example, 'I could hear someone talking to me that no one else could hear, but it sounded to me just like anyone else talking — except this voice said things like "You're a liar; you deceive people and hurt them". This was really scary for me. I'm pleased I don't hear them now.'
- *Visual* — seeing things that are not there. For example, 'When I was unwell in hospital, I could see a young boy leaning over a small animal. I asked other people whether they could see it. They said no.'
- *Tactile* — feeling things that are not there, such as feeling the presence of a parasite under the skin. For example, 'I could feel worms crawling under my skin. They felt like they were moving up my legs. It hurt and I was worried about where they might go next. Now I know they weren't real, but at the time I was totally convinced they were real.'
- *Gustatory* — tasting things that are not there. For example, 'I started getting this weird taste in my mouth. It was salty. Then I worked out that it was sweat I was tasting. I couldn't get away from the taste of sweat. I started drinking water, then I tried sweet drinks, but the taste of sweat would always come back. That lasted for about a week.'
- *Olfactory* — smelling things that are not there. For example, 'Burning rubber was all I could smell. It stank! When I first started to smell it, I thought there was a fire, but there wasn't. The smell got stronger in my bedroom, but everyone else said there was no smell around. I even sprayed room freshener, which smelt a little better, but underneath it all I could still smell the burning rubber.'

When the person is relatively well, they can often recognise that these perceptions are not real and they learn ways of managing or ignoring the hallucinations (Mental Health Association NSW, 2008).

Delusions

A delusion is a fixed and false belief that the person cannot be dissuaded from despite contradictory evidence. The belief is not based in the person's cultural, religious/spiritual, educational or social experience and is maintained despite it not being shared by other members of the same culture. For example, believing that there is the possibility of life elsewhere in the universe would be in keeping with the beliefs of many other people in society, but believing that the health worker is an alien would not be in keeping with beliefs of others and so would be classified as a delusion.

Delusions can also be bizarre or non-bizarre in nature. Bizarre delusions are beliefs that are implausible. For example, a person may believe that an alien has put a camera in their brain. Based upon scientific evidence, there is no likelihood that this has actually occurred. On the other hand, a non-bizarre delusion would involve a belief that on a balance of probability could possibly occur. For example, a person may believe that their manager is constantly checking up on them.

Before writing off a belief as a delusion, health professionals are always wise to explore the person's context, life experiences and the level of the belief. For example, is the person obsessed with the belief? How much is the belief driving their behaviour or consuming their lives? Answers to these questions are perhaps more significant to the care and treatment provided than the content of the delusions.

Delusions may also be described in relation to their relationship with the person's mood. For example, an individual whose mood is low may become utterly convinced that a particular person or group of people hates them. However, a delusion can also be mood neutral; for example, a person may believe that people with dark hair all follow a particular football team.

More generally, delusions are classified according to theme. The most common of these themes are as follows.

- *Persecutory or paranoid delusions* — a false belief that a person is the victim of a conspiracy. A person may believe they are being spied on, poisoned or about to be harmed in some way.
- *Grandiose delusions* — a false belief that a person possesses special powers, talents or abilities. This may extend to a belief that they are royalty, a film star, an entrepreneur or millionaire, or a leader in their field.
- *Somatic delusions* — a false belief that a person has an illness, which is not supported by medical evidence. Great care must be taken by health professionals to ensure that the symptoms being reported actually are delusional. People with a mental illness do become physically ill and some illnesses are difficult to diagnose. Just because a person has been diagnosed with a serious mental illness does not mean the symptoms the person reports are not real.
- *Ideas of references* — a false belief that insignificant events have personal significance. This often displays itself in a person believing the television or radio has special messages for them.

- *Religious delusions* — a false belief with religious or spiritual content. This can display as the person believing they are Jesus Christ or a special prophet who has come to save the world.

As with hallucinations, when the person is relatively well, they may be able to recognise that these delusions are false personal beliefs. This level of insight helps the person to challenge their own thinking.

Disorganised thinking

The types of disorganised thinking experienced by people with schizophrenia can vary. However, disorganised thinking is most often exhibited by the way the person speaks to the health professional. Disorganised thinking can lead to conversation that lacks structure and purpose or remains focused on the specific issue or idea that is causing distress for the person. Disorganised thinking is exhibited through speech and includes:

- pressure of speech — increased amount and rate of speech that is difficult to interrupt
- thought blocking — the person forgets what she is thinking or saying
- circumstantial speech — highly detailed and lengthy conversations where a simple statement would suffice
- tangentiality — moving from one topic to a loosely associated topic
- 'clanging' — clang associations are a form of rhyming speech or use of words with similar sounds rather than selecting words to make logical sense
- loose associations/derailment — this is where a person slips from topic to topic
- echolalia — repeating words or phrases used by the other person in a conversation
- neologisms — making up new words
- word salad — where a person combines words in a way that does not make logical sense
- perseveration — where a person repeats ideas and has difficulty moving on to new ideas.

Again, a person will be able to recognise and manage their disordered thought patterns as they begin to respond to treatment.

Grossly disorganised or abnormal motor behaviour (including catatonia)

Grossly disorganised or abnormal motor behaviour may present in a variety of ways, ranging from childlike actions (including silliness) to unpredictable agitation. Such difficulties may be observed in any form of goal-directed behaviour, leading to difficulties in performing and achieving activities of daily living (ADLs).

Catatonic behaviour, a significant symptom within this category, presents as a marked decrease in reactivity to the environment. This may be observed as resistance to instructions (negativism); maintaining a rigid, inappropriate or bizarre posture; or a complete lack of verbal and motor responses (mutism or stupor). It can include purposeless and excessive motor activity without obvious cause. Other features include repeated stereotyped movements, staring, grimacing and the echoing of speech.

Negative symptoms

The negative symptoms of schizophrenia are generally less obvious than the positive symptoms. This is because the symptoms involve the withdrawal or retreat of the person from social contact. The negative symptoms of schizophrenia are also more difficult to manage or treat; although the more recent **atypical antipsychotic medications** have been found to be helpful.

atypical antipsychotic medications the newer generation of antipsychotic medications that treat psychosis

UPON REFLECTION

Schizophrenia's negative symptoms

The negative symptoms of schizophrenia include a lack of motivation and initiative, cognitive deficits and apathy.

Questions

1. How do these symptoms influence the provision of clinical treatment and the role that a health professional will need to take?
2. What ethical and treatment considerations could arise for the health professional working with a patient from a diverse cultural background who is experiencing a religious delusion?
3. How can health professionals engage with people experiencing negative symptoms to promote healthy and socially active lifestyle choices?

Negative symptoms of schizophrenia are often very frustrating for the person who is experiencing them. They can also be quite distressing for partners, carers and family members. Examples of the negative symptoms of schizophrenia are as follows.

- *Blunted emotions*. A person's emotional responses are restricted, making them appear to be disinterested and withdrawn.
- *Cognitive deficits*. These impact upon the person's ability to communicate; for example, the person may have difficulty in concentrating and be slow to react to sensory input.
- *Apathy*. The person has difficulty in undertaking straightforward tasks. They may appear slow and unmotivated.

As already noted, the negative symptoms of schizophrenia are less responsive to treatment than the positive symptoms of schizophrenia.

Even so, a range of treatment options is available for the symptoms of schizophrenia. Antipsychotic medication may be prescribed and is usually continued on a long-term basis. A combination of pharmacological, social and psychological interventions, plus help and support to undertake specific activities of daily living, is the usual approach to treatment. The following 'Big picture' feature outlines one way that people with serious mental illness are provided with community support. Programs such as these have been rolled out across Australia and are demonstrating positive outcomes.

THE BIG PICTURE

Early intervention for young people with complex mental illness

In 2013, the Federal government announced that it would invest $247 million in an early intervention model to support young people with complex mental illnesses. Early psychosis youth services, based on the Early Psychosis Prevention and

➜

Intervention Centre (EPPIC) model, will roll out over a three-year period. Starting with hubs in Melbourne, Sydney, Adelaide and Perth, services will become available in nine locations in each state and territory.

Regarded as the 'world's best practice model', the services available under the EPPIC mantle comprise:

- 24-hour home-based care and assessment
- community education and awareness programs
- easy access to acute and sub-acute services
- continuing care case management
- mobile outreach
- medical and psychological interventions
- functional recovery, group, family and peer support programs
- workforce development
- youth participation.

EPPIC aims to facilitate early identification and treatment of psychosis and therefore reduce the disruption to the young person's functioning and psychosocial development. Without early intervention, there is often an extended period of delay (2–3 years on average) when problems intensify. Delayed assessment may be damaging to a young person's development, often in the crucial period of adolescence. Maturation is sometimes put on hold, social and family relationships are strained or sometimes severed and vocational prospects are derailed.

Secondary problems such as substance abuse, unemployment and behavioural problems may develop or intensify and the illness itself may become more deeply entrenched.

The aims of EPPIC are:

- early identification and treatment of the primary symptoms of psychotic illness
- improved access to and reduced delays in initial treatment
- reducing frequency and severity of relapse, and increasing time to first relapse
- reducing secondary morbidity in the post-psychotic phase of illness
- reducing disruption to social and vocational functioning and psychosocial development in the critical period following onset of illness when most disability tends to accrue
- promoting wellbeing among family members and reducing the burden for carers.

The aims of treatment are to:

- explore the possible causes of psychotic symptoms and treat them
- educate the young person and their family about the illness
- reduce disruption in a young person's life caused by the illness
- restore the normal developmental trajectory and psychosocial functioning
- support the young person and their carers through the recovery process
- restore normal developmental trajectory and psychosocial functioning
- reduce the young person's chances of having another psychotic experience.

Sources: Aftercare (2013); EPPIC (n.d.)

IN PRACTICE

An experience of psychosis

You are working in a busy emergency department (ED) when the police bring in Ben, a 22-year-old Aboriginal Australian, at 1600 hours in the company of an older woman (his mother). Prior to his arrival at the ED, Ben's neighbours became frightened and called the police. The police arrived to assess the situation, at which time Ben came running out of the house in their direction, armed with a large kitchen knife.

Ben is dressed in dirty jeans, a T-shirt and he is barefoot. His head is shaven, his arms are covered in cuts and scratches, and he has strong body odour. He is very tense and sits very still, looking at the ground. However, periodically he gets up and paces the ED corridor, wringing his hands and mumbling incoherently to himself. Upon approaching the older woman, he would scowl before sitting down and continuing to stare at the ground.

He then begins to respond instantly to any person walking by him — intensely staring at them, alternating his gaze between being intrigued, afraid and hostile. He follows the ED bed coordinator and yourself to the bed/cubicle he has been allotted but insists upon as much distance as he can get from any physical contact. The young man hesitates before entering the cubicle, as though he's about to enter a 'trap'. The older woman nurtures him carefully and reassuringly guides him into the cubicle.

You decide to ask Ben some questions, who is smiling at you but then looks up to the ceiling, terrified. He mutters to himself and then nervously smiles again this time to himself before he asks you 'Why am I here? You won't tell them anything will you?' You begin to tell him that his treatment here is confidential but Ben interrupts: 'You know, don't you? You know they are always watching!' Ben stares intensely around the cubicle and up at the ceiling, presumably at a nearby vent. Before you can answer he adds, 'They are everywhere. Everywhere . . . in everything, always watching! Every one of us is being monitored.' He begins to mumble incoherently to himself, and then looks up at the ceiling once more and shouts 'Shut up, shut up, shut up! Leave me alone!' Extremely distressed, he then proceeds to scream and hold his ears as if to block out a loud noise. Suddenly, there is a security guard and two nurse colleagues by your side.

Questions

1. Describe the possible positive and negative symptoms of psychosis that Ben is displaying?
2. What cultural considerations would need to be implemented to ensure a consumer focus and improve Ben's self-efficacy?
3. What would Ben's assessment need to include? What might his treatment in the emergency department involve?

This section describes the signs and symptoms of schizophrenia. In the next section, bipolar disorder is described. As noted, bipolar disorder is viewed as a serious mental illness because it has the potential to substantially affect a person's lifestyle, relationships and social functioning. Significantly, some people with bipolar disorder will experience symptoms such as delusions and hallucinations that are similar to those experienced by a person with schizophrenia. Likewise, many people with a depression will experience a number of the symptoms previously described, including hallucinations, delusions and disorganised thinking. Table 9.1 shows which of the disorders are characterised by symptoms of delusions, hallucinations and disorganised thinking.

TABLE 9.1 Symptoms seen in serious mental illness

	Delusions	Hallucinations	Disorganised thinking
Schizophrenia	Often	Often	Often
Bipolar disorder	Sometimes	Sometimes	Sometimes
Depression	Sometimes	Rarely	Rarely

This table is useful to help health professionals differentiate between the major mental illnesses. This, in turn, will enable health professionals to talk to consumers in a more informed way about their symptoms and how to manage these experiences.

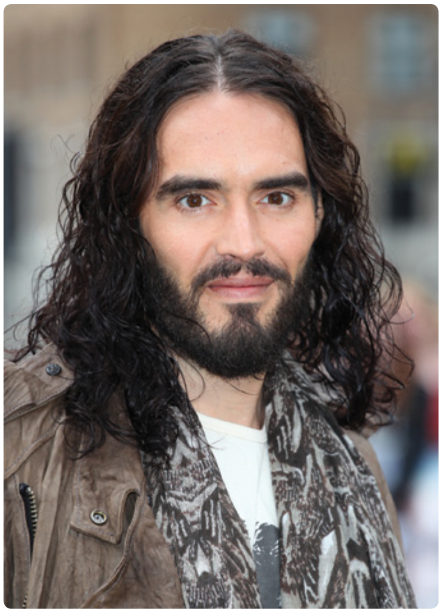
Bipolar disorder

In the past, bipolar disorder has been referred to as 'manic depression'. The condition is now called 'bipolar disorder', as this term more accurately describes the cycling of moods that is experienced by the person between the two poles of 'high' or elevated mood and 'low' or depressed mood.

A person with bipolar disorder is likely to be symptom-free for the majority of the time and live a productive life in the community. In fact, some people with a bipolar disorder say they would not like to be 'cured' of bipolar disorder as they view the creativity and energy that is generated during the hypomanic phase as a positive influence on their lives. On the other hand, there are other people who are unequivocal in their desire to ensure the symptoms are minimised by treatment because of the destructive influence they have on their lives. Clearly, different people experience the symptoms of bipolar at different levels of intensity and respond to these experiences in different ways.

The criteria for bipolar disorders as described in DSM-5 (2013) are complex. In simple terms, Bipolar I refers to people who have experienced at least one manic episode, though many will have experienced more than one episode of mania and also experienced episodes of depression. Bipolar II refers to people who have experienced episodes of hypomania and depression. Rapid cycling bipolar disorder describes people who cycle from elevated mood to depression at least four times in a year. This rapid cycling is more common among women than men.

Health professionals who do not work in a mental health specialty field do not need to know how to differentiate between the two different types of bipolar disorder. What is most important is a general understanding of the symptoms and their potential to impact on a person's life.



Russell Brand, an author, comedian and actor who also has a bipolar disorder.

Causes

Bipolar disorder affects 0.6 and 0.8 per cent (for bipolar I and bipolar II respectively) of the population at some time in their lives (APA, 2013). Onset is usually before the age of 30 years, but can occur at any time. The most common pattern involves repeated episodes of mania or depression, usually followed by a period of remission.

Genetics are thought to be largely responsible for determining an individual's likelihood of developing a bipolar disorder. In families where one person has bipolar disorder, there are often other family members who have experienced episodes of depressive illness or hypomania.

Neurotransmitters have also received attention as a possible cause of bipolar disorder. Some studies suggest that a high or low level of a specific neurotransmitter — such as serotonin, norepinephrine or dopamine — or an imbalance of these substances, is the cause of bipolar disorder (Elder, Evans, & Nizette, 2012). Others again suggest that stressful life events are the main cause. These events lead to the onset of symptoms, which then progress into a disorder.

These disparate views suggest there is no single cause of bipolar disorder. For this reason, health professionals are encouraged to assist individuals who have been diagnosed with bipolar disorder to reflect upon their own particular predisposing, precipitating and perpetuating factors, including the situations or events that may trigger particular symptoms. Such consideration, particularly of the perpetuating factors, provides an excellent means by which the consumer can develop strategies for managing their symptoms.

Mania

Mania refers to a period of elevated, expansive or irritable mood, high energy levels and inappropriate behaviours, which have the potential to cause major problems in relationships or the work setting. Mania is likely to require hospitalisation and will usually last at least one week. The person may also exhibit symptoms of psychosis.

mania an episode of highly elevated mood which interferes significantly in day-to-day life

A manic episode can include any number of the following symptoms:

- **grandiosity**
- decreased need for sleep
- excessive talkativeness
- racing thoughts
- distractibilty and psychomotor agitation
- sexual disinhibition
- decreased ability to make sound or rational decisions
- increased focus on goal-directed activity
- disproportionate involvement in pleasurable activities.

grandiosity overvalued sense of self — often related to elevated mood state in bipolar disorder

People who experience a mania often have disjointed or distorted thinking. Hallucinations and delusions are also common and often appear very real to the person. People can also experience 'mystical experiences' where they see special connections between events or other experiences. During an episode of mania, the person is at risk of behaving in an antisocial way (which may be out of character for them) and this may lead to serious financial, legal and relationship problems. The person may neglect their personal hygiene and physical health, and other symptoms of mental illness may also be present. This often leads to the person being hospitalised.

Hypomania is similar to mania; however, the symptoms are less severe and cause less impairment for the individual. Usually no psychotic features are evident in a hypomanic episode and the person may not require hospitalisation (APA, 2013).

In addition to mania and/or hypomania, the person with a bipolar disorder will typically experience episodes of depression. The frequency or lengths of the cycles between mania and depression will depend upon the person's individual experience. However, mood stabilising medication will often give rise to longer periods between the highs and the lows, as well as decreasing the extremes of the highs and lows.

hypomania a period of elevated mood which has less impact on functioning than mania

Depression

Depression is described at length in chapter 7. It is the opposite of mania — the person's thoughts will be slow and their mood will be low, sad or pessimistic. People with depression find it difficult to make decisions and they are generally uninterested in performing the tasks of everyday life or being involved in activities they once found pleasurable. Their sleep patterns may be disturbed and they will often lose their appetite and sex drive. The depression that is felt by those with a bipolar disorder has no real differences to the depression that is felt by people with a unipolar depression.

According to the Black Dog Institute, the management of bipolar disorder involves two parts: treating the current episode of mania or depression, and preventing the long-term recurrence of mania and depression (www.blackdoginstitute.org.au). Specific treatment options for bipolar disorder, including pharmacological and psychological therapies, are outlined later in this chapter. Principles for providing care are also outlined.

The Black Dog Institute is a not-for-profit organisation that offers specialist expertise in depression and bipolar disorder.

Comorbidities in people with serious mental illness

People who experience the symptoms of schizophrenia or bipolar disorder have increased rates of **morbidity** and **mortality**. For example, it has been estimated that approximately half of the people with schizophrenia also have a comorbid physical or other mental disorder. People with schizophrenia have an average lifespan that is at least 15 years shorter than their age-related counterparts (Bradshaw, Lovell, Bee, & Campbell, 2010). Hoang, Goldacre and Stewart (2013) go on to suggest that there is also a higher mortality rate in people with a serious mental illness. This higher mortality rate is a logical consequence of the higher morbidity rate. Specifically, death from cardiovascular, respiratory, cerebrovascular, and endocrine disorders is higher due to lifestyle factors, biological factors, adverse pharmacologic effects, and health provision/disparities in health care.

morbidity the incidence of ill health or disease

mortality the incidence of death in a population

According to Ahire, Sheridan, Regbetz, Stacey and Scott (2012), people with a serious mental illness experience a range of morbidities including coronary heart disease, diabetes, cancer, infections, obesity, respiratory disease, dental disease and poor outcomes following acute physical illness such as myocardial infarction or stroke.

Factors that contribute to poor physical health

There are many reasons why a person with a serious mental illness is more likely than other people in the population to develop physical health problems. These include the following.

- *Social factors*. People with a serious mental illness experience higher levels of poverty, unemployment, social isolation and exclusion, poor access to and low uptake of mainstream health services such as primary care, dental services, ophthalmology, personal health and lifestyle facilities (e.g. gyms and leisure centres).
- *Psychological factors*. People with a serious mental illness experience low self-esteem, **self-stigma**, lack of personal assertiveness.
- *Mental illness-related factors*. People with a serious mental illness experience unwanted side effects or complications of the medication used to treat serious mental illness. There also seems to be a decreased awareness in consumers that their physical health and wellbeing is important, perhaps due to the focus that is placed upon their mental state by health professionals. Another factor arises from the negative symptoms of schizophrenia, including a lack of motivation and self-neglect (Lawn, 2012).
- *Personal factors*. People with a serious mental illness experience higher rates of smoking, alcohol consumption, other substance use, poor diet, lack of physical exercise and high-risk behaviour (Lawn, 2012).
- *Professional factors*. Research suggests that health professionals are less likely to offer preventive health care, reflecting a lack of 'ownership' for the physical health of people with a serious mental illness from both primary care and mental health staff (Jones, 2004). Consumers who have had adverse encounters with health services or health professionals in the past are also less likely to seek help for a physical illness (Lawn, 2012).

self-stigma when people with mental health issues view themselves in a negative light, giving rise to low self-worth, feelings of shame and a negative self-image

Significantly, many of these factors relate to lifestyle and also quality of life. While some individuals with a serious mental illness require education about healthy lifestyle issues, there are others who have knowledge regarding healthy living but have difficulty implementing lifestyle changes necessary to improve their health risk status (Brunero & Lamont, 2010). Health professionals would do well to consider if this is any different to the behaviour of many other people in the community; in short, lifestyle changes do not come easily to any population group. It is also important to factor in the extent to which a lack of drive and initiative may affect the capacity of a person with a serious mental illness to change. This in turn will affect the strategies used by the health professional to support the person.

Smoking

Smoking contributes significantly to the burden of physical disease in Australia. The rate of cigarette smoking among people accessing mental health services is much higher than in the wider community. This leads to higher morbidity and mortality related to smoking in that population. It is of great concern that this preventable cause of morbidity is frequently overlooked by health professionals in this population group (Ragg, Gordon, Ahmed, & Allan, 2013).

Research has shown that death from smoking-related causes is one of the most common reasons for mortality in people with schizophrenia (Brown, Kim, Mitchell, & Inskip, 2010). Smoking also impairs the effectiveness of antipsychotic medication. As a group, people with a serious mental illness who smoke are less likely to receive advice on the harmful effects of smoking and the benefits of smoking cessation (Lawn, 2012). Smoking is often seen as more acceptable for people with a serious mental illness by those who regard it as 'their only pleasure'. The stigma associated with mental illness may also lead health professionals to believe that the value of the lives of people with a serious mental illness is somehow less than that of other people and so it is not as important to promote good strategies for maintaining good health.

Despite more positive public health policy approaches to smoking cessation in the general population, there is a general perception that smoking cessation for someone with a serious mental illness will exacerbate their mental illness. For many, smoking is seen as a coping mechanism for the psychological and emotional distress expressed by people with a mental illness. Stigma may lead health professionals to believe that people with a serious mental illness just don't have the capacity to stop smoking completely. This is despite the growing evidence of the effectiveness of smoking cessation programs for people with a serious mental illness (Lawn & Campion, 2010).

Common physical illnesses

Some types of physical health disorders have a high prevalence in people with serious mental illness. It is vital that health professionals are aware of this, as awareness is the first step to improving outcomes. If the health professional, consumer and carers are aware of the risks, they are more likely to identify problems sooner rather than later. This, in turn, enables the implementation of treatment and gives rise to improved health outcomes. The following sections provide health professionals with some guidance to the different types of physical illnesses that people with a serious mental illness are more likely to experience.

Cardiovascular disorders

People with a serious mental illness, especially schizophrenia, experience an increased incidence of cardiovascular disorders (Brown, Kim, Mitchell, & Inskip, 2010; Lin, Chen, Lee, & Lin, 2010). Adverse effects of medication and lifestyle issues are thought to be contributing factors. Notably, many antipsychotic medications are associated with weight gain and sedation which can both contribute to risk factors associated with cardiovascular disease.

Gastrointestinal disorders

The higher use of alcohol in people with a serious mental illness is thought to contribute to increased rates of peptic ulceration, gastrointestinal cancers, pancreatic cancers and irritable bowel syndrome (Bouza, Lopez-Cuadrado, & Amate, 2010).

Neurological disorders

Comorbid neurological symptoms are common. Contributing factors include higher rates of head injuries, prenatal trauma and excessive alcohol use. Antipsychotics reduce seizure thresholds and excessive alcohol increases vulnerability to seizures. The use of antipsychotics can cause neurological complications, including **dystonia** and **tardive dyskinesia** (Ono et al., 2011).

dystonia symptoms that include prolonged and unintentional muscular contractions of the voluntary or involuntary muscles

tardive dyskinesia symptoms that include repetitive, involuntary, purposeless movements, such as grimacing, tongue protrusion, lip smacking, puckering and pursing of the lips and rapid eye blinking

Endocrine disorders

People with schizophrenia are more likely to develop **metabolic syndrome** and type 2 diabetes than the general population (Liu, Zhang, Deng, Yi, & Shi, 2011). In fact, weight gain and metabolic disorders are among the major challenges facing people taking antipsychotic medication and the services providing treatment.

metabolic syndrome related to a set of risk factors associated with heart disease and diabetes; symptoms include central obesity, insulin resistance, high blood pressure and high lipids

Research has also demonstrated that consumers with schizophrenia who are treated by public community mental health services are less likely to be able to manage their diabetes (Ogawa, Miyamoto, & Kawakami, 2011). It is recommended that people with a serious mental illness who also have diabetes are referred to a diabetes clinic or specialist diabetes health professional (Pendlebury & Holt, 2008).

Given the high prevalence and morbidity associated with type 2 diabetes in people with schizophrenia, it is important that all health professionals actively assist in raising awareness of diabetes and the risk of people with a serious mental illness developing the disorder. In particular, an emphasis needs to be placed on the importance of all people eating well and exercising regularly. Health professionals are advised that one-off information sessions do little to change a person's approach to eating well and exercising regularly. Rather, information needs to be provided on an ongoing basis. It is also important to involve carers or family members in the information session. This is discussed in more detail following, when the role of carers is explored.

Infections

People living with a serious mental illness may be at higher risk of engaging in behaviours such as intravenous drug use and higher risk sexual activity, leading to an increased risk of acquiring infections such as hepatitis C, HIV and sexually transmissible diseases. In particular, people who use substances intravenously are at higher risk of developing blood-borne infections (Sanger et al., 2013). It is important that health professionals educate all people about the risks of acquiring any infection, blood-borne or otherwise. This may be as simple as providing information on hand washing.

Musculoskeletal disorders

Antipsychotic medication, particularly when prescribed for older people, can cause postural hypotension, leading to falls and fractures. There is reportedly a higher incidence of osteoporosis in people with schizophrenia (Stubbs, 2009). Again, health professionals have an important role in providing information to people about the side effects and in monitoring people with a serious mental illness for symptoms related to these side effects.

Respiratory disorders

High rates of cigarette smoking lead to higher incidence of emphysema and recurrent chest infections among people with serious mental illness. There is also an increased risk of mortality in people with asthma who are prescribed antipsychotics (Bouza, Lopez-Cuadrado, & Amate, 2010).

This list of physical disorders provides the health professional who works in a health context where treatment for physical illness is required with some background information that may help them to provide more informed care and treatment. Strategies the health professional may find helpful when caring for the person with a serious mental illness in this context are outlined in the next section.

Care and treatment

In light of the higher prevalence rates of physical illness in people with serious mental illness, and also the psychosocial issues they experience in their lives, it is very likely that health professionals will encounter people with serious mental illness, regardless of where they work. It is important to note, however, that if the person's symptoms are well managed with medication, the health professional may not even be aware that the person has a serious mental illness.

On the other hand, if the person is exhibiting symptoms, the health professional will need to know what to do to help the person. In particular, the **florid positive symptoms** of schizophrenia or the symptoms of mania will affect the person's thinking and behaviour, which, in turn, will affect the person's ability to cooperate with health professionals who are providing care and treatment for a physical condition.

florid positive symptoms positive symptoms of schizophrenia that are pronounced or in their fully developed form

Receiving health care and treatment for a physical condition is a stressful event for all people. The health service context can seem formal and daunting to any person who seeks help, leaving them feeling disempowered. A person with a serious mental illness will feel doubly disempowered because of the stigma attached to their mental illness. They may also find it more difficult than others to tolerate and cope with sudden and unfamiliar events, giving rise to reactions that can increase their symptoms of mental illness.

It is important, then, for health professionals to work hard to engage in order to develop a rapport and therapeutic relationship with the person with a serious mental illness. Such a connection can realise the following benefits.

- The health professional can gain an accurate picture of the person's health issues through the acquisition of comprehensive and accurate clinical information, in turn leading to the effective application of appropriately matched treatment.
- The person is less likely to feel distressed, fearful, anxious and uncertain, and express this through behaviours that are difficult to manage in a health environment.
- The person is more likely to be satisfied with their care and accept the interventions that are being offered by health professionals.
- The person is more likely to adhere to the treatment that is being provided for their physical and mental health issues.

The principles of building rapport and establishing an alliance are described in chapters 2, 5 and 6. The importance of developing and maintaining a therapeutic relationship to improve outcomes of treatment are also outlined. A summary of these principles and outcomes is provided as follows.

Establishing rapport

Some health professionals can use a maternalistic or paternalistic approach to care, and forget that people with a serious mental illness have the same hopes, fears, needs or expectations as other people. However, it is important to remember that people with a serious mental illness are people first and foremost. Like all people, they have relationships, day-to-day responsibilities to attend to, interests and relationship issues. Similarly, each person has their own individual story to tell. It is important that health professionals give people with a serious mental illness the same respect and common courtesy that they give to all service users while bearing in mind that it may take a little longer to engage with a person who has a serious mental illness.

Health professionals can establish rapport with a person with a serious mental illness by following the same principles and using the same strategies that they use when establishing a rapport with any person. These principles and strategies include:

- attending to what the person is saying or trying to communicate
- actively listening to the person
- validating what the person is saying is their experience (without reinforcing any delusions)
- demonstrating empathy.

Sometimes the person's delusions or behaviours may seem amusing or bizarre to the health professional, who may be tempted to laugh or ridicule the person. Health professionals must work hard to respond rather than react to what a person tells them or to the way the person behaves. Society has had a tendency to ridicule the 'crazy' person and the health professional has a role in modelling appropriate responses. This, in turn, will help to educate the community and bring about a general change in community attitudes.

Additional suggestions

When a person is experiencing the positive symptoms of schizophrenia or a mania, it is best to provide them with a low stimulus environment with little noise and low levels of activity and interruption. Health professionals are advised to speak slowly and calmly, and check frequently that what they are saying is clear. If a person shares the content of their delusional ideas with a health professional, it is best to neither agree with the content nor try to persuade the person that they are mistaken. Instead, health professionals can respond empathically by saying, for example, 'It must be hard for you when you believe these things and other people don't' or 'Although I do not share the same belief, I believe that these thoughts must be distressing for you'. If the person asks the health professional outright if they agree, the health professional may respond by saying, for example, 'I don't see it the same way you do, but I can see that this is very real for you'.

Health professionals will also find it helpful to establish boundaries or practise limit setting with the person experiencing a hypomania or mania. Most often, people with these symptoms are unable to set their own limits and, once they have commenced treatment, will usually appreciate being guided by the health professional. A person who has experienced symptoms of mania will sometimes look back at their behaviour when they were unwell and feel embarrassed or have great regrets. It is also important that health professionals talk to the person about limit setting and negotiate the rules and consequences together. An authoritarian approach must be avoided as it will increase the person's level of irritability and it also contravenes the consumer-centred person-focused approaches that are outlined in chapter 2.

Other suggestions for working with a person with a serious mental illness who is exhibiting acute or florid symptoms are outlined in table 9.2 (overleaf).

Negative symptoms of schizophrenia and depression can have a profound but less dramatic impact on the way in which health care is provided to people with a physical illness. When working with a person who has significant negative symptoms, the health professional must find a balance between maintaining a positive therapeutic approach while also accepting that less than optimal adherence to treatment may be the norm. People with negative symptoms may not always keep appointments or retain a full understanding of their health needs despite being provided with relevant information.

TABLE 9.2 Tips for working with a person experiencing acute symptoms

Intervention	Rationale
Maintain your own safety and the safety of the person who is acutely unwell.	A person who is acutely unwell may behave in ways that are out of character for them — particularly if they are experiencing psychotic phenomena or are suicidal.
Ensure evaluation of mental state as part of health professional's assessment.	Provides a baseline against which to assess improvement or deterioration.
Use non-judgemental and non-critical responses; offer reassurance and demonstrate acceptance.	Reduces the stress associated with alterations in thinking and perception.
Maintain regular social contact — do not avoid the person or isolate them.	Isolating and avoiding the person is likely to increase feelings of anxiety and suspicion.
Use clear straightforward language (e.g. avoid jargon, approach unhurriedly, maintain eye contact and open posture). Avoid overt criticism and negative comments; be accepting of bizarre conversations.	Ensures that communication is clear and unambiguous. Reduces the likelihood of the person displaying apparently uncooperative or 'difficult' behaviours.
Reassure the person that they are safe and of your non-harmful intent.	Can act to reduce suspicious thoughts and anxious feelings.
Maintain accurate records of the person's verbal and non-verbal behaviour (e.g. angry, hallucinating, impulsive, irritable, withdrawn, dietary and fluid intake).	Enables any improvements or deterioration in symptomology to be monitored and evaluated. Ensures that physical health needs are met.
If the person is disturbed or agitated, refrain from unnecessary actions or procedures.	These may increase feelings of anxiety and suspicious thoughts.
If possible and practicable, involve the person's partner/carer/significant other in the assessment and delivery of care.	Can provide reassurance and consistency in care delivery and helps maintain a vital link to the person's usual routine.

Specific negative symptoms require targeted interpersonal responses; for example, problems with concentration can be addressed by checking the understanding of the person. Other helpful strategies for working with people who have negative symptoms of schizophrenia and depression include:

- offering reminders, or setting up a system of reminders or schedules
- involving carers and family members when providing health advice and education, wherever possible

- making appointments later in the day to allow for the sedating side effects of the previous evening's antipsychotic medication to wear off
- providing written information to reinforce verbal advice.

It is essential that health professionals show patience and a willingness to work with the person, regardless of the difficulties.

UPON REFLECTION

Violence and schizophrenia

A commonly held belief is that all persons with schizophrenia are violent and dangerous and therefore should be avoided and dealt with within the criminal justice system. In fact, research suggests that this is not correct and that the majority of mental health patients are not violent. Current estimations indicate that only 8.5 per cent of patients with schizophrenia have one or more convictions of violence (Fazel, 2009).

Questions

1 What do you think are the major contributors to this myth?
2 What are the vital elements within any mental health assessment in the determination of violence risk?
3 If aggression does occur, how might a mental health clinician deal with it?

'Who has the time?'

Health professionals are often poorly resourced and pushed for time. This situation makes it difficult to engage with a person who is experiencing symptoms of serious mental illness. Engaging with the person will take more time than the health professional ordinarily spends with a consumer. Even so, the time spent initially with a person with schizophrenia will improve health outcomes for the individual in the long run.

A lack of engagement with the person with a serious mental illness early in the treatment process will reduce clinical understandings, treatment adherence and may lead to poorer health outcomes. It is necessary to ensure that the person is given adequate time to express their needs, even though this can be challenging in a busy clinical environment. If adequate attention is not given to these issues, it is likely that the person will not fully understand the care and treatment being offered. Complications and further difficulties can then ensue, which will prove even more costly in terms of time.

When is a mental health assessment required?

A person who is exhibiting the signs and symptoms of serious mental illness and is not already receiving treatment must be assessed by a specialist mental health professional. The comprehensive assessment conducted on a person with a serious mental illness is described in chapter 2. The difference is the complexity of the assessment. The role of health professionals who do not have specialist training or skills is to monitor the person and keep them safe until the mental health specialist arrives. This may involve listening to the person's story and recording information as it is stated or observed. Strategies for engaging with the person with a serious mental illness have already been outlined.

A person with a serious mental illness who has been stabilised by appropriate treatment does not routinely require a comprehensive mental health assessment. Generally, a full assessment will only be required if there has been a change or deterioration in the mental state of the person.

Comorbidity and assessment

If the person with a serious mental illness has a comorbid physical illness and is receiving treatment for that physical illness, there may be times when an additional mental health assessment is necessary, especially if the physical symptoms (e.g. pain) may induce the psychotic symptoms. Some health services will be able to access mental health consultation liaison services to assist with this assessment (see chapter 12). However, there may also be times when it is not possible for clinicians to access any kind of specialist mental health support. For example, many rural and remote areas do not have any kinds of specialist mental health service. Alternatively, there may be an emergency situation and the clinicians will be required to undertake an assessment to help the team to manage the situation. In cases such as these, it is necessary for health professionals to undertake a mental health assessment, including a mental state examination (MSE) and a risk assessment, to determine the immediate needs of the person.

As already noted, details of how to undertake a mental health assessment are provided in chapter 2. This includes a description of the MSE. Risk assessments are detailed in chapter 8. Health professionals are encouraged to reacquaint themselves with this information in light of the symptoms that are experienced by a person with a serious mental illness, as previously outlined.

A comprehensive mental health assessment may also be necessary when:

- the person reports or experiences any change in mental state
- the person reports or experiences any change in level of risk of self-harm, suicide, or risk to others
- the person reports or experiences a physical condition that has the potential to impact on mental health status
- collateral information is received from the carer or community services to suggest an assessment if necessary.

If specialist assistance from a mental health professional cannot be obtained to support the mental health assessment, health professionals need to ensure they take the following steps.

- Establish a therapeutic alliance with the person.
- Reassure the person and minimise their level of stress and distress.
- Talk to the person to gain an understanding of the person's issues.
- Undertake the comprehensive mental health assessment and risk assessment.
- Discuss findings with the multidisciplinary team.
- Consult with a specialist mental health service to seek advice on appropriate courses of treatment.
- Refer on to a mental health specialist if required.
- Negotiate a treatment and Recovery plan with the person and their carer.

An important part of this process would be to ensure that the care and treatment provided for the physical health problem is compatible with the treatment already being received for the serious mental illness. In particular, it is important to consider interactions between medications. This is explained in detail in later sections of the chapter.

Comorbid treatment options

People with a serious mental illness who have comorbid physical health problems are provided with the same care and treatment as any other person with the same physical health problems. Any differences will relate only to the type of medication the person may be taking and consequent interactions between these medications and other treatment options that may be suggested for the physical illness. Psychotropic medication is outlined later in the chapter.

In addition, health professionals will need to ensure they provide information to other health professionals about the physical illness. This includes mental health professionals who may be working closely with the person, such as a case manager, general practitioner (GP) or other community-based organisations. This could include non-government organisations that provide long-term accommodation and community support to the person.

Indeed, it is important to fully involve all stakeholders — consumers, carers and all members of the multidisciplinary team — in aftercare and follow-up arrangements. Clear and transparent communication, including the exchange of relevant clinical information, with all members of the wider multidisciplinary team, is essential to enable the best possible outcomes for the person. This may include providing a degree of coordination to ensure all services are engaged. It would also involve working closely with carers. The role of carers is now explained.

UPON REFLECTION

Treatment gatekeeping

A person seeking treatment will very often present with multiple issues — for example, substance misuse and serious mental illness — only to be met with a 'gatekeeping response'. That is, they are often told that the service they have contacted is not suitable for them and they need to deal with their comorbid issue first and then come back. However, this contravenes good practice policy, frequently leaving a distressed and unwell person without help. This issue often occurs in practice between drug/alcohol services and mental health services.

Questions

1. Should mental ill-health and substance use disorders be considered two separate conditions? Why?
2. What do you think are the inherent problems of managing these two conditions separately?
3. What are the best treatment options, practices and approaches for a person with comorbid mental illness and substance misuse?

THE BIG PICTURE

Ruah Community Services: Involving the non-government mental health services in care

Ruah Community Services is an example of a non-government mental health service that aims to provide a diverse range of services to persons experiencing serious mental illnesses and disadvantage. Ruah Inreach supports people to meet their psychosocial and mental health goals, improve their quality of life, and enhance their recovery journey by tailoring interventions relevant to the client's goals.

Reflecting the spiritual heritage of its founders, the Daughters of Charity, the service's staff and volunteers take an inclusive approach to spirituality and recognise the different paths that may be taken to nurture it in the individual. *Ruah* is a Hebrew term that means 'spirit', 'breath' and 'wind', and its inclusion in the organisation's title complements Ruah Community Services' mission and core values.

The organisation's key in-reach service delivery efforts comprise:

- four local teams that provide families and individuals with psychosocial and Recovery support
- a metropolitan intensive team that works with homeless people with a mental illness
- an Early Episode Partnership program in Rockingham
- a Specialist Recreation Program that operates in Perth's lower northern suburbs
- Urban Network and Wellness Recovery Action Plan (WRAP) peer programs.

The core work is based on a relationship developed through regular one-to-one contact with an individual and, where relevant, their family. Service delivery is community based, and so it can occur in a home environment or a more neutral community locale.

Ruah Community Services also participates in projects that enhance service delivery for children of parents with a mental illness (COPMI) and promote and develop improved services delivery practices, workforce development, systemic change and community capacity-building work.

The organisation provides homelessness/housing support through its facility-based services (e.g. an inner-city centre and two refuges) and mobile services that cover the greater Perth region. It also undertakes lobbying and systemic advocacy work to improve the housing situation and quality of life of people in disadvantage.

Source: Ruah Community Services, www.ruah.com.au

Carers

According to the Department of Health and Ageing (2012), a carer is a person who, through family relationship or friendship, looks after someone with a chronic illness, with a disability, or who is old and frail, in the community or in their own home. Carers play an important and valuable role in Australia's health system. This is recognised by the Australian government, and state/territory governments across the nation.

Despite this recognition, there is sometimes a difference between policy and practice, and many carers feel that the work they do goes unrecognised by health professionals. There are many reasons for this. The pressure of workloads and institutional cultures can mean that carers and their needs are sometimes sidelined. There has also been lack of clarity about the carer's role for professionals and carers alike. The next section outlines some of the roles and responsibilities that are undertaken by carers.

Roles

According to Morris and Thomas (2002) and Healey (2012), there are five main aspects to the caring role.

1. *Co-workers*. Carers and health professionals help each other care for people with mental health issues.
2. *Consumer advocates*. Carers monitor the care provided by health professionals and try to ensure it is the most appropriate care.
3. *Personal needs*. Carers need personal, emotional and psychological support. For example, they need help to develop effective ways to manage their stress levels, their relationships, their individual reactions to the experience of caring.
4. *Everyday life*. Carers need to provide shelter, food and clothing for themselves and those who depend on them, as well as maintain their own social networks and have breaks.
5. *Coordination*. Carers need to constantly juggle priorities and tasks so that everything occurs in an appropriate order.

These many aspects to the role often mean that carers feel overwhelmed and unable to meet the challenges with which they can be faced.

Table 9.3 outlines the similarities and differences between the roles of the carer and the health professional. One of the most important differences is the preparation or training that each receives to undertake their role.

TABLE 9.3 Comparison of role of carers and health professionals

Activities	Carers	Health professionals
Choice	Carers have little choice in taking on the role Cannot exit role at own will	Health professionals choose to enter and leave health workforce at any time
Preparation for role	Occurs after carers have taken on the role	Occurs before
Training	Limited and self-directed	Extensive formal education prior to starting. Course of study determined by professional bodies Ongoing education once in the role

(continued)

TABLE 9.3 *(continued)*

Activities	Carers	Health professionals
Supervision	None	Part of ongoing quality assurance
Relationship with person with mental health issues	Not a professional–client relationship There is a different basis for negotiating May be pre-existing Long term	Professional–client relationship Starts after a person becomes ill May be transitory
Hours and breaks	Can be 24 hours a day, seven days a week with no breaks	Determined by work hours
Formal status in health care team	No formal status	Formal status defined by profession
Number of 'consumers'	One	Many

It is important that health professionals understand that carers have varying levels of skill. Generally carers have not been prepared or educated for their role of carer, unlike health professionals who spend many years receiving an education and supervision in practice. For this reason, carers may not recognise if or when a situation is deteriorating. Likewise, they may not be able to communicate what is happening with the consumer to the health professional.

Carers need training and support to undertake what is often expected of them. Health professionals are key stakeholders in helping carers to identify their needs. Health professionals are also in a key position to identify where the carer may find this training and support, as is appropriate to their needs.

Another important difference between carers and health professionals is that carers can be 'on duty' for 24 hours a day, seven days a week. The carer does not receive a break. This is unlike health professionals, who go home after eight hours at work, have weekends or a few days off, and annual leave. It is important, then, for health professionals to talk to carers about fatigue and how they are managing their personal needs. This conversation will include identifying options for respite.

Providing information

Alongside training and support, carers also need information to do their job (Healey, 2012; Morris & Thomas, 2002). This could be brief information or extensive training. The skills, abilities and attitudes of carers change over time. At the start of their caring career, carers do not necessarily know what is important or unimportant. Questions a carer may have or the information they need at the start of their caring career will be different to their requirements later in their caring 'career'. Therefore, it is always necessary when meeting a carer to assess what stage the carer is at in their caring career, and the knowledge they possess.

Carers commonly seek out:

- information about the illness (e.g. the symptoms they are most likely to encounter and how to deal with them)
- education about coping skills
- information about what to do in a crisis (Mottaghipour & Bickerton, 2005).

It is important that health professionals realise that carers often take on the caring role or come into contact with health professionals in times of high stress. This impedes the carer's ability to absorb the information the health professional provides them or to develop skills the health professionals may be trying to teach them. Carers nevertheless need the same information that health professionals need to provide safe and effective care to their partner, friend or family member. This could include clinical information about assessment, risk, treatment and Recovery planning. It could also include practical information about employment, tasks at home, socialising and so on. Health care professionals should always enquire as to whether carers are accessing support and information when they need it. Organisations such as the Association of the Relatives and Friends of the Mentally Ill, and the Schizophrenia Fellowship can offer support and information to people who care for a person with a serious mental illness.

UPON REFLECTION

Ethical dilemma

A person with a serious mental illness will sometimes ask health professionals not to provide information about their condition to their carer. In accordance with Australia's Privacy Acts, the health professional often responds by providing the carer with no information at all.

Questions

1. In what circumstances would a health professional not involve the carer and/or give information at the request of the patient?
2. If the health professional cannot provide all relevant information to a carer about the person they are caring for, how reasonable is it for the health professional to hand over the care of that person to the carer?
3. What are the options for a health professional in relation to sharing information, if a consumer has asked that only limited information be provided to the carer?

Information sharing

Carers need information to help them to provide safe and effective care for the person with a mental health issue. While carers may not have a 'health professional' status and are not paid for their role, they necessarily have a number of responsibilities. Carers are also a valuable resource for health professionals who are undertaking an assessment and require ongoing information. Indeed, carers spend more time with the person with a mental illness than the health professional and so they are often more able to report how the consumer is feeling or behaving. A carer may share information with the health care professional without breaching laws or codes of conduct. Significantly, the carer will often have more time or opportunity than the health professional to influence the consumer and the Recovery process (Healey, 2012); Kuipers, Onwumere, & Bebbington, 2010). Effective health professionals will work closely with carers to facilitate positive outcomes.

Many health professionals are concerned about how much information they can give a carer and whether they are breaching confidentiality. Health professionals often make presumptions and refuse to pass on any information whatsoever to the carer. Often this presumption is nothing more than exactly that; that is, the health professional makes the decision without checking. It is always worth finding out whether a carer is happy for information to be shared. This could include discussing the advantages and disadvantages of limiting the flow of information. Such a discussion can save much time and distress for all concerned.

Mental health legislation across Australia is currently being reviewed in relation to the role of the carer and their rights. Carers now have more rights in relation to receiving information about the person's condition and also in making treatment decisions. It is important to note that, at this point in time, in Western countries like Australia, a person with a mental health issue does not have the right to prevent a health professional from talking to a carer or giving that carer information, advice and support. Further, a person with a mental health issue does not have the right to prevent a carer from talking to a health professional about carer issues. However, personal information that has been identified between the service user and health care professional as confidential should not be disclosed during these conversations (The Princess Royal Trust for Carers and National Mental Health Development Unit, 2010).

One way to address the issues of providing information to carers is for the health professional to arrange for a group or family meeting where the multidisciplinary team, consumer and carer meet together to talk about all aspects of care, with the consumer present. This enables a clear and transparent flow of information between all stakeholders at a time when they are all present and can discuss the issues. A carer may be unaware of the range of information available to them. They may also be unaware that they may have gaps in their knowledge. The health care professional has a role to play in identifying these issues and providing assistance — rather than waiting to be asked.

Treatments for serious mental illness

There is currently an array of treatment options for people with a serious mental illness. A range of factors — including personal choice, the stage of the illness, the availability of treatment options and the health context in which the person is receiving treatment — will influence the choice of treatment.

Common treatments utilised in Australia include pharmacological therapies and psychological therapies (e.g. social, recreational and vocational) and psychoeducation. It is important that the person with the serious mental illness is informed about the range of treatments available and encouraged to participate fully in the decision-making process. All services — both government and non-government — should be explored ensuring that the care provided is well coordinated.

The pathway of care that the consumer chooses is not always straightforward. For example, mental health treatment often involves many ethical dilemmas, concerned with the balance between an individual's right to choose their preferred treatment option or decline treatment altogether; and a paternalistic approach to care, where health professionals direct or prescribe treatment. Indeed, there may be times when the person with the serious mental illness lacks the capacity or insight, due to the symptoms of their mental illness, to make rational decisions that will lead to better health outcomes. A person may experience several episodes of acute illness before acceptance of their experiences leads to action. The action involves treatment, the provision of support, and self-management that in turn leads to control, self-esteem and new or renewed meaning in life. On occasion, this pathway will also involve mental health legislation.

All states and territories in Australia have mental health legislation that allows for the provision of mental health treatment to people who need assistance but decline care and treatment due to their mental state. Treatment is nevertheless provided to protect the person, ensure treatment and, in some cases, protect others. Information about mental health legislation in Australia was provided in chapter 3.

Pharmacological therapies

Many people with a serious mental illness who present to general health settings for treatment of physical disorders will be receiving pharmacological treatments for their pre-existing mental health condition. For this reason, it is important that all health professionals are aware of the mode of action and possible side effects of these medications, as all medications have the potential to interact with one another.

Polypharmacy results from the prescription of multiple medications for various comorbidities. These multiple medications may affect the **pharmacokinetic** and **pharmacodynamic** properties of one another. It is also important to remember that over-the-counter medications and herbal remedies may interact with prescribed medications (Ferrando, Levenson, & Owen, 2010). Concurrent substance use will also impact on the pharmacokinetic and pharmacodynamic properties of prescribed medications. Health professionals are advised to carefully consider all of the medications that a person with a serious mental illness has been prescribed and check how the interactions may impact on the person physically, mentally and socially. This is particularly important in relation to psychotropic medication, which affects the mind, emotions and behaviour. Interactions have the potential to significantly impact upon the person's life.

polypharmacy the concurrent use of multiple medications by a person; these medications often interact in a way that is problematic for the person

pharmacokinetic the absorption, metabolism, distribution and elimination of a drug

pharmacodynamic the physiological action of a drug on the body

Antipsychotic medication

Antipsychotic medication is used as an effective treatment in the acute phase and long-term management of psychotic illnesses such as schizophrenia (Royal Australian and New Zealand College of Psychiatrists [RANZCP], 2005). There are two broad classes of antipsychotic medication that are currently in use:

1. 'typical' or 'first generation' antipsychotics, which were first developed in the 1950s
2. 'atypical' or 'second generation' or 'novel' antipsychotics, which were developed from the 1970s onwards.

Both classes of antipsychotic medication have an effect on dopamine activity, attributed to their action of attenuating dopamine transmission at the synapse. This effect is in line with the dopamine hypothesis related to schizophrenia (see explanation earlier). Figure 9.1 provides a simplified diagrammatic representation of the dopamine antagonist action of antipsychotic medication. This diagram shows an antipsychotic medication binding to the post-synaptic dopamine receptor preventing normal transmission of dopamine across the synapse.

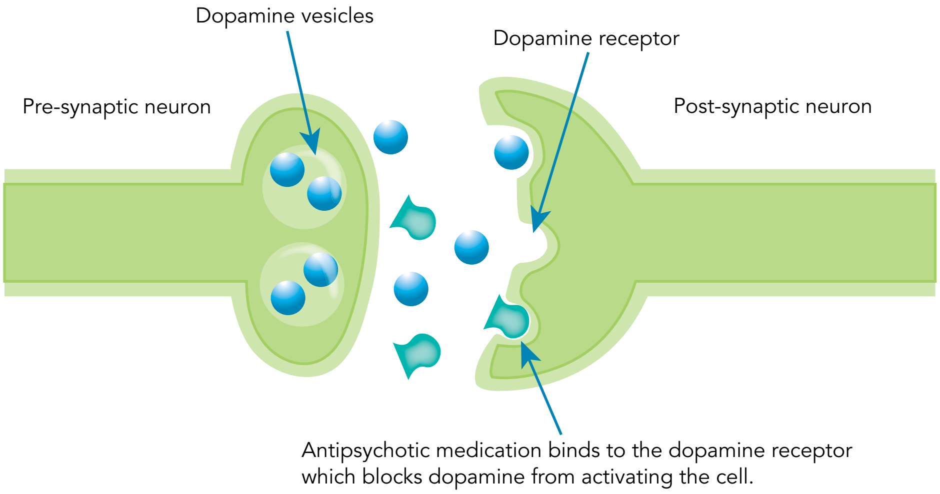


FIGURE 9.1 Antipsychotic medication blocking transmission of dopamine at the synapse

As already noted, antipsychotic medication is generally effective in reducing the positive symptoms of schizophrenia and relapse rates (Larson, Walker, & Compton, 2010, Nastro et al., 2010). Antipsychotic medication can also have some impact on reducing the negative symptoms and cognitive decline.

Typical antipsychotics

As already noted, 'typical' or 'first generation' antipsychotics were first developed in the 1950s. Typical antipsychotics have strong **D2 antagonist** properties. This gives typical antipsychotics greater efficacy in treating positive symptoms of schizophrenia than negative symptoms (Usher, Foster, & Bullock, 2009).

Examples of 'typical' antipsychotic medications used in Australia include:

- chlorpromazine (Largactil®)
- pericyazine (Neulactil®)
- droperidol (Droleptan®)
- flupenthixol (Fluanxol®)
- fluphenazine (Modecate®)
- haloperidol (Serenace®)
- haloperidol Decanoate (Haldol®)
- trifluoperazine (Stelazine®)
- zuclopenthixol dihydrochloride (Clopixol®)(tablet form)
- zuclopenthixol decanoate (Clopixol **Depot**®) (depot medication)
- zuclopenthixol acetate (Clopixol Acuphase®) (depot medication) (MIMS Australia, 2009).

D2 antagonist the D2 receptor is a specific type of dopamine receptor in the brain; an antagonist binds to a receptor without activating it

depot medication that is given by intramuscular injection and absorbed over a period of weeks (please note zuclopenthixol acetate is a shorter acting depot with its effect peaking at 48–72hrs)

One reason for the decline in the use of first generation antipsychotic medications is the successful marketing of the second generation antipsychotic medications, which tend to have similar efficacy but better tolerability. Indeed, the first generation antipsychotic medications are associated with a range of common and undesirable side effects including sedation, postural hypotension and **extra pyramidal side effects (EPSEs)**. These are described in more detail below.

These are described in more detail as follows.

Atpical antipsychotics

Atypical antipsychotic medications appear to provide some relief from both the positive and negative symptoms of schizophrenia and also reduce the cognitive decline that is often associated with the disorder. Atypical antipsychotic medications are thought to impact on **serotonin transmission** in addition to their D2 antagonist properties (Banks et al., 2010). An understanding of this is important as the side-effect profile of the two groups differs. Though atypical antipsychotic medications are associated with reduced risk of EPSEs compared to first generation antipsychotics, they are more likely to be associated with **metabolic side effects** (Therapeutic Guidelines Ltd, 2008).

Examples of 'atypical' antipsychotic medications used in Australia include:

- amisulpride (Amipride®, Solian®, Sulprix®)
- aripiprazole (Abilify®)
- clozapine (Clopine®, Clozaril®, CloSyn®)
- olanzapine (Zyprexa®)
- paliperidone (Invega®)
- quetiapine (Seroquel®)
- risperidone (Risperdal®)
- ziprasidone (Zeldox®) (MIMS Australia, 2009).

These medications, with the exception of clozapine, are recommended as first-line treatment in people with newly diagnosed schizophrenia (Usher, Foster, & Bullock, 2009).

Clozapine has been shown to have superior efficacy in helping people overcome treatment-resistant schizophrenia (e.g. Agid, Foussias, Singh, & Remington, 2010). Treatment resistance is a term used to describe the situation when a person has at least two adequate trials of classical neuroleptic medication but continues to experience persistent moderate to severe positive symptoms, or disorganisation, or negative symptoms together with poor social and work function over a prolonged period of time. This definition reflects the viewpoint of people with this illness, their family members, and mental health professionals. Although clozapine has been shown to provide effective treatment in some of these cases, this medication can induce very serious side effects for some people, such as **agranulocytosis**, **cardiomyopathy** and **neutropenia**, which could precipitate a medical emergency.

There are stringent procedures for monitoring people who have been prescribed clozapine involving blood tests and physical observations. Clozapine cannot simply be discontinued or restarted at previous doses. Its use is also contraindicated in a variety of medical conditions. People who are being treated with clozapine in Australia must be monitored through a standardised system called the Clozapine Patient Monitoring System, which involves pre-treatment medical screening followed by weekly to monthly blood tests.

extra pyramidal side effects (EPSEs) physical symptoms sometimes associated with antipsychotic medications, including tremor, dystonia, slurred speech and akathasia

serotonin transmission serotonin is a neurotransmitter associated with mood, sleep cycle, learning, memory, appetite and muscle contraction; antidepressant medications are the best known medications that modulate serotonin transmission at the synapse

metabolic side effects a collection of symptoms associated with antipsychotic medications that includes weight gain, hyperglycaemia, lipid abnormalities, metabolic syndrome and potentially type 2 diabetes mellitus

agranulocytosis medically serious condition relating to low levels of white blood cells

cardiomyopathy deterioration of the myocardium or heart muscle

neutropenia low levels of neutrophils — a subtype of white blood cells

Side effects of antipsychotic medication

All medications have a potential to induce side effects. Factors influencing the overall tolerability of a medication include the seriousness of the side effects and the frequency with which they occur. Many of the side effects of antipsychotics are quite difficult for consumers to manage and so it is important that health professionals have detailed information on hand to assist the consumer. This information can be obtained from relevant pharmaceutical companies. The internet is also a valuable resource; for example, SANE Australia: www.sane.org.

Side effects to antipsychotic medications generally include:

- cardiovascular effects — antipsychotic medication can cause postural hypotension and **electrocardiograph (ECG)** changes, in particular increased Q-T interval
- weight gain
- metabolic and endocrine problems — some antipsychotic medication can give rise to elevated levels of prolactin — often leading to erectile dysfunction in men and menstrual problems in women
- type 2 diabetes
- sedation
- sexual dysfunction — also linked to hyperprolactinaemia; that is, production of breast milk in males and females who are not lactating, breast growth in men, erectile difficulties and/or ejaculation problems, menstrual irregularities
- hepatic side effects
- lower seizure threshold
- **anticholinergic** effects — blurred vision, dry mouth, constipation, urinary retention, memory and cognitive impairments and hallucinations
- extrapyramidal side effects (EPSEs).

electrocardiograph (ECG) a graphical representation of readings of electrical activity in the heart

anticholinergic an action that inhibits the effects of the neurohormone acetylcholine or inhibits its cholinergic neuroeffects

EPSEs are the most common side effects.

In addition to the general side effects listed above, there are also some quite specific side effects caused by the 'atypical' antipsychotics medications. These include:

- **haematological** side effects including agranulocytosis (clozapine)
- increased risk of type 2 diabetes
- changes in lipid metabolism — increase in serum triglycerides.

haematological relating to the blood

As noted, side effects for atypical antipsychotics are metabolic in orientation and require blood tests to identify. Even so, it is important that health professionals monitor for signs and symptoms so that consumers who are affected can be treated sooner rather than later.

Extrapyramidal side effects

Extrapyramidal side effects (EPSEs) are often overlooked or mistaken as symptoms of agitation. They can also be mistaken as part of the underlying illness. It is important to remember that EPSEs also occur with medically prescribed drugs that have antidopaminergic properties, such as metaclopramide. A list of the major EPSEs is provided in table 9.4. Table 9.5 goes on to identify the relative frequency of common adverse effects of antipsychotics at usual therapeutic doses. It is important that health professionals are aware of these side effects, monitor consumers for symptoms, and provide them with relevant information to manage them.

TABLE 9.4 Extrapyramidal EPSE side effects of antipsychotic medication

Side effect	Characterised by	Treatment
Parkinsonism	Shuffling gait, tremor, muscle stiffness, limb '**cog wheeling**'	Responds to dose reduction or treatment with anticholinergic medications such as benztropine or benzhexol
Dystonia	Involuntary muscular contraction	Responds to anticholinergic medication such as benztropine and dose reduction
Akathesia	Subjective or inner feeling of restlessness	Responds to dose reduction and treatment with propanolol or diazepam
Tardive dyskinesia (TD)	Involuntary movements of the mouth, lips and tongue, which may progress to the head, neck and trunk. This is most likely to be seen as a result of long-term treatment. Often irreversible	Dose reduction or treatment with anticholinergics may worsen TD. As treatment is complex, contact specialist mental health professional, ward pharmacist and local drug information service. TD has been known to affect muscles of the respiratory and gastrointestinal systems

cog wheeling muscular tension in limbs that gives way in small jerks when the limb is extended or flexed

TABLE 9.5 Approximate relative frequency (not intensity) of common adverse effects of antipsychotics

Drug	Anti-cholinergic	Dys-lipidaemia	Extra-pyramidal	Hyper-glycaemia	Hyper-prolactinaemia	Orthostatic hypotension	Sedation	Weight gain
Second-generation antipsychotics								
amisulpride	–	?	+	–	+++	–	+	+
aripiprazole	+	–	+	–	–	+	–	+ [NB2]
asenapine [NB3]	+	++	+	++	+	+	+	+
clozapine	+++ [NB4]	+++	–	+++	+/–	+++ [NB5]	+++	+++
olanzapine	++	+++	+/–	+++	+	+	++	+++
paliperidone	+	++	+	+	+++	++ [NB5]	+	++
quetiapine	+	++	+	+++	+	++	++	++
risperidone	+	++	+	++	+++	++ [NB5]	+ [NB5]	++

(continued)

TABLE 9.5 *(continued)*

Drug	Anti-cholinergic	Dys-lipidaemia	Extra-pyramidal	Hyper-glycaemia	Hyper-prolactinaemia	Orthostatic hypotension	Sedation	Weight gain
Second-generation antipsychotics *(continued)*								
sertindole	–	–	–	–	+	+ [NB6]	–	+
ziprasidone	+	–	+	+	++	+	+	+
First-generation antipsychotics								
amisulpride	–	?	+	–	+++	–	+	+
aripiprazole	+	–	+	–	–	+	–	+ [NB2]
asenapine [NB3]	+	++	+	++	+	+	+	+
clozapine	+++ [NB4]	+++	–	+++	+/–	+++ [NB5]	+++	+++
olanzapine	++	+++	+/–	+++	+	+	++	+++
paliperidone	+	++	+	+	+++	++ [NB5]	+	++
quetiapine	+	++	+	+++	+	++	++	++

Approximate frequencies of adverse effects: ? = little or no information reported; – = negligible or absent; + = infrequent; ++ = moderately frequent; +++ = frequent

NB1: The information in this table is based on a combination of reported adverse effect data and expert opinion; it is intended only as a guide and should be interpreted in the context of the patient's particular situation (eg concurrent drugs, drug history, physical health, the considerable interindividual variation in elimination half-lives) and the doses of the drugs.

NB2: Weight loss reported.

NB3: Data on asenapine adverse effect frequencies are limited.

NB4: Hypersalivation reported.

NB5: Frequency may be higher at the start of therapy or with rapid dose increase.

NB6: Frequency may be higher with rapid dose increase, but data are conflicting.

NB7: More frequent with rapid dose increase.

NB8: Lower incidence with depot formulation.

NB9: Reported to occur but no definitive data published as to the incidence.

Source: Reproduced with permission from Psychotropic Expert Group. Table 9. Approximate relative frequency (not intensity) of common adverse effects of antipsychotics. In: Therapeutic guidelines: psychotropic. Version 7. Melbourne: Therapeutic Guidelines Ltd; 2013. www.tg.org.au

Mood stabilisers

The term 'mood stabiliser' is often used to describe medications prescribed in the treatment of bipolar disorder. Medications falling into this category may be used with good effect to manage acute episodes of mania and depression (RANZCP, 2004). Some medications have also prophylactic properties that assist in the management of manic and/or depressive episodes (Rossi, 2010).

The term 'mood stabiliser' is not listed as a therapeutic class of medication in MIMS. However, medications that have some mood-stabilising properties are listed as antipsychotic medications and others as anti-epileptic medications:

- lithium carbonate (Lithicarb®, Quilonum SR®).
- olanzapine (Zyprexa®). This is also an antipsychotic.

- quetiapine (Seroquel®). This is also an antipsychotic.
- carbamazepine (Tegretol®, Teril®). This is also an antiepileptic.
- sodium valproate (Epilim®, Valprease®, Valpro®, Valproate Winthrop®). This is also an antiepileptic.
- lamotrigine (Elmendos®, Lamictal®, Lamidus®, Lamogine®). This is also an antiepileptic. It is important to note that lamotrigine has been associated with a severe and potentially life-threatening rash. If a rash develops, cease administration of lamotrigine and consult a medical officer immediately (MIMS Australia, 2009).

While all of these mood stabilisers are commonly used for people with a bipolar disorder, perhaps the most important of these medications is lithium carbonate.

Lithium carbonate

Lithium carbonate has been around for many years and was first used to treat mania in the late 1800s. An Australian psychiatrist, John Cade, a survivor of the Changi prisoner-of-war camp, is credited with discovering the mood-stabilising effects of lithium carbonate in the 1940s. Today, it remains a first-line treatment and is often given in conjunction with antipsychotic medication if the person has psychotic features to their symptoms. An important fact to remember about pharmacological treatment that includes lithium is that it is the serum concentration rather than the dose of lithium that will determine effective treatment. The oral dose required to maintain a therapeutic serum concentration of around 0.90 mmol/l will vary between individuals. Lithium has a narrow therapeutic index and an optimal serum lithium concentration needs to be maintained. Outside of this range, a lower level will be ineffective and may lead to relapse. It is essential to remember that if the level rises above the therapeutic range, toxicity can occur and concentrations in excess of 2.00 mmol/l can be potentially fatal. Blood tests for lithium levels need to be taken after the person has been taking a regular dose of the medication for 5–7 days. Blood must be taken 12 hours following the last dose of lithium to test for lithium levels. If levels are above 1.5mmol/l, the authorised prescriber needs to be consulted before the next dose is administered (Usher, Foster, & Bullock, 2009). Risk factors for developing lithium toxicity are conditions that lead to sodium depletion; for example, diarrhoea, vomiting and excessive sweating. Medication that reduces renal excretion of lithium, such as thiazide diuretics and certain non-steroidal anti-inflammatory drugs, can also lead to toxicity.

If a person who is receiving lithium therapy is admitted to hospital for a physical illness, a baseline serum lithium level must be taken. The signs and symptoms of acute lithium toxicity are:

- nausea, diarrhoea, vomiting
- severe tremor, **ataxia**, slurred speech, irregular jerky movements, and **parkinsonian** movements, muscular twitching, seizures
- impaired concentration, drowsiness, disorientation.

Treatment needs to be discontinued and serum lithium, urea and electrolytes monitored. The provision of adequate salt and fluids, including saline infusions, will reduce toxicity. Caution is also needed when prescribing lithium to individuals with renal failure, heart failure, recent myocardial infarction, electrolyte imbalance, and to pregnant women and older people.

ataxia difficulty with coordination, leading to people becoming unsteady on their feet

parkinsonian slow rhythmic movements and tremor

Managing ongoing psychotropic treatment

As a general rule, if a person attends a health service for treatment and is currently receiving psychotropic medication, this medication needs to be continued during medical and surgical treatment. There will obviously be exceptions to this in certain situations. For example, if the medication is specifically contraindicated in people with specific medical conditions or when potentially serious drug interactions may occur as a result of newly instigated treatment, the person must stop taking the medication. If a person is admitted to hospital and currently receives antipsychotic medication by intramuscular injection (e.g. depot injection), the multidisciplinary team needs to ascertain the frequency and details of when the medication is next due, as well as any other individual needs associated with its administration. To clarify these points it will be necessary to make contact with the health professional who usually administers the medication; for example, a member of the community mental health team, the general practitioner (GP) or a practice nurse.

Psychological therapies

Psychological interventions for people with a serious mental illness differ according to the particular phases of the illness. In the last 15 years, cognitive behaviour therapy, cognitive remediation and vocational rehabilitation have been developed and are showing positive results in targeting the symptoms of schizophrenia, as well as addressing the wider psychosocial consequences (RANZCP, 2005). Psychosocial interventions are used in the treatment of bipolar disorder to 'reduce symptoms, prevent relapse and recurrence, restore social and psychological functioning and support patient and family' (Royal Australian and New Zealand College of Psychiatrists, 2004). A selection of the more commonly used interventions are now described briefly.

Motivational interviewing

Motivational interviewing (MI) can be used in the short term for people with a serious mental illness during an acute phase of their illness or when they are being cared for or treated by health professionals for a physical illness. The aim of motivational interviewing is to engage people with their treatment. Used throughout the field of health, motivational interviewing uses four primary and guiding principles:

1. to resist the righting reflect
2. to understand and explore the patient's own motivations
3. to listen with empathy
4. to empower the patient, encouraging hope and optimism.

These four principles can be remembered by the acronym RULE: Resist, Understand, Listen, and Empower (Rollnick, Miller, & Butler, 2008, p. 7). As stated by Rollnick, Miller and Butler (2008, p. 6):

> MI is not a technique for tricking people into doing what they do not want to do. Rather, it is a skilful clinician style for eliciting from patients their own good motivations for making behaviour changes in the interest of their health. It involves guiding more than directing, dancing rather than wrestling, listening at least as much as telling.

Cognitive behaviour therapy

Cognitive behaviour therapy (CBT) was described in chapter 1. It is a goal-oriented, psycho-educational approach, which has been rigorously evaluated in many contexts and has been utilised with some effect for individuals with serious mental illness; for example, to correct exaggerated and irrational thoughts and errors in judgement. People most likely to benefit from CBT are those with some insight into their illness (Addington & Lecomte, 2012). For this reason, it has limited scope for people with a serious mental illness in the acute phase. However, a number of the strategies used in cognitive behavioural therapy could be utilised to assist or support people with a serious mental illness who are being treated in a hospital-based setting for a physical illness. These could include, for example, relaxation strategies to assist the person in managing their levels of stress or distress.

Acceptance and commitment therapy

Traditional treatments for mental health disorders such as medication and cognitive-behaviour therapy have focused on the reduction or elimination of symptoms. Acceptance and commitment therapy (ACT), however, offers a radically different approach because it recommends the active acceptance of symptoms by the consumers. Health professionals who utilise ACT hold the view that 'the ongoing attempt to get rid of "symptoms" actually creates a clinical disorder in the first place' (Harris, 2009, p. 4). Within the ACT framework, symptom reduction is seen a 'by-product' rather than goal of treatment.

The aim of ACT is to assist the individual to develop a different relationship with their challenging thoughts and feelings. These thoughts and feelings are no longer viewed as 'symptoms' but rather as harmless and transient psychological events. Individuals are taught mindfulness to help them 'let go' of unhelpful thoughts, beliefs and memories. The process of 'mindfulness' supports the person to be fully engaged in the experience of the 'here and now' and encourages an attitude of openness and curiosity.

The consumer comes to accept painful feelings and worrying thoughts or beliefs. The feelings are felt with a learned objectivity; for example, 'Oh, there is that feeling back again. That is interesting, but I am not going to allow that feeling to interfere with my life.' Likewise, troubling thoughts and beliefs are accepted as something that 'is', rather than a state of being to be reckoned with. Acceptance is linked to commitment to move on with life regardless of these feelings, thoughts or beliefs.

Assertive community treatment

Assertive community treatment was first developed in the 1970s as a means of delivering services to people with serious mental illness. Multidisciplinary teams with fixed caseloads delivered services when and where they were needed 24 hours a day, seven days a week. This intensive system of service delivery allowed for the monitoring of a person's mental state and physical health, enhanced medication adherence, social skills training and enhanced family contact.

Assertive community treatment has been demonstrated to reduce hospital admissions; however, it requires fidelity to its 1:10 staffing ratio to maintain efficacy. This makes it an expensive and human resource-intensive program to deliver. For this reason, there are few programs in Australia that are able to effectively provide assertive community treatment.

Case management

People with serious mental illness are often involved with a number of specialist mental health professionals and services. It is therefore essential that there is a nominated clinical or case manager who knows the individual and is aware of their history and their individual health needs. This case manager focuses on coordinating access to services and collaborating with the consumer and other service providers to develop and follow a Recovery plan. The effectiveness of case management will depend on the education, training and level of competence of the individual health professional. The benefits of case management cease if the case manager has too many consumers to support (Lauriello & Pallanti, 2012).

Vocational therapy

There are a variety of interventions and treatment settings available to assist a person with serious mental illness to regain or develop vocational skills. The therapy includes working closely with the consumer to identify occupational goals and ways or means of achieving these goals. The program developed will often include working with employers, or future employers, to identify potential stressors associated with the return to or commencement of employment.

Psychoeducation

In its simplest form, psychoeducation involves providing information to a person about their mental health disorder. The aim of providing this information is to allow the person to make decisions regarding their treatment and lifestyle based on reliable information.

While formal, structured psychoeducation programs are predominantly delivered by mental health care providers, all health professionals can contribute by repeating and reinforcing important health information. The health professional can be very influential when speaking with people regarding information about their illness and health care choices. The individual with an illness may be influenced to consider a treatment option or to rule out another treatment option based on the information they receive and the manner in which it is presented.

It is important to remember that all of us make lifestyle decisions based on our own assessment of information presented to us, though at times our actions may appear 'ill considered' to others. Offering psychoeducation provides a platform for the health professional to reiterate the importance of the person retaining control over their life, in order to prevent a poorly managed illness assuming control.

Psychoeducation can include a range of elements in verbal and written form including:

- information about the disorder
- information about treatment options presented in a manner suited to the person's readiness to consider information (refer to 'Cycle of Change' in chapter 10) and their current cognitive capacity
- motivational enhancement (refer to 'Motivational interviewing' in chapter 10)
- assistance with problem solving/decision making regarding treatment
- family/carer education and support
- support where necessary to help the person cope with difficult and sometimes life-changing personal information (e.g. being diagnosed with a serious physical illness).

Topics can include:

- overview of the illness
- discussion of possible treatments
- managing symptoms and coping strategies
- managing side effects of medications
- wellness planning/relapse prevention/self monitoring
- coping with stigma
- managing emotions and expressing them
- stress — vulnerability model including substance use
- relationships, families, friends, acquaintances and partners
- communication skills
- secondary prevention of common comorbidities.

Providing psychoeducation on an individual basis can be useful as it allows for the tailoring of information to the person's individual needs with respect to diagnosis, symptoms, treatment and environment. Many health professionals also feel more comfortable providing interventions on a one-to-one basis. There are some distinct advantages though, of providing psychoeducation either in a group setting or in a family setting. The benefits of providing group psychoeducation include the advantages to the person of interacting with other people who are dealing with the same issues. This can reduce the feelings of isolation and alienation sometimes felt following a diagnosis of a serious mental illness. It is also beneficial to have peers contributing information in group sessions, providing information on the lived experience (Bisbee & Vickar, 2012; Deane, Mercer, Talyarkhan, Lambert, & Pickard, 2012).

Many health professionals do not initially envisage themselves as group facilitators, but persisting through the early discomfort in facilitating a psychoeducation group can be rewarding. The best way to explore group facilitation as an option is to co-facilitate some groups with a more experienced leader before facilitating groups alone. Another point to consider is to plan the style of group well. Exercise more facilitator control in early groups, making them brief and didactic in early sessions, then as you feel more comfortable, allowing group participants to have more input into the group process. Some points to consider in preparation for group facilitation are as follows.

- Prepare well; spend time planning the session — this will increase your confidence and competence.
- Have a handout containing some information for people to take away with them.
- Ask people what they already understand about their illness. (*Tip:* When asking this question, begin by seeking a response from the person most likely to provide a reasonable response.)
- Explain to group members that while health care professionals have some knowledge about the biology of illnesses and some treatments, the people with the illness are the real experts because they know what is happening in their lives. Their knowledge is an essential component in Recovery planning.
- Explain information in simple terms — avoid the use of jargon.
- Encourage interactivity in group sessions, while being prepared to manage over-talkative members.
- Emphasise choice and self-determination.

- Check with people if they have understood the information.
- Summarise points of the presentation. A good presenter always provides a brief summary of the key points at the end of each session.

Psychoeducation has been shown to improve quality of life for people (Bechdolf et al., 2010). Psychoeducation that includes the education and involvement of family members has been found to be superior to psychoeducation for the person alone (Bisbee & Vickar, 2012).

Recovery

The Recovery approach to care is outlined in chapter 1. The principles of Recovery include a focus on hope, optimism, individual strengths and wellness; collaboration and community engagement; empowerment and agency; and personal growth. Many people assume that people with a serious mental illness will never 'recover'; however, it is important that health professionals consider what it is that they understand by this term. As noted in chapter 1, the Recovery journey for mental health consumers is not to be mistaken for the biomedical notion of 'cure'. The Recovery approach is less about an absence of symptoms or illness and more about enabling consumers to move beyond the negative consequences of their condition, accept that they may continue to experience symptoms of mental illness, and move on towards a future framed by hope (Australian Parliament, 2008). This includes supporting the person's capacity to overcome the discrimination, community ignorance and self-stigma associated with serious mental illness. The Recovery approach also includes providing the person with the means to gain a sense of control over their lives and be given the choice to actively participate as a member of their community (Mental Health Advocacy Coalition, 2008). Finally, Recovery involves the health professional enabling access to community resources, community participation, opportunities for employment, and the person to achieve a way of life that is meaningful to them.

A Recovery framework requires a different relationship between the health professional and the person with a mental illness to that of traditional approaches. This is because Recovery occurs when a person moves from being a passive recipient of treatment to become an active participant in the management of their illness. Within the Recovery context, the health professional moves from the role of 'expert' and 'authority' to that of a 'life coach' or 'trainer' (Shepherd, Boardman, & Slade, 2008). The health professional assists the person by providing information about the symptoms they are experiencing, treatment options, stress management, coping strategies and how to recognise and respond to the early warning signs of relapse. The health professional assists the person to maximise the benefits of support networks and access the resources necessary to manage their own illness and live fulfilling lives. While 'Recovery' is an option for everyone, it may not be taken up to the same extent by every individual (and that is their 'choice') (Andresen, Caputi, & Oades, 2006).

Perhaps one of the most important messages to emerge from the Recovery movement is that people with serious mental illness can and do recover (Hopper, Harrison, Janca, & Sartorius, 2007; Warner, 2009). With support from health professionals, partners and carers, family members, friends, or community services, people with a serious mental illness can look forward to living a long and meaningful life in the same way as other people in the community (Meadows, 2012).

SUMMARY

This chapter provides an overview of the symptoms experienced by people with a serious mental illness and the major treatment options that are available. The term 'serious mental illness' is defined as a mental illness that significantly impacts upon a person's lifestyle, relationships and social functioning. It is explained that the seriousness of a person's illness is dependent upon the nature and severity of symptoms, the duration of the experience and the extent to which it has impacted on the person's life and ability to function independently. The focus of this chapter is schizophrenia and bipolar disorder.

It is noted that people with a serious mental illness have a much higher risk of developing physical comorbidities than the general population. The major principles of caring for a person with a serious mental illness who is also experiencing symptoms of physical illness are described. An explanation is then provided of the major treatment interventions for schizophrenia and bipolar disorder. A particular emphasis is placed upon psychopharmacology, and the side effects that a person can experience. The need for health professionals to be aware of these side effects, and ways and means of helping the person to manage them, are discussed.

The role of carers who support people with a serious mental illness is also described. Many health professionals do not consider the influence of carers, nor how important it is to provide them with information and support. By supporting carers, the health professional is also supporting the person with a serious mental illness. Carers have many needs and the provision of comprehensive care to a person means that the health professional must seek to meet the needs of the carer in addition to the needs of the consumer.

The chapter concludes by considering the notion of Recovery when caring for the person with a serious mental illness. Recovery occurs when a person moves from being a passive recipient of treatment to become an active participant in the management of their illness. The role of the health professional is to support the person in their Recovery, not only by addressing their biopsychosocial needs, but also by enabling them to access support services.

Review questions

1. What do you understand by the term 'serious mental illness'?
2. Describe the positive and negative symptoms of schizophrenia.
3. Describe the five types of hallucinations a person might experience.
4. Describe the essential features of a delusion.
5. Describe the clinical presentation of someone with bipolar types I and II.
6. List some of the factors that contribute to poor physical health in an individual with severe mental illness.
7. List some side effects of antipsychotic medications.
8. Describe some of the benefits of group-based psychoeducation for people with a serious mental illness.

9. How has the term 'Recovery' been described for individuals with a severe mental illness?
10. Describe what would be the best way to involve carers in the treatment of a person with a serious mental illness?

Discussion and debate

1. How does stigma influence Recovery for a person with a serious mental illness?
2. What can you as a health professional do to ensure the development of a positive and strong rapport with a person with a serious mental illness?
3. What is the importance of coordinated care when working with a person with a serious mental illness, their families/carers and other services??
4. Why is it important to have an understanding of serious mental illness when working in all health care environments?
5. Why is it important that all allied health professionals, families/carers and general health services have a working knowledge of pharmacological interventions for schizophrenia?

Web exercise

Visit the mindhealthconnect website (www.mindhealthconnect.org.au) and explore its interface. This website provides a large amount of information about many different mental health issues, and includes a range of multimedia and social media aspects that explore information relating to services and recovery.

Pay particular attention to the information relating to people with a serious mental illness such as schizophrenia and bipolar disorder, and the types of services that are available. View some videos available through this site and consider the ways in which people can recover from mental illness. What can you learn from their experiences? How does understanding their experiences help you to know how to assist people recovering from these illnesses?

Websites

The Australian Association for Cognitive and Behaviour Therapy (AACBT) is the national professional body for cognitive and behavioural therapy practitioners and provides a variety of resources and training opportunities: www.aacbt.org

The Black Dog Institute is a not-for-profit educational, research, clinical and community-oriented facility offering specialist expertise in depression and bipolar disorder: www.blackdoginstitute.org.au

The Mental Health Carers ARAFMI Australia is an organisation with members in each state and territory. Their mission is to represent at a national level the interests of ARAFMI (Association for Relatives and Families of the Mentally Ill) groups throughout Australia and the needs and concerns of their constituency — families and others voluntarily caring for people with mental illness. Its website can be accessed at: www.arafmiaustralia.asn.au

The Mental Illness Fellowship of Australia Inc is a non-government, not-for-profit, grassroots, self-help, support and advocacy organisation dedicated to helping people with serious mental illnesses, their families and friends: www.mifa.org.au

MindHealthConnect is an e-mental health strategy that provides a gateway to issues surrounding mental health care and the first steps for finding relevant support and resources: www.mindhealthconnect.org.au

SANE Australia is a national charity working for a better life for people affected by mental illness — through campaigning, education and research: www.sane.org

The Schizophrenia Fellowship is a not-for-profit, community-based organisation working in the field of mental illness. The Schizophrenia Fellowship of NSW Inc. is committed to improving the circumstances and welfare of people living with schizophrenia, their relatives and carers, and professionals working in the area: www.sfnsw.org.au

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10

Caring for a person with a substance use disorder

LEARNING OBJECTIVES

This chapter will:

- outline the difference between substance use and misuse
- describe the attitudes of health professionals and the community to substance use and misuse
- consider health promotion and harm minimisation approaches
- describe the categories of substances — stimulants, depressants and hallucinogens
- examine issues related to substance use disorders
- explore common substances misused
- outline screening and assessment for substance use issues and disorders
- explain the issues facing family members of a person with a substance misuse issue
- explain how care is provided to people with a substance use disorder, including the use of motivational interviewing and brief interventions
- describe how the stress–vulnerability model can explain how various factors interact with a person's biological vulnerability to developing a mental illness.

Introduction

The use of substances such as alcohol and tobacco has been occurring in Australian society from the time of European settlement, with mixed benefits (King, Ritter, & Hamilton, 2013). People most often use substances for pleasure; however, substance use also has the potential to place a person's health at risk (Newton, O'Leary-Barrett, & Conrod, 2013). Substance use can cause a variety of social, physical and mental health problems, including intoxication that results in accidental injury, toxicity, dependence and withdrawal (Miller & Spicer, 2012).

The focus of this chapter is substance use and misuse and its effects on a person's mental, physical and social wellbeing. The chapter begins with a definition of the difference between use and misuse followed by a summary of the prevalence of substance use in Australia and its effects. This is followed by a description of the harm minimisation approach taken by health services across Australia when assisting people with substance use problems. There is an explanation of the screening and assessment tools that are available to assist health professionals to identify the extent of the person's substance use, and a discussion of the most common issues related to substance withdrawal. Treatment options that can be used when caring for the person with a substance use problem are outlined, together with the role of the health professional in promoting good health and encouraging personal change. The chapter concludes by outlining the transtheoretical model or 'Cycle of Change', the core principles of motivational interviewing and the stress–vulnerability model.

Background to substance use and misuse

There are many different terms used by health professionals who work with people who use and/or misuse substances. In this chapter, the term **substance** refers to materials such as alcohol, caffeine, nicotine or other drugs that are used by people to achieve certain effects. The terms substance misuse and substance dependence relate to the continued use of a substance despite negative consequences often leading to various substance use disorders that will be discussed in greater detail in a later section of this chapter. The distinction between **substance use** and **substance misuse** needs to be clear before proceeding in this chapter to ensure that the distinctions can be made in assessment and treatment.

substance material such as alcohol, caffeine, nicotine or other drugs that are used by people to achieve certain effects

substance use the use of any substance that does not lead to detrimental health effects

substance misuse the use of any substance that does lead to detrimental health effects for example physical ill health or mental health problems; usually occurs in the context of physical and psychological dependence

The majority of people who do use substances are able to do so without significant adverse consequences. For some though, the overuse or misuse of substances can cause a variety of social, physical and mental health problems.

People's patterns of substance use will vary from substance to substance and will often change over time. Common patterns of use may include:

- experimental use — for example, when a teenager tries a cigarette for the first time
- recreational use — for example, when a person drinks a glass of wine each night after work to help them to relax
- situational use — for example, when a person smokes cannabis at a party when it is offered to them

- bingeing — for example, when a person drinks huge amounts of alcohol each weekend with friends, but does not drink any alcohol at all during the week. Thorley (1988) further added to our understanding of patterns of drug use by articulating a model that focuses on the problems that can arise from the use of various substances
- dependent use — for example, when a person repeatedly prioritises their substance use over other activities in their life, possibly as a result of psychological or physical yearning
- intoxication — problems that arise from getting drunk/stoned as a result of the short term effects of the substance. These problems are seen most often and include violence, accidents, risky sexual behaviour and high risk behaviour that may lead to drowning or drink driving
- regular excessive use — problems that arise from using substances regularly and excessively over a sustained period of time. The use does not allow for the body to recover completely from the last time they used, consequences include the physical or medical consequences e.g., disease of the liver, brain damage, or cancer.

Prevalence of substance use

The overall prevalence of substance use in Australia is outlined in table 10.1, which shows that the use of legal substances across the nation is much higher than the use of illicit substances. A National Drug Survey found that 83.6 per cent of the population had used alcohol in the previous 12 months, and almost 91 per cent had used it at some time in their life. Tobacco had been used by just under 21 per cent of people in the previous 12 months and just over 47 per cent of the population at some time in their life. The most commonly used illicit substance was cannabis, with just over 11 per cent of respondents reporting that they had used cannabis in the 12 months preceding the survey and 33.6 per cent at some time in their life. The prevalence of both lifetime and current use of the other illicit substances is lower than that of cannabis.

TABLE 10.1 Use of substances in Australia in the population 14 years and older

	2010 (%)	Preceding 12 months (%)
Alcohol	80.5	83.6
Tobacco	42.2	15.1
Cannabis	35.4	10.3
Meth/amphetamine	7.0	2.1
Ecstasy	10.3	3.0
LSD, mushrooms, ketamine, other hallucinogens	8.8	2.3
Cocaine	7.3	2.1
Heroin	1.4	0.2

Source: Ross (2007, p. v)

In addition, the trends related to the use of substances in Australia suggest that health promotion and disease prevention strategies have had some effect. As noted in figure 10.1, Australians have reduced their use of substances over the last decade or so. The exception to this trend is the use of alcohol.

Between 1993 and 2007, the daily drinking of people in Australia aged 14 years or older remained largely unchanged, at around 8%. However, in 2010, there was a statistically significant decrease (since 2007) in the proportion of people drinking daily from 8.1% to 7.2% (AIHW, 2011). Males were almost twice as likely (9.6%) as females (4.9%) to drink daily in 2010; this pattern was seen from 2004 to 2010. The decline in drinking was mainly due to the proportion of male daily drinkers declining between 2007 and 2010 (from 10.8% to 9.6%). The proportion of people aged 14 years or older abstaining from alcohol (never had a full serve of alcohol) increased statistically significantly between 2007 and 2010, for both males (from 8.2% to 10.0%) and females (12.1% to 14.2%).

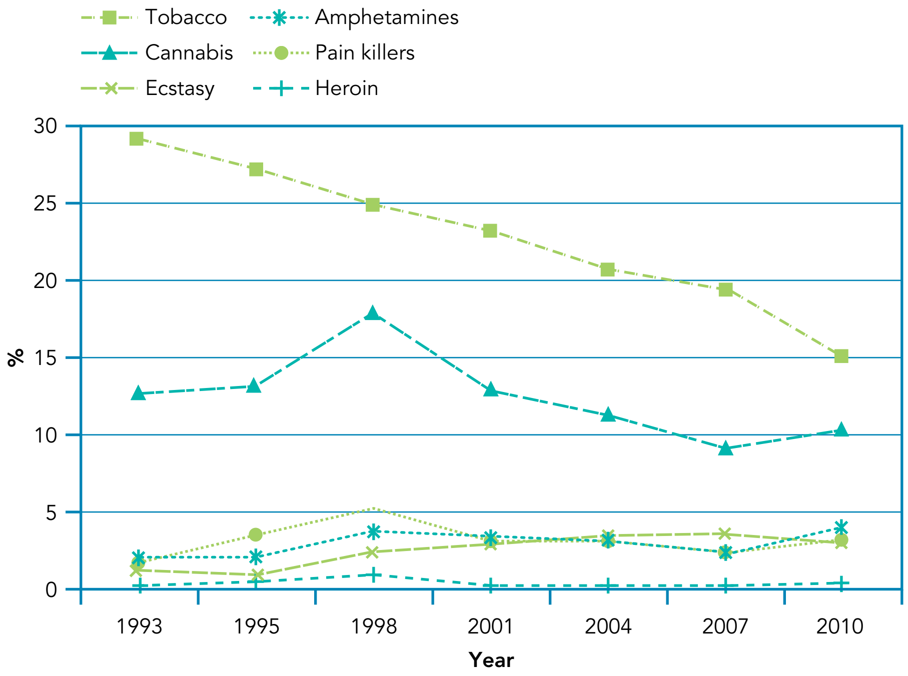


FIGURE 10.1 Australian recent substance use trends excluding alcohol: people aged over 13 years

Source: AIHW (2011); AIHW (2008); Roxburgh, Ritter, Slade, & Burns (2013)

Adverse effects of substance use

There are a number of health risks associated with the use of substances. For example, use of injectable substances such as methamphetamines or heroin, can impact upon a person's physical, mental and social wellbeing. There is an increased risk of psychosis, depression, accidental injuries, overdose, bloodborne infections, physical illness and nutritional deficiencies (Collins & Lapsley, 2008).

Affecting even more people are the adverse effects associated with tobacco use and excessive alcohol use. For example, the adverse effects of tobacco use include cardiovascular disease, chronic obstructive pulmonary disease, including emphysema and chronic bronchitis, and cancer (Collins & Lapsley, 2008). Smoking also causes peripheral vascular disease and hypertension. Likewise, the effects of excessive alcohol consumption include challenging behaviours such as aggression and violence (see chapter 6), accidents and injury, and higher levels of cancers, diabetes, overweight and obesity, cardiovascular disease, liver disease, pancreatic disease, diseases of the peripheral nerves and nutritional deficiencies (World Health Organization, 2004). Excessive alcohol use also affects the mental health of a person, often giving rise to cognitive impairment.

There are obvious pleasurable effects associated with using substances. Just as obvious are the potential long-term harms associated with problematic substance use. Given the preventable nature of substance use disorders, the role of the health professional extends beyond treating the health sequelae of problematic substance use and extends into a health promotion and harm prevention focus.

Roizen in 1979 determined a simple model for health professionals to use with patients to assist in the identification of the impact of substance use and misuse — the 4 L's: Live, Lover, Livelihood and Law.

1. Liver: Problems related to the user's physical or psychological health such as cirrhosis; cancer; overdose; psychiatric, psychological, or emotional problems (amnesia, depression, paranoia, etc.); accidents or other injuries while intoxicated; etc.
2. Lover: Problems related to relationships, family, friends, intimate partner, and children.
3. Livelihood: Problems related to the user's professional live (e.g., lack of concentration at work or school) and other non-professional activities such as hobbies.
4. Law: Legal problems related to illegal drug use, drug acquisition, and/or trafficking, including driving under the influence of drugs.

Attitudes to substance use

In Australia, there are mixed attitudes towards the use of substances. Most people will drink tea or coffee without considering the fact that they are using a substance. Indeed, it is quite acceptable to 'use' caffeine in our culture.

Likewise, there is evidence that the Australian community lauds the use of alcohol — alcohol forms the centrepiece of social interactions at various functions and also of advertisements at major sporting events. This is despite the cost to taxpayers through the health budget, at an estimated $15b with $10.8b attributed to tangible costs (eg labour and health costs) and $4.5b to intangible costs such as loss of life through violence (Manning, Smith, & Mazerolle, 2013).

On the other hand, attitudes to the use of nicotine are gradually changing, with legislation in states and territories across Australia now banning smoking in public buildings and spaces, restaurants and hotels. Smoke-free health campuses have also been implemented across the nation, with health services actively discouraging the use of nicotine by staff and service users alike. Prisons, too, are becoming smoke-free — with bans implemented in the Northern Territory in 2013, Queensland in 2014, and New South Wales and Tasmania following suit in 2015 (Dorsett, 2013). Twenty per cent of the population of Australia continue to smoke — attitudes towards people who use nicotine in Australia are ambivalent as social norms slowly swing away from acceptance.

Community attitudes to the use of **illicit substances**, however, remain firmly negative. The use and distribution of a number of stimulants, depressants and hallucinogens have been outlawed in Australia. The legislation was instituted to minimise the risk of harm to the physical, mental, emotional and social wellbeing of the population that can be caused by the misuse of these substances. Some narcotic-based medication may be legally prescribed and administered by authorised health professionals for medical reasons.

illicit substances
substances that have been outlawed by governments but continue to be used illegally by people to achieve certain effects

UPON REFLECTION

Decriminalisation of illicit substance use

Over the past decade, there has been a debate within legislative domains about the decriminalisation of illicit substances. Part of this debate includes the legalisation of illicit substances like marijuana. Often these debates influence the way in which health professionals interact with, assess and provide treatment to persons misusing substances.

Questions

1. What is the difference between the decriminalisation and the legalisation of illicit substances?
2. What has been the experience of countries like Denmark who have legalised certain illicit substances (for example, marijuana)?
3. How might decriminalisation impact on the prosecution of persons charged with drug related offences?

Substance use and stigma

Stigma is the term used to describe society's negative and stereotypical attitudes toward people who are different. Stigma may be based on gender, race, religion, sexual orientation, mental health and substance use problems. Stigma labels some people or groups as less worthy of respect than others. People with a substance use disorder are often stigmatised in the community — while people with comorbid substance use and mental health issues are further stigmatised. This situation has a profound impact on the lives of people, leading to feelings of low self-worth and the avoidance of contact with mainstream society, and also with health professionals. With regard to people who use substances, research in the United Kingdom identified the following issues.

- The street policing of problem drug users can be publicly humiliating and add to feelings of injustice, alienation and stigmatisation. For recovering users, the continued labelling of them as drug users makes change extremely difficult.
- Attending a drug and alcohol program can increase stigmatisation with some people feeling that the very act of seeking treatment serves to cement an 'addict' or 'junkie' identity, leading to further rejection from family and friends.

- The supervised consumption of methadone in pharmacies provides a context where a person's problems are made public, with many feeling stigmatised by the attitudes of pharmacy staff and other customers (United Kingdom Policy Drug Commission, 2010).

Clearly, across the Western world, there is much work to be done to change attitudes. People with substance use issues have a health problem, not a personality deficit or criminal tendencies. They must be provided with fair and equitable care and treatment.

Attitudes of health professionals

The attitudes of health professionals are influenced by both personal and professional factors. This is particularly true in relation to the attitudes of health professionals towards those who have substance use issues. On a personal level, the health professional may have individual beliefs that substance users are 'bad' or 'weak willed'. The health professional may believe that the client has made the choice to use the substance, so the problems they have are their own fault and they do not deserve to receive treatment. Health professionals are encouraged to reflect upon their personal attitudes, values and judgements towards the choices and lifestyles of the people they are helping and consider how they affect the attitudes they display.

On a professional level, many health professionals may think that the assessment and treatment of drug and alcohol issues lie outside of their scope of practice. For this reason, they lack confidence in their ability to treat the person who has a substance use issue or they do not believe that any interventions will make a difference. Further, there may be specific organisational mandates that disallow a health professional to provide a more holistic approach to the treatment of persons with substance use issues. This is often referred to in practice as gatekeeping; for example, mental health services often reject referrals on the basis that the person has substance misuse issues and as such would be better treated in a drug and alcohol setting. This is also true for drug and alcohol services that reject referrals on the basis that the referred person has mental health issues and as such would be better treated in a mental health setting.

It is essential that all health professionals view the person who has substance use issues from a health perspective, rather than a moralistic or legalistic perspective. It is also crucial that all health professionals develop a level of confidence in providing care to people with substance use issues. The health professional will most certainly encounter a person who uses substances in the course of their work. Health professionals who are not confident in what they do are less likely to inspire confidence in the person seeking assistance.

More broadly, each and every person's prejudice and discrimination plays a role in perpetuating stigma in the wider community. Health professionals can play a role in bringing about social change by challenging their own prejudices (see chapter 2). A first step to this for health professionals is to proactively seek out training (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013). It is also important that health professionals are familiar with local policy and procedures related to substance abuse, and the availability of local support services.

Substance use disorders are health issues that require intervention in the same way as any other health issue. Effective health professionals will place their personal values to one side when providing health care and respond in a professional manner (non-judgemental) rather than react to the needs of an individual, with the response framed by the findings of rigorous research rather than community attitudes or personal perceptions.

Language use

The use of labels and pejorative language works to reinforce the shame, guilt and embarrassment that challenge people with substance use issues who seek treatment (Kelly & Westerhoff, 2010). For example, terms such as 'junkie' and 'addict' connote social decay in many communities. A person is less likely to seek help from a health professional who uses language such as this. Likewise, the descriptor 'drug seeker' is a negative label often imposed by health professionals upon a person who is requesting assistance to manage physical symptoms after ceasing to use a substance. This label often gives rise to health professionals and their respective service environments (e.g. emergency departments) generally treating the person punitively. Research suggests that there is a need for health professionals to consider how 'words can be powerful when used to inform, clarify, encourage, support, enlighten and unify. On the other hand, stigmatising words often discourage, isolate, misinform, shame, and embarrass . . .' (Substance Abuse and Mental Health Services Association, 2004, p. 1). Pejorative language is more likely to be used when the person with the problem is not present. One way to encourage staff to use less pejorative language is to speak as though the person you are speaking about is present in the room. Similarly, write each note in someone's file as though you expect they will be reading it.

There are a range of strategies that health professionals and health services can employ to challenge negative community attitudes towards people with substance use disorders. These strategies include:

- becoming more active in challenging inaccurate or sensationalised media reporting of substance use and dependence
- encouraging iconic public figures to talk openly about their recovery from substance use and dependence
- participating in training to develop skills and confidence in assisting people with health issues arising from substance use
- providing education and information to service users about substance use and substance dependence

It is important to note that partners and families/carers will likewise struggle with the stigma associated with substance use. Health services and community organisations across Australia now provide excellent resources, including pamphlets and information sessions on substance use, together with support groups for families/carers. Information is also readily available on the internet through a range of government and non-government sources. There is more detailed information about the kind of support available for partners and families of people with substance use issues in later sections of this chapter.

Health professionals may also use the points outlined in figure 10.2 when providing information to a person with a substance use issue or their family member. Perhaps the most important thing for the health professional to remember is to be non-judgemental and willing to listen.

The following points are useful to remember when providing information to the partners, family members or friends of people with a substance use problem.

- Substance dependence is often a physical condition. For this reason, people will use substances to control uncomfortable physical withdrawal symptoms.
- When someone is substance dependent, their ability to make a connection between their substance use and the negative consequences is often impaired.
- These factors do not abrogate the person from being responsible — just as the person with diabetes needs to make difficult lifestyle changes to manage their disorder, so too does a person who is dependent on a substance.
- Managing substance dependence is not just a matter of 'will power'. While will power, including a desire to change, is an important factor in changing behaviour, the person may also need assistance to manage different aspects of their behaviour change.
- Partners, family members or friends may love the person without condoning their challenging behaviours. 'Trust the person — not the addiction.'

FIGURE 10.2 Useful information about substance use

UPON REFLECTION

Dependence versus addiction

There appear to be two general approaches to conceptualising a person's misuse of a substance — substance 'dependence' and 'addiction'. Generally, 'dependence' is defined within a behavioural paradigm that holds people's misuse of substances as a type of coping mechanism (maladaptive). The second approach defines 'addiction' within a medical paradigm; that is, it relates people's misuse of substances to an illness state or biological malfunction.

Questions

1. How could the difference between dependence and addiction affect treatment outcomes for persons with substance use issues?
2. What could happen if the health professional's approach to treatment and the service's approach to treatment do not match?
3. What types of treatment programs fit within each of the identified paradigms?

Comorbidities

There is overwhelming evidence that the rates of substance use issues are much higher in people with mental health problems and, likewise, that the incidence of mental health problems is significantly higher in people seeking treatment for substance use issues (Mills et al., 2009). In clinical practice, it is often found that a high proportion of people seeking assistance for substance misuse concurrently experience psychological distress. **Comorbidity** is a broad term that indicates the simultaneous presence of two health conditions, illnesses or disorders. In this chapter, 'comorbidity' refers to the coexistence of a mental illness and an alcohol or drug problem. Health professionals need to be aware that there are ranges of terms used within health services that for the most part mean the same thing. For example, the terms 'dual-diagnosis' and

comorbidity the simultaneous presence of two or more health conditions, illnesses or disorders 'co-occurring disorders' are used interchangeably with comorbidity. In fact, the genesis of this group of terms comes from the disability field where often consumers have co-occurring physical and intellectual disabilities.

In Australia, 30–60 per cent of substance users have a mental health problem (NSW Health, 2009). These include:

- major depression
- schizophrenia
- bipolar disorder
- obsessive–compulsive disorder
- anxiety
- post-traumatic stress disorder.

On the other hand, 45–55 per cent of people with a mental health problem have a substance use disorder (NIDA, 2010). Reasons for this include:

- 'self-medication' to manage the symptoms of mental illness
- 'self-medication' to manage side effects of psychotropics
- lower levels of coping or capacity to deal with stress
- boredom
- loneliness.

There have been many discussions about which came first — the substance use issue or the mental health problem (Banerjee, Clancy, & Crome, 2002). Likewise, there have been many discussions about which is the 'primary' disorder — the mental health problem or the substance use issues (NSW Health, 2009). Determining the answer to this discussion is interesting; but, even so, health professionals are strongly encouraged to ensure that their focus is on the person they are helping. For nonprescribing health professionals, the treatment would usually be the same no matter which disorder emerged first. When screening and assessing clients with comorbidity disorders it is useful to consider how a client perceives his or her symptoms presentations and attitudes towards both disorders (substance misuse and mental illness). Please refer to the Integrated Motivational Assessment Tool (Clancy & Terry, 2007) in the 'Understanding motivation' section of this chapter. It is vital that health professionals stay with the 'here and now' experience of the person, identify their particular needs, and provide options for them so they can make informed lifestyle choices.

It is also crucial for health professionals to acknowledge the importance of addressing comorbidity issues with **integrated treatment**. Many people with comorbid mental health and substance use issues report being pushed from the mental health service to the drug and alcohol service and back again, with health professionals from both services suggesting that the responsibility for providing care and treatment lies with the others. Health outcomes for the person seeking help are reduced. For this reason, all health professionals must give due consideration to the person first and foremost, and who they 'belong' to second. This is often referred to as the 'no wrong door policy' within service policy; essentially all persons are assessed at their first access point and not just 'turned away' because they do not have the 'primary' condition required for entry. This is person-centred care at its best.

integrated treatment the synthesis of mental health and substance use treatment interventions for the consumer

Most states in Australia have developed guidelines for the management of people with coexisting mental health and substance use disorders. Each of these guidelines emphasises the importance of integrating treatment and ensuring that the person does not fall between the gaps between services. Integrating information for consumers reduces the likelihood that they will receive conflicting information by accessing multiple services.

Comorbidity is a key contributing factor associated with poor engagement and retention in treatment and, most likely, relapse (NSW Health, 2009). Also, people with comorbid issues are viewed as 'complex' by health service providers and may be rejected for entry into particular programs (e.g. accommodation support) because of this label. This demonstrates the level of need — and also of stigma — with which people with comorbid issues struggle. All health professionals have a duty of care to assist people with comorbid issues, regardless of so-called complexity.

IN PRACTICE

Collaborative clinical practice models

For the past decade across Australia, youth drug and alcohol services have collaboratively worked together to provide an integrated service to young people with comorbid drug and alcohol and mental health issues. Based in East Perth, Western Australia, the Drug and Alcohol Youth Service (DAYS) operates as a free and confidential service, which offers treatment and support to young people experiencing drug and alcohol related problems.

DAYS is a partnership between the Drug and Alcohol Office and Mission Australia, providing inpatient withdrawal and respite services, inpatient residential rehabilitation service and outpatient counselling and support, psychotherapy and medical assessment to young people aged between 12 and 18 years of age (with some flexibility up to the age of 21 for people who are experiencing significantly problematic drug use).

Staffed by doctors, nurses, clinical psychologists, drug and alcohol workers, and Aboriginal and youth mentors, the service also gives young people access to educational, recreational and exercise programs, and offers complementary therapies such as art, music and drama therapy.

Family interaction is encouraged, with families and other key people involved through support, information and referral. Both outpatient and withdrawal and respite programs are available from the East Perth site, with a three month residential rehabilitation program offered in Carlisle.

Treatment services offered within these programs include:

- comprehensive assessment
- case management
- individual counselling
- medical assessment and review
- clinical psychology services
- group programs

➜

- mentoring and outreach (including Aboriginal mentoring)
- opiate and alcohol pharmacotherapy
- parent and family counselling
- alternate therapies (including music and reiki).

Source: Drug and Alcohol Office (2013)

Questions

1 What do you think are the essential elements of an effective collaborative treatment model?

2 What are the pros and cons of multi-disciplinary approaches to integrated treatment?

Health promotion and disease prevention

Health promotion programs have the ability to change health behaviours at a population level (Schumaker, Ockene & Riekert 2009). In Australia, current health promotion strategies are tackling the community's beliefs about health and illness. A number of primary health care initiatives related to substance use issues have been rolled out across Australia. These form part of the National Drug Strategy (NDS), which is a cooperative venture between the Australian and state/territory governments and the non-government sector. The NDS aims to improve health, social and economic outcomes for Australians by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in the community (www.nationaldrugstrategy.gov.au).

The *National Drug Strategy 2010–2015: A Framework for Action on Alcohol, Tobacco, and Other Drugs* was ratified in 2011. The NDS includes the establishment of advisory structures that support the strategy, national drug campaigns, key research and publications. The strategy stands on three pillars.

- *Demand reduction* — to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community.
- *Supply reduction* — to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.
- *Harm reduction* — to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs (Ministerial Council on Drug Strategy, 2011, p. 4).

The positive outcomes achieved by the National Drug Strategy's programs have already been identified in figure 10.1, and include a reduction in the prevalence of and harms from substance use, such as:

- far fewer Australians are smoking and being exposed to second-hand smoke
- far fewer people are using illegal drugs
- increases in seizures of illegal drugs

- the heroin shortage that began in 2000 has been sustained
- harms associated with injecting drug use have also been reduced
- since its introduction in September 2005, non-sniffable *Opal* fuel has contributed to a 70 per cent reduction in petrol sniffing across 20 regional and remote communities in Western Australia, South Australia, the Northern Territory and Queensland
- drink driving has become largely unacceptable within the general Australian population
- far more is known about what works in the treatment of alcohol and other drug dependence, including through brief interventions, detoxification, pharmacological and psychosocial treatment approaches (Ministerial Council on Drug Strategy, 2011, p.10).

The NDS continues to build on these successes, with various programs and initiatives planned to continue in the future, targeting excessive alcohol use, smoking and drug misuse. Health professionals with an interest in public health strategies are encouraged to visit the NDS website to obtain more information about these exciting developments.

Harm minimisation

In the Australian health system, the approach taken to the care and treatment of people with substance use issues is **harm minimisation** (Allan, 2010). This concept acknowledges that substance use will continue in the community and the work of health services and health professionals is to assist to reduce the harm associated with substance use for individuals and also for the community as a whole.

harm minimisation
a pragmatic approach taken by health services and health professionals to reduce harm to the individual and the community

Adopting a harm minimisation approach does not preclude abstinence-based interventions. In fact, if the health professional were to view harm minimisation interventions on a continuum, abstinence-based interventions would be placed at one extreme end of the continuum; that is, the ultimate form of harm minimisation (AIHW, 2011). However, if the health professional were to adopt an abstinence-based approach only, then people who are not prepared to consider abstinence would not be offered help at all. This means that no harm minimisation would be achieved. For this reason, the Australian health system offers a range of interventions, with an acceptance that many people will choose to continue to use substances.

Since the National Drug Strategy began in 1985, harm minimisation has been its overarching approach. This encompasses the three equally important pillars of demand reduction, supply reduction and harm reduction being applied together in a balanced way.

- Demand reduction means strategies and actions that prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community.
- Supply reduction means strategies and actions that prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.
- Harm reduction means strategies and actions that primarily reduce the adverse health, social and economic consequences of the use of drugs.

It is important to reiterate that accepting a person and their choice does not imply that health professionals, health services or even governments condone that person's choice. Rather, such acceptance acknowledges that every person has the right to choose. This is one of the basic ethical principles upon which Australian society stands.

The National Drug Strategy 2010–2015 seeks to build on this multi-faceted approach which is recognised internationally as playing a critical role in Australia's success in addressing drug use.

Categories of substances

As already noted, the use of substances in Australia, including **psychoactive substances**, is not uncommon. The Australian Drug Foundation breaks psychoactive substances into three major categories based on their effect on the **central nervous system** (CNS) during intoxication. These three categories are stimulants, depressants and hallucinogens. Each of these categories is now described in turn.

psychoactive substances substances that act on the brain to alter the way a person feels or thinks or acts

central nervous system the part of the nervous system that consists of the brain and spinal cord. It is one of two major divisions of the nervous system, with the peripheral nervous system lying outside of the brain and spinal cord

Stimulants

During intoxication, stimulants speed up neurochemical activity in some areas of the brain. Stimulants also have a level of peripheral sympathomimetic action, which produces mild tachycardia, hypertension and tachypnoea. Substances classed as stimulants include amphetamine-type substances, cocaine, caffeine and nicotine. Ecstasy (methylenedioxymethamphetamine or MDMA) is a stimulant that also possesses some hallucinogenic qualities.

People use stimulants for a variety of reasons, including:

- they are potent stimulants that give a person a sense of euphoria and wellbeing
- they boost energy levels
- they induce wakefulness and self-confidence
- they improve physical and cognitive performance
- they reduce appetite.

Once a person has developed a **tolerance** for a substance, or becomes **physically dependent** or **psychologically dependent** on that substance, the dependence itself — including withdrawal avoidance — will contribute to a person's continued substance use (Latt, 2009).

tolerance when the body adapts to a substance so that increasingly larger doses are required to produce the same effect obtained earlier with smaller doses

physically dependent when signs and symptoms with a physiological basis are experienced or manifested when a person is no longer able to use a substance

psychological dependence a strong urge or desire or attachment in relation to a substance based on the feelings aroused by the substance or the social and emotional needs it meets

Depressants

The major defining quality of a substance that is a CNS depressant is the slowing down of neurochemical activity. This affects cognitive processing, impairs coordination and induces sedation. In larger doses, CNS depressants may cause respiratory depression.

Substances classed as depressants include alcohol, benzodiazepines, fantasy (gamma hydroxybutyrate or GHB), inhalants and opiates. Cannabis (delta-9-tetrahydrocannabinol or Δ9 THC) is a depressant, which also has some mild hallucinogenic properties.

People often use depressants such as alcohol to socialise and relax. Opiates are also commonly used for their pain relieving qualities, which make them useful for the treatment of short-term pain.

Hallucinogens

Hallucinogens alter the perceptions of the user. This alteration may affect the senses (visual, auditory, kinaesthetic, olfactory or gustatory), awareness of the passage of time, and gating (the ability to dismiss extraneous stimuli). Out of body experiences may also be reported. Substances classed as hallucinogens include LSD (lysergic acid diethylamide) trips, mushrooms (psilocybin), Special-K (ketamine), angel dust (phencyclidine or PCP) and datura (scopolamine). Cannabis and ecstasy may also have some hallucinogenic properties.

A summary of these three categories of substances and the different types of substances that fall into these categories is provided in table 10.2. As already noted, not everyone who uses substances will develop a substance use disorder. Instead some people use substances recreationally, with no issues, for many years. Substance use disorders are described in the next section.

TABLE 10.2 Types of substances

Depressants	Stimulants	Hallucinogens
Alcohol	Amphetamines	Ketamine
Inhalants	Cocaine	LSD (acid)
Opiates	Nicotine	Magic mushrooms
Cannabis	MDMA/Ecstasy	Cannabis
	Caffeine	Datura

Substance use disorders

Defining a substance use problem is challenging especially since the identifiable line between use and misuse is not always apparent to the health professional or the consumer. For some people, the amount of substances they use may be the problem, while others will experience problems even though they use small amounts of substances infrequently. For this reason, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5) (American Psychiatric Association [APA], 2013) defines a substance use disorder as 'a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems' (p. 483).

As defined by the DSM-5, substance use disorders can be characterised as a change or alteration in brain chemistry whereby symptoms and impacts may continue well beyond detoxification or withdrawal. The following are the criteria groupings for the recognition of a substance use disorder (APA, 2013, p. 481).

1. Impaired control — consumption of the substance in larger amounts or over a longer period than was originally intended; a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or continue use; large amounts of time spent obtaining the substance, using or recovering from a substance; in more severe substance use disorders, all daily activities may centre around the substance; craving as seen by an intense desire or urge for the drug.
2. Social impairment — recurrent use may result in a failure to fulfil major role obligations at work, school, or home; continued use despite having persistent or recurrent social or interpersonal problems; withdrawal from or reduction of important social, recreational, or occupational activities.
3. Risky use — recurrent use of the substance in situations considered hazardous; continuation of the substance despite knowledge of having a persistent or recurrent physical or psychological problem.
4. Pharmacological criteria — tolerance as seen by a markedly increased level of use to achieve the desired effect or a reduced effect of the substance when usual dose levels are used.

The DSM-5 (APA, 2013) also distinguishes between problems directly associated with patterns of substance use (substance use disorders) and secondary mental health issues that develop as a result of substance use (substance-induced disorders). The classification of substance-induced disorders includes intoxication, withdrawal, and other substance/medication-induced mental disorders (e.g. substance-induced psychosis, substance-induced depressive disorder).

The essential features of substance-induced disorders are as follows:

1 the development of a reversible substance-specific syndrome due to the recent ingestion of a substance
2 clinically significant problematic behavioural or psychological changes associated with intoxication (e.g. belligerence, mood lability, impaired judgement) that are attributable to the physiological effects of the substance on the central nervous system and develop during or shortly after use of the substance
3 the symptoms are not attributable to another medical condition and are not better explained by another mental disorder.

Reward pathways

An exciting field of neuropsychiatric research involves the study of the mesolimbic dopaminergic pathway otherwise known as the **reward pathway**. This pathway has its roots deep in brain structures of the ventral tegmental area, through the nucleus accumbens and connecting to the prefrontal cortex (as shown in figure 10.3). The role of the reward pathway is to reinforce behaviours to ensure the survival of individuals and ultimately humankind. When a person participates in behaviours such as eating, drinking, having sex, sheltering and socialising, they receive a small burst of dopamine along this pathway that is related to the activity. This gives rise to feelings of wellbeing, and increases the person's likelihood of repeating the behaviour. Likewise, when a person uses substances, these substances provide a large boost in dopamine along this 'reward pathway'. Eventually the pathway becomes desensitised, resulting in diminished pleasure from the non-drug activities. The net result is that the nucleus accumbens reconfigures a person's priorities so that using a substance becomes more important than socialising, eating, drinking and sex (Koob & Volkow, 2010).

reward pathway a system of dopamine neurons that reinforce behaviours such as sex, eating and drinking; also implicated in substance dependence

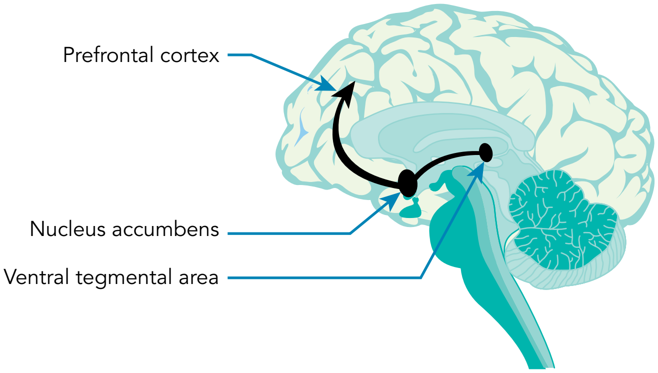


FIGURE 10.3 The brain's reward pathway

Acute intoxication

Acute intoxication occurs after the use of psychoactive substances and results in altered consciousness, **impaired cognition**, altered perception and out-of-character behaviour (e.g. disinhibition) or changes to other psycho-physiological functions and responses. It is the outcome of the acute pharmacological effects of the use of substance. It resolves in time with complete recovery, except where specific complications have arisen; for example, trauma or inhalation of vomit.

acute intoxication the altered mental state following intake of a psychoactive substance

impaired cognition a reduced capacity to think and analyse information

Substance withdrawal

Substance **withdrawal** is a group of symptoms that occur following sudden cessation or reduction of the substance after persistent use. The onset, course and symptoms of the withdrawal are time-limited and related to the type and dosage of the substance. It is important that health professionals are aware of the symptoms of withdrawal across the range of substances that are most commonly used. Withdrawal from most substances is an unpleasant experience, but generally will not require hospitalisation (although the withdrawal may begin to manifest itself while the person is admitted to hospital for another condition). Severe alcohol or benzodiazepine withdrawal on the other hand can be potentially life threatening and hospitalisation may be required. Severe opiate withdrawal, while not life threatening, is such an uncomfortable experience, that many people will choose to undertake their detoxification in a specialised detoxification facility. Cessation of many other substances including stimulants, hallucinogens, cannabis and solvents can be undertaken without significant physical complications (NSW Health, 2007).

withdrawal the objective and subjective symptoms following abrupt cessation or dose reduction of a psychoactive substance after a period of continued use

This section has provided general information about each of the substance use disorders that a person may experience. In the next sections, more specific information is provided about the substances that are used most often in Australian society, their effects, and the major disorders that a person who uses substances can experience. It is also acknowledged that substances other than those listed in this chapter are used. Health professionals who require more detail are encouraged to seek out a specialised text.

Commonly misused substances

As outlined earlier in this chapter, substance use is quite common in Australia. Substance use issues are more prevalent among people who present to health services for treatment of other disorders. Therefore it is important for all health professionals to have a basic understanding of the major issues relating to commonly misused substances. The following section outlines some basic information on a range of substances that clinicians may encounter in health care settings.

Alcohol

The use of alcohol by Australians is widespread. According to the 2010 National Drug Strategy Household Survey, the number of people drinking in Australia remained largely unchanged with more than 80 per cent of Australians over the age of 14 having consumed a full serve of alcohol during the preceding year (Australian Institute of Health and Welfare, 2011).

Virtually every system in the human body can be damaged by alcohol (see table 10.3). Individuals who use excessive amounts of alcohol are also at an increased risk of psychological problems, including impaired judgement and decision making, as well as increasing levels of impulsiveness. For some, this can lead to antisocial and disinhibited behaviour, such as engaging in violent or criminal activity.

TABLE 10.3 The health and medical complications of excessive alcohol use

Body system	Complication
Gastrointestinal	Cirrhosis of liver, hepatitis Gastritis Pancreatitis Gastrointestinal haemorrhage Malnutrition, weight loss, malabsorption
Cardiovascular	Cardiac arrhythmias Cardiomyopathy Hypertension — often difficult to treat
Neurological	Blackouts Convulsions Peripheral neuropathy Acute confusional states Head injuries Long-term brain damage Depression
Respiratory	Pneumonia — inhalation of vomit while intoxicated
Reproductive	*Men* Hypogonadism — loss of libido, impotence, loss of secondary sexual characteristics, enlarged breasts in males Infertility *Women* Hypogonadism — loss of libido, menstrual irregularities, loss of secondary sexual characteristics
Musculoskeletal	Gout
Other	Increased risk of certain cancers, in particular of the mouth, oesophagus, liver and colon Increased incidence of alcohol-related trauma Increased risk of self-harm and suicide

Safe drinking levels

As noted, alcohol is a CNS depressant. Ethanol or ethyl alcohol is the active, intoxicating ingredient in all alcoholic beverages including beer, wine and spirits. In small doses, people report feeling relaxed with mild euphoria after consuming alcohol. At larger doses, people become disinhibited and report poor concentration and coordination. A healthy person metabolises alcohol at the rate of around one standard drink per hour. It is important to note that gender, physical build and health will influence an individual's blood alcohol levels after consuming alcohol. Women generally have a lower blood volume than men, so will tend to record a higher blood alcohol level than males who have consumed the same amount of alcohol.

The National Health and Medical Research Council (2009) has released comprehensive guidelines on the ways to reduce harm associated with alcohol consumption. To understand these guidelines, there is a need to understand the concept of the Australian 'standard drink'. This concept was developed to help drinkers monitor their alcohol consumption and help simplify communication about the amounts of alcohol that it is safe to drink.

In Australia, a 'standard drink' refers to a drink containing 10 g of alcohol, and equates to:

- schooner of light beer (425 ml)
- 'middy' or 'pot' of full strength beer (285 ml)
- small glass of wine or sparkling wine (100 ml) (note that some red wines have a higher alcohol content)
- glass of fortified wine (60 ml)
- nip of spirits (30 ml).

These drinks sizes are illustrated in figure 10.4.

SPARKLING WINE	WINE	LIGHT BEER	REGULAR BEER	FORTIFIED WINE	SPIRITS
100 mL	100 mL	425 mL	285 mL	60 mL	30 mL
13% alc/vol	13% alc/vol	2.7% alc/vol	4.9% alc/vol	20% alc/vol	40 % alc/vol

Source: Drug and Alcohol Services South Australia, Government of South Australia © 2011

FIGURE 10.4 What is a standard drink?

Source: Alcohol and Drug Services South Australia, © Government of South Australia (2011)

According to the National Health and Medical Research Council (2009) guidelines, for healthy men and women to reduce their risk of alcohol-related harm over a lifetime, they should drink no more than two standard drinks on any one day. The guidelines also recommend that people should consume no more than four drinks on any single occasion to reduce the risk of alcohol-related injury due to intoxication.

The physiological and pharmacokinetic effects of alcohol are influenced by factors such as gender, body weight and the rate and amount of alcohol consumed. To reach the same blood level concentration, a greater amount of alcohol will generally be required by a heavier person than one of lower body weight. For example, there is little difference in associated risk for men and women while at lower levels of drinking; at increased levels of consumption, however, women place themselves at significantly higher risk than men of alcohol-related disease. Men on the other hand have greater risk of alcohol-related injuries. The highest risk group for alcohol-related injuries are individuals aged 15–24 years. This is primarily due to traffic accidents where alcohol is involved.

For people under the age of 18, the National Health and Medical Research Council (2009) guidelines advise that the safest option is not to drink alcohol at all. This is especially important for people under 15. Women who are pregnant or breastfeeding are likewise advised not to drink. The guidelines also warn people with mental health issues or with physical conditions that may be exacerbated by alcohol (e.g. diabetes or liver disease) that drinking even at the lowest levels can cause harm.

UPON REFLECTION

What is 'safe' drinking?

The National Health and Medical Research Council has set levels of safe drinking; however, they clearly state that there is no level of drinking alcohol that can be guaranteed to be completely safe.

Questions

1. Do you feel that there are 'safe levels' of alcohol consumption? Can these guidelines be applied to all Australians? Explain your reasons.
2. Given the statistics for the 15–24-year-old people, how successful you think these guidelines are in reducing alcohol-related harm in this age group? What might be a barrier to promoting 'safe drinking' in this age group?
3. Other than the safe drinking guidelines set by the National Health and Medical Research Council, how else can we encourage people to drink at appropriate levels?

Alcohol withdrawal

One complication of excessive alcohol use over time is the risk of withdrawal. When a person who is physically dependent on alcohol ceases their drinking or reduces their intake, there is a risk they will experience the symptoms of withdrawal. The cessation of the use of alcohol may be unplanned; for example, if the person has been admitted to hospital for treatment of an acute illness or injury.

The Australian *Guidelines for the treatment of alcohol problems* (Haber, Lintzeris, Proude, & Lopatko 2009) include evidence-based information to support health professionals in managing people at risk of alcohol withdrawal. The onset of alcohol withdrawal symptoms is most likely to occur in the first 6–24 hours after the last drink, although drinkers with a heavy dependence may experience symptoms of withdrawal when their blood alcohol level indicates they have consumed alcohol more recently.

The use of an alcohol withdrawal scale such as the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale is the most reliable way to monitor the severity and progression of withdrawal symptoms. Severe, untreated alcohol withdrawal is a life-threatening condition.

Early identification of the possibility of withdrawal is the key to providing effective care. Health professionals are advised not to rule out the risk of alcohol withdrawal simply by the appearance of the person. While social stigma and stereotypes may suggest a person who is withdrawing from alcohol has a particular appearance, in reality any person who consumes a particular level of alcohol regularly may experience symptoms of withdrawral. For this reason, a routine and comprehensive substance-use history should be obtained from all people.

The information may be obtained by self-report, collateral sources of information and clinical examination. Indicators of risk of alcohol withdrawal include:

- alcohol consumption pattern of eight or more standard drinks per day (higher consumption is associated with greater risk)
- history of withdrawal symptoms such as tremor, nausea or anxiety on awakening that are relieved by consuming alcohol
- past history of severe withdrawal including seizures or delirium tremens
- comorbid biomedical conditions including epilepsy, liver disease, infection, head injury, pain, malnutrition
- comorbid mental health issues such as anxiety, depression or psychosis
- other substance use.

By identifying those at risk early, the heath professional may provide early interventions and strategies that have been demonstrated to improve health outcomes.

Complications of withdrawal

Most people will experience mild symptoms when withdrawing from alcohol. The following early symptoms of alcohol withdrawal are classified as 'minor':

- coarse tremor of the hands, tongue or eyelids
- nausea, abdominal discomfort and loss of appetite
- paroxysmal sweats
- tachycardia
- insomnia
- irritability.

If unaddressed, however, these symptoms can develop into more serious or 'moderate' symptoms, such as:

- disorientation
- confusion
- perceptual disturbance (most commonly visual hallucinations), 'seeing things', possibly insects or spiders
- marked tachycardia
- profuse sweating and flushed appearance.

If these symptoms are left untreated, withdrawal can progress to the very serious **delirium tremens** (DTs) and other complications of alcohol withdrawal.

delirium tremens the 'DTs' is a complication of alcohol withdrawal involving perceptual disturbances, confusion, agitation and tremor; not to be mistaken for 'the shakes', which is a milder symptom of withdrawal

These complications are related to the CNS being in a state of hyper-excitement. There are three main complications of withdrawal that health professionals must observe for or monitor. These include:

1. *seizures* — these generally occur 6–48 hours after the last drink
2. *delirium* — the DTs are characterised by confusion, disorientation, psychomotor agitation, seizure, coma and eventual death

3 *hallucinations* — these perceptual disturbances may be visual, tactile or auditory, and may be accompanied by paranoid ideation and/or abnormal affect such as anxiety, agitation or **dysphoria**.

dysphoria generalised feeling of emotional discomfort

Such complications can be life threatening and the health professional must treat the situation as a medical emergency.

Individuals with a history of seizures should be reviewed and considered for inpatient treatment during initial withdrawal from alcohol as seizures can become so severe that they warrant urgent medical treatment. As already noted, untreated acute alcohol withdrawal can be fatal.

Providing care

The care provided to a person who is withdrawing from alcohol will depend upon the specific symptoms the person is experiencing.

Mild withdrawal (including people with a CIWA-Ar score of <10) in people with low indicators of risk can be managed with supportive care in a destimulating environment. Most people in this state of mild withdrawal will not require medication to help to deal with the symptoms. Care provision would address the following.

- The ideal environment is quiet and calm, and lighting needs to be clear but not too bright.
- Health professionals are best to communicate in a quiet, reassuring and confident manner.
- Provide frequent reassurance and reorient the person to their environment as needed.
- Offer the person fluids and monitor their hydration.
- Continue to monitor using the CIWA-Ar or similar standardised withdrawal scale.
- For people who experience a moderate withdrawal (CIWA-Ar >10), diazepam may be prescribed early in the withdrawal process according to local protocols. Although treatment protocols will vary, it is uncommon for diazepam to be prescribed for more than two to six days.
- Symptom relief may also include medications such as paracetamol for headaches, metoclopramide or prochlorperazine for nausea or vomiting and possibly loperamide for diarrhoea (NCETA Consortium, 2004).

Health professionals need to ensure that they provide this care with a non-judgemental attitude and encourage the person as much as possible.

Acute alcohol withdrawal

The following list offers some suggestions for the health professional who is providing care and treatment options for acute alcohol withdrawal. These suggestions are similar to those provided for mild withdrawal symptoms, but also involve a much closer monitoring of the person for signs of physical deterioration.

- Maintain a non-judgemental attitude — avoid implied or overt criticism.
- Use clear, straightforward communication strategies (e.g. avoid complex instructions and maintain eye contact).
- Ensure that the person is easily observed.
- Monitor vital signs closely — blood pressure, pulse, temperature and respiration.
- Ensure adequate hydration — may require intravenous fluids.
- Monitor effects and side effects of medication used to manage withdrawal.

- Involve the person's family, partner or significant other in the planning and delivery of care, if appropriate.
- Manage the person in an area with good lighting and appropriate environmental cues (e.g. clocks that work, a calendar and natural light).

It is also important the health professional observes for the signs and symptoms of Wernicke's encephalopathy and Korsakoff syndrome, which are described below.

Wernicke's encephalopathy and Korsakoff's syndrome

There are two conditions that can result in brain damage which are a consequence of a lack of vitamin B1 (thiamine): **Wernicke's encephalopathy** and Korsakoff's syndrome. Heavy drinkers undergoing alcohol withdrawal need to be treated with **thiamine** or Vitamin B1. This is because people who are dependent upon alcohol are often deficient of nutrients, which can cause severe complications during alcohol withdrawal. Of particular importance are thiamine and folic acid. The deficiency in thiamine can trigger the development of Wernicke's encephalopathy.

Wernicke's encephalopathy a form of acute brain disorder resulting from a lack of thiamine most commonly occurring in people with chronic alcohol dependence

thiamine a vitamin, also called vitamin B1, that is found in yeast, cereal grains, beans, nuts and meat

Vitamin B1 is an essential nutrient required by all tissues within the body, including the brain (Gupta et al., 2012). Reduction in the availability of thiamine to the brains of individuals who are chronic consumers of alcohol can result in brain damage or even death.

Wernicke's encephalopathy is a short-term but severe condition, while Korsakoff's syndrome is a more debilitating long-term condition. Wernicke's encephalopathy causes damage to the lower parts of the brain, namely the thalamus and hypothalamus, and is completely reversible with treatment. Korsakoff syndrome, also known as Korsakoff psychosis, affects areas of the brain associated with memory. There is only a 20 per cent recovery rate among individuals with Korsakoff's syndrome (Thomson, Guerrini, & Marshall, 2012).

Symptoms of Wernicke's encephalopathy

Wernicke's encephalopathy can seriously complicate the alcohol withdrawal process and is characterised by the following:

- confusion — global memory impairment
- ataxia — most notably a wide gait
- vision changes — abnormal eye movement, most notably nystagmus.

It is important to note that not all people will exhibit all three of these signs and symptoms. Indeed, health professionals working with people with alcohol-use disorders need to be aware that Wernicke's encephalopathy may be present even if the person presents with only one or two of the symptoms (Lough, 2012). Providing care to these individuals may be challenging for health professionals — the person may present as intoxicated, dishevelled, malodorous or abusive. However, if left untreated, Wernicke's encephalopathy may progress to Korsakoff's psychosis, which can result in permanent cognitive damage (Lough, 2012; Thompson, Guerrini, & Marshall, 2012).

Caring for the person with Wernicke's encephalopathy

Wernicke's encephalopathy can be prevented in heavy alcohol users by providing balanced nutritional intake and the early routine use of thiamine in all people who present for treatment. The condition responds rapidly to large doses of thiamine, which is known to be useful in preventing the progression to Korsakoff's syndrome. All people presenting with alcohol withdrawal should routinely receive thiamine as per local treatment protocols. Initially, thiamine must be given intramuscularly or intravenously (Lough, 2012; Thompson, Guerrini, & Marshall, 2012). Thiamine also needs to be administered before giving glucose in any form. A carbohydrate load in the presence of thiamine deficiency risks precipitating Wernicke's encephalopathy.

Symptoms of Korsakoff's syndrome

Korsakoff's syndrome is a preventable memory disorder that can emerge (though not always) as a result of Wernicke's encephalopathy. The main symptom — memory loss — is the result of damage to the areas of the brain associated with memory. Symptoms include:

- inability to form new memories
- difficulty gaining new information and skills
- memory impairment, which can be severe
- fabrication of stories (confabulation)
- seeing or hearing things that are not really there (hallucinations).

People with Korsakoff's syndrome may also exhibit a change in personality. They may demonstrate a lack of interest and concern for people and things around them or they may become overly talkative and repetitive in their behaviour. Their sense of responsibility may diminish and they will have difficulty in initiating good behaviour (Thompson, Guerrini, & Marshall, 2012).

This section outlined the major issues related to the use of alcohol. These include the signs and symptoms experienced by people who are withdrawing from alcohol and the importance of health professionals monitoring these signs and symptoms. Acute alcohol withdrawal is a potentially life-threatening condition and it is important that all health professionals are aware of the best-evidence care required to support a person through this difficult time. The next section outlines the major issues related to the use of amphetamines.

Amphetamines

Amphetamines are the third most widely used illicit drug in Australia (see figure 10.1). Amphetamines are CNS stimulants: they stimulate dopaminergic, serotonergic and noradrenaline activity, which gives the user a euphoric sense of wellbeing and confidence. In intoxication a person also has increased physical and cognitive performance as well as reduced appetite and need for sleep (NCETA Consortium, 2004). Most street amphetamines available in Australia are methamphetamine-based. Four types of methamphetamine are broadly available:

1. base — looks like gluggy paste (smoked, snorted, swallowed or injected)
2. crystal — looks like crushed ice (smoked, snorted, swallowed or injected)
3. powder — looks like white or coloured powder (injected, snorted or swallowed)
4. pills — look like prescription pills (swallowed).

The physical signs of intoxication from stimulants include pupil dilation, tachycardia, hypertension, increased respiratory rate and increased body temperature. If the level of ingestion is high, seizures and cardiovascular collapse can occur. The use of amphetamines is associated with a range of physical and psychological problems.

The route of administration determines some of the physiological risks for people who inject amphetamines. Concerns include bloodborne viruses, abscesses, infected injection sites and emboli related to injection of undissolved contaminants. People who snort amphetamines risk damaging the mucosa and surrounding tissues of the nose (e.g. damage to the septum). For people who smoke amphetamines, there are risks around irritation to the airways leading to sore throat, blood in the sputum and exacerbation of asthma in those who are susceptible. People who swallow amphetamines have less identifiable risks related to the mode of administration, although the delay in intoxication may lead people to increase their dose. People who choose 'shelving' or 'shafting', which involves placing the substance in the anus or the vagina, may irritate the mucosa (NCETA Consortium, 2004).

Other physical effects of using amphetamines include, but are not limited to:

- severe hypertension, which can lead to cerebrovascular and cardiovascular accidents, seizures, coma and death
- psychological sequelae, including dysphoria, depression, delirium, psychosis, anxiety, sleep disorders and sexual dysfunction (Rincon, 2012).

When health professionals are working with women who are pregnant and using amphetamines they need to refer to the *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn* (Bell & Ali, 2006), which are available on the web.

Benzodiazepines

Benzodiazepines are also known as tranquillisers, sometimes referred to as 'benzos'. They are most often prescribed by doctors to relieve stress and anxiety, relax muscles, and help a person to sleep. Benzodiazepines are CNS depressants — they work by slowing down the activity of the CNS. There are many benzodiazepines on the market and a list is provided in table 10.4. Benzodiazepines are highly addictive.

Risks associated with benzodiazepine use include overdose, either alone or in combination with other substances, especially other CNS depressants including alcohol and opiates. Complications with overdose include respiratory depression. Benzodiazepine overdose alone is often not life-threatening. The risk of developing benzodiazepine dependence is increased when benzodiazepines are used for periods exceeding one month, particularly at high doses and those benzodiazepines with a shorter **half-life**. The risk of dependence continues to increase with the duration of treatment even at low doses. While there is significant individual variability, it is estimated that about a third of people who have been taking benzodiazepines over a long period will have significant difficulties reducing their dose or stopping. For this reason, the benzodiazepines are viewed as highly addictive.

half-life the time it takes for the body to break down or reduce the plasma concentration of a drug by half

TABLE 10.4 Common benzodiazepines used in Australia

Generic name	Trade name
Alprazolam	Xanax®, Kalma®, Alprax®
Bromazepam	Lexotan®
Clobazam	Frisium®

(continued)

TABLE 10.4 *(continued)*

Generic name	Trade name
Clonazepam	Rivotril®, Paxam®
Diazepam	Valium®, Ducene®, Valpam®, Antenex®, Ranzepam®
Flunitrazepam	Hypnodorm® — previously Rohypnol®
Lorazepam	Ativan®
Midazolam	Hypnovel®
Nitrazepam	Mogadon®, Alodorm®
Oxazepam	Serepax®, Murelax®, Alepam®
Temazepam	Normison®, Temaze®, Temtabs®, Euhypnos®
Triazolam	Halcion®
Zolpidem	Stilnox® — related to benzodiazepines

The delay of onset of benzodiazepine withdrawal will vary considerably depending on the half life of the benzodiazepine used, and may commence one to ten days or more, after the last dose. The withdrawal syndrome may include symptoms that resemble alcohol withdrawal, including anxiety, dysphoria, irritability, insomnia, nightmares, sweating, memory impairment, hallucinations, hypertension, tachycardia, psychosis, tremors and seizures (Therapeutic Guidelines Limited, 2013).

As with alcohol withdrawal, severe untreated withdrawal from the benzodiazepines can be life threatening. People withdrawing from benzodiazepines will require a medical review to assess the need for inpatient treatment and the process of withdrawal supervised by a treating team.

Cannabis

Cannabis is the most widely used illicit drug in Australia. It comes in three forms — **marijuana**, hashish and hash oil. The cannabis that is commonly smoked in Australia, comes from the plant cannabis sativa. Over 480 compounds have been isolated in cannabis, including over 60 **cannabinoids**. The main cannabinoid responsible for the cannabis 'high' is known as delta-9-tetrahydrocannabinol or THC. The subjective perception of cannabis intoxication may continue for three to five hours following use.

The psychoactive effects of cannabis are difficult to classify. Cannabis can possess some CNS depressant qualities, and in higher doses has some hallucinogenic properties. These properties distort perception of time, distance and some sensory input.

It is important to note that a positive urine drug screen result for cannabis does not necessarily indicate recent use. This is because cannabis metabolites are stored in fat cells; chronic cannabis users may continue to show positive urine screen results for around six weeks after cessation. In intoxication, people may become talkative or introspective. Many people refer to increased hunger (the 'munchies') after using cannabis. External signs of intoxication may include bloodshot eyes and changes in behaviour as previously described.

marijuana the least potent form of cannabis; contains the dried flowers and leaves of the cannabis plant; generally smoked by the user

cannabinoids chemicals which resemble delta-9-tetrahydrocannabinol

Cannabis and mental health

The longer term effects of cannabis use on the mental health of a person have been debated in the literature over many years, but the synthesis of information is now pointing towards the view that cannabis causes psychosis and schizophrenia in vulnerable individuals (Lynch, Rabin, & George, 2012). Cannabis use is also associated with depression. Smoking cannabis can lead to mild cognitive impairments, reduced sperm count, respiratory diseases such as chronic bronchitis, and the development of several cancers (NCETA Consortium, 2004). The risk of cancer is exacerbated by the common practice of combining tobacco (spin) with cannabis prior to smoking.

The safety of cannabis use in pregnancy has not been established (Gerardin, Victorri-Vigneau, Lourigne, Rivoal, & Jolliet, 2011). Breastfeeding mothers are advised not to use cannabis as it is passed through the breast milk to the baby.

Cannabis withdrawal

Cannabis withdrawal syndrome is usually a mildly uncomfortable experience for people. Gorelick, Levin, Copersino, Heishman, Liu, and Boggs (2012) evaluated the diagnostic criteria in the DSM-5 relating to the symptoms of cannabis withdrawal:

- irritability, anger and aggression
- anxiety
- reduced appetite
- restlessness
- sleep disturbance including unusual dreams
- dysphoria/depressed mood.

Physical symptoms that occur less frequently can include:

- chills
- tremor
- stomach pain or discomfort
- night sweats.

Cannabis withdrawal is a self-limiting syndrome. Health professionals can provide reassurance to people that these symptoms tend to last for only one or two weeks. Assisting people to manage the individual symptoms may be beneficial.

Cocaine

Cocaine is another potent CNS stimulant. Derived from the coca plant, most cocaine originates from South America. For this reason, cocaine is a relatively expensive substance in Australia and so is less commonly used. It has a shorter duration of ‘high’ than other potent psychostimulants. Cocaine powder is snorted or sometimes injected, while freebase or ‘crack’ cocaine is smoked. In large doses cocaine can cause myriad unwanted effects including agitation, anxiety, psychosis, aggression, delirium, convulsions, dizziness, angina, respiratory failure, elevated blood pressure, stroke, hyperthermia and myocardial infarction (NCETA Consortium, 2004).

Ecstasy

Ecstasy (3,4-methylenedioxymethamphetamine) or MDMA is also known as ‘E’ or ‘eccies’. It is a ‘designer’ methamphetamine that has both stimulant and hallucinogenic properties. An estimated 3 per cent of the Australian population aged over 13 years reported using ecstasy in 2010, making ecstasy second only to cannabis as the most used illicit drug in Australia (AIHW, 2011).

Ecstasy is usually sold in tablet form, although many tablets sold as ecstasy contain no MDMA. According to the 2010 National Drug Strategy Household Survey report (AIHW, 2011) the mean age of first use of ecstasy was 18 years. As in previous years, persons using ecstasy typically reported using two tablets in a session approximately once a fortnight. Swallowing pills remained the most common form of ecstasy use with about one-third of participants having recently binged on ecstasy. The report indicates that alcohol was most commonly combined with ecstasy, with 57 per cent of surveyed individuals using other drugs to come down from ecstasy. One concerning result from this survey is that over half of participants (53%) reported that all or most of their friends and acquaintances used ecstasy. Given that long-term use of MDMA contributes to problems such as depression, insomnia, headaches, teeth grinding and hyperthermia, predictions of increasing problems within this age brackets are evident. Furthermore, the risk of **hyponatraemia** following MDMA use is heightened when people consume excessive quantities of water.

hyponatraemia a blood electrolyte imbalance where levels of nitrogen are low

People need to be informed of the recommendation to drink water regularly if using MDMA, but not in excess of 500 ml/hr. People who choose to use MDMA also need to be warned of the potentially fatal risk of serotonin syndrome associated with using large amounts of MDMA or using other serotonergic substances and medicines (e.g. antidepressants and tramadol) (Pilgrim, Gerostamoulos, & Drummer, 2010).

Hallucinogens and GHB

As already noted, hallucinogens typically distort a person's perceptions. Types of hallucinogens include:

- lysergic acid diethylamide — LSD, trips and acid
- datura (angels' trumpet) containing chemicals including atropine and scopolamine
- magic mushrooms (gold tops, mushies) containing psilocybin
- ketamine (Special K), a dissociative anaesthetic.

Intoxication with a hallucinogenic drug is usually characterised by mild signs of autonomic arousal such as tachycardia and pupillary dilation. Protecting the person from harm and 'talking them down' is usually sufficient when providing care to the person who is intoxicated. Dependence is not common with the hallucinogenic drugs. While tolerance to the psychotropic effect of hallucinogens does occur, no withdrawal syndrome is reported (American Psychiatric Association, 2013).

Gamma hydroxybutyrate (GHB, fantasy, liquid ecstasy, GBH), is a substance which is difficult to classify. It is a dissociative anaesthetic and has some depressant qualities (NCETA Consortium, 2004). It is classified as a depressant that also distorts perceptions.

Opiates and opioids

Although the term opiate is often used interchangeably with **opioid**, the term **opiate** actually denotes the natural alkaloids found in the resin of the opium poppy. This group of drugs includes opium, morphine, heroin, and codeine. In contrast, an opioid is a chemical that works by binding to opioid receptors, which are found principally in the central

opioid a chemical that works by binding to opioid receptors, which are found principally in the central nervous system, peripheral nervous system and the gastrointestinal tract

opiate a natural alkaloid found in the resin of the opium poppy nervous system, peripheral nervous system and the gastrointestinal tract. The receptors in these systems mediate both the beneficial effects and the side effects of opioids.

Opiates are sometimes referred to as narcotics. They are a group of drugs that are used legally and very effectively as analgesics, to relieve pain. They are also used illicitly for the relaxing or 'good' feeling they give the user. Pethidine and methadone are examples of synthetic compounds that work in a similar way as morphine on opioid receptors. Other opiates, such as morphine, heroin and codeine come in a variety of forms including powder, capsules, tablets, syrups, solutions and suppositories.

Dependence on prescribed narcotics has recently developed into a serious public-health issue. As already noted, in the health care setting, it is important that professionals view any substance use as a health issue and provide appropriate interventions to reduce harm to the individual and the community (Kenny et al., 2009).

Heroin

Heroin is processed from the same raw gum opium that can produce morphine, codeine or thebaine. It is a product of morphine. Heroin is known on the streets as 'hammer, 'harry', 'H', "junk', 'gear' and 'smack'. It can be a white or brownish powder with a bitter taste that is usually dissolved in water and then injected. Most street preparations of heroin are diluted or 'cut' with other substances such as sugar or quinine. Heroin can be injected, snorted, smoked, eaten or dissolved in a drink. Health professionals may also hear those who use heroin talk about the equipment they need. The most common is a needle and syringe — also known as a 'fit'.

The risks of using heroin include:

- high risk of addiction
- mood swings
- depression
- menstrual irregularity and infertility in women
- loss of sex drive in men
- anxiety disorders
- chronic constipation
- infection at the site of injections
- HIV and hepatitis infections through needle sharing
- non-fatal overdose
- death from overdose (Rastegar & Walley, 2013).

People who use heroin will begin to withdraw after 8–12 hours after their last dose. The symptoms of acute withdrawal can last for five days while craving may continue considerably longer. Symptoms will include sweating, dilated pupils, goose bumps and cravings. Withdrawal from heroin can be painful and very difficult for the person to manage, but it is not life-threatening. Strategies for supporting the person who is withdrawing from an opiate are outlined in the next section.

Prescription opiates

In recent years, there has been increasing discussion about people who have developed dependencies on medications that have been prescribed for pain by authorised health professionals (e.g. Lustman, Svrakic, & Freedland, 2011). This discussion has encompassed the deaths of a number of celebrities, including Australian actor Heath Ledger, from accidental overdoses of prescription medications.

As noted, the narcotics are a group of drugs that can be legally prescribed and are effective analgesics to relieve pain. Chronic pain can be debilitating as it is pain that persists over a long period of time, often unrelentingly. Examples of chronic pain include headache, lower back pain, cancer pain, arthritis pain, inflammatory bowel disease, neurogenic pain resulting from damage to the peripheral nerves or central nervous system, and psychogenic pain, which has no identifiable cause. The use of narcotics by people with chronic pain can provide some much needed relief and improves their quality of life.

However, a small number of people will go from health professional to health professional, complaining of pain and requesting more medication. These people may have a prescription pain killer dependency.

The signs and symptoms of this dependency are the same as for other narcotic dependencies. It is recommended that health professionals monitor for behaviours that may suggest such a dependency — while also ensuring that they do not react punitively. It is important to remember that prescription drug dependencies are the same as other substance dependencies and the person needs to be treated without judgement. Providing information about the health risks, including accidental death from **polypharmacy** issues or overdose, can also be provided.

polypharmacy the concurrent use of multiple medications by a person; these medications often interact in a way that is problematic for the person

Caring for the person with an opiate dependence

As with regular alcohol consumption, the sudden cessation of an illicit opiate by a person may occur for a number of reasons, including unexpected hospital admission. Although opiate withdrawal is not a life threatening or particularly hazardous process, it can nevertheless be an extremely distressing experience for the person. As a result there is a need to minimise the impact of withdrawal and provide substitute alternatives to illicit narcotics. Taking a proactive approach to the provision of care and treatment options to the person with a dependence has the following benefits:

- prevention of the experience of unpleasant withdrawal symptoms
- increase in the likelihood of establishing the person's participation and cooperation with care and treatment interventions. If the person is pre-occupied and concerned about withdrawal symptoms, they are less likely to collaborate
- reduction of the personal, health and social risks associated with the use of illicit drugs; for instance, quantities of opiates used are controlled, the need for the person to engage in antisocial or potentially criminal behaviour is avoided
- provision of opportunities for harm reduction and physical and mental health promotion.

Methadone is the medication of choice for the short-term care and treatment provided to people who are experiencing opiate withdrawal. Methadone is now described in more detail.

methadone a synthetic opiate used as a substitute for people who are dependent on or withdrawing from an opiate

Methadone

Methadone is an opioid agonist that is used as an opiate substitute. It has a long half-life, ranging from 14–72 hours and does not provide the 'rush' that heroin gives. It is itself addictive and can be lethal in overdose or when taken in combination with other opiates, benzodiazepines or alcohol. Methadone is one of several medications prescribed in the community as a substitute for heroin or other opiates to reduce the harm associated with the use of illicit opiates.

Methadone usually comes in syrup form, but it is also available in a tablet form (Biodone Forte®) as an **analgesic**. For individuals to be prescribed methadone, they must meet the criteria for dependence, which are outlined in the National Methadone Guidelines. There are strict controls to the prescribing of methadone, and the prescriber must be authorised.

analgesic medication or drug that acts to relieve a person's pain

Methadone has a number of benefits. Firstly, it gives the person some stability in their lives — they are no longer driven by their dependence and can be sure their needs will be met. As methadone is an oral preparation, there is no risk of the person acquiring a bloodborne disease or condition such as HIV/AIDS or Hepatitis C as well as a reduced risk of a person who already has a bloodborne virus from spreading the infection to others. It is low cost for the person, which reduces the crime associated with continued use of heroin. Perhaps best of all, the methadone program provides an opportunity for the health professional to monitor the person for health issues each time the person picks up their dose.

Only a small proportion of those who are prescribed methadone go on to reduce the dose completely. Even so, methadone provides an excellent means by which the social issues that are associated with opiate dependence or addiction can be managed.

Other medications that can be prescribed for care and treatment of opiate dependence include:

- buprenorphine (Subutex®)
- buprenorphine/naloxone combination (Suboxone®).

Subutex® is now described in more detail.

Subutex®

Buprenorphine is another maintenance replacement drug that acts to halt the symptoms of narcotic withdrawal. It comes in a tablet form and is dissolved under the tongue. Many people prefer Subutex® over methadone as it provides them with more freedom. This is because Subutex® is taken every two to three days, rather than daily. However, other people dislike Subutex® for subjective reasons, including the taste, and so prefer methadone.

Buprenorphine is a partial agonist/antagonist, giving it the additional benefit that it is safer than methadone in overdose. As such, it has a lower risk of death by accident or suicide.

When a person is dependent on opiates and seeks admission to a hospital, there is an immediate requirement to review the person's need for care and treatment for withdrawal. This will include reviewing their need for substitute opiates. Where a person who has been admitted to hospital is on a treatment program, protocols must be followed to ascertain information from the prescriber about the person's medication, usual dose, time of last dose and takeaway doses dispensed. It is also important that the usual dosing agency is contacted and given information about dosing during the hospital stay. This communication is usually undertaken by the alcohol and other drugs team, medical officer or nurse practitioner (NCETA Consortium, 2004).

Naltrexone

Naltrexone or Revia is an opioid receptor antagonist that is used primarily in the management of alcohol and opioid dependence particular with post-withdrawal to increase the likelihood of sustained abstinence. It comes in the form of a tablet or depot injection and works by blocking the opioid receptors in the brain and therefore blocking the effects of substances like heroin and other opioids. It particularly is used to assist people to maintain the detox status in that it prevents the patient from achieving a 'high' from using heroin. It does not stop a person wanting to use, although it ma reduce or prevent the cravings. There have been a lot of media reports on naltrexone, often describing it as a 'miracle cure' for heroin dependence. However, most health professionals agree that the success of naltrexone treatment depends on multiple factors including the person's particular situation, their level of commitment to change, and the involvement of a treatment team of multi-disciplinary professionals.

Pain management

As already noted, people who experience chronic pain are prescribed narcotics to help them to manage that pain. Chronic pain is a debilitating condition and opiates provide an important means by which people are able to participate meaningfully in life. Pain management is an important consideration for people who are dependent on opiates. Where available, a pain team needs to be consulted as the opiate-dependent person will have developed a tolerance to the analgesic effects of opiates and may require significantly higher doses or combinations of analgesic medication to achieve adequate pain relief. The pain management plan needs to consider the future reduction and cessation of the analgesic medication. It is vital that analgesia is not withheld from people because they are dependent on the medication, unless a decision is made by the multidisciplinary team due to immediate medical risks. It is also important to remember that if opiate analgesia is administered in inadequate amounts, or withdrawn too early, it can exacerbate behaviour that some health professionals may describe as 'drug seeking'.

Opiate withdrawal

As described in table 10.5, the symptoms of opiate withdrawal can be very unpleasant. However, they are rarely life threatening, except in cases of severe comorbid physical illness. Opioid withdrawal in pregnant women also places the foetus at risks and the neonate likewise at risk of opioid withdrawal.

TABLE 10.5 Opioid withdrawal symptoms

Subjective symptoms	Objective signs
Drug craving	Dilated pupils
Abdominal discomfort and cramps	Sweating
Nausea	Tremor
Aching muscles and joints	Diarrhoea
Appetite loss	Rhinorrhea (runny nose)

Subjective symptoms	Objective signs
Hot and cold flushes	Vomiting
Fatigue	Tachycardia (increased heart rate)
Restlessness	Hypertension
Irritability	Frequent yawning
Low mood	Lacrimation (tears)
	Sneezing
	Pyrexia (high temperature)

It is important that health professionals across Australia refer to local guidelines to review the recommended supportive therapies to manage symptoms of opioid withdrawal. Consultation with a drug and alcohol specialist is also recommended.

Tobacco

Nicotine, the addictive component of tobacco, is a mild CNS stimulant. Cigarettes, which contain tobacco, contain upward of 4000 chemicals, many of which are known to cause harm. This includes over 40 known carcinogens.

Of all the substances discussed in this chapter, tobacco will kill more people than any other (ABS, 2012). The people, who are still smoking today, despite years of public health campaigns educating people on the health risks associated with cigarettes, are arguably among the most heavily dependent substance users. A number of these people will have made several previous attempts to stop and it is important for health professionals to inform people that there are new options available that have demonstrated effectiveness.

Of all the substances discussed in this chapter, tobacco will kill more people than any other.

In Australia, the national Quitline (13 78 48) provides excellent support and resources to help people to develop a plan and make a decision about nicotine replacement. Other options include:

- nicotine replacement therapy (NRT), which is available over the counter in various forms including patches, gum, inhalers and lozenges
- Bupropion (Zyban®), which is available from a general practitioner by prescription (this is a medication that reduces the urge to smoke)
- Varenicline tartrate (Champix®), which reduces the urge to smoke and also reduces the enjoyment the person experiences from smoking if a lapse occurs.

As with all substance dependence, the most important and influential approach that can be taken by health professionals in changing smoking behaviours is to raise the issue with a non-judgemental approach (NSW Health, 2007).

This section provides information about the different types of substances, licit and illicit, that are available in Australia. This includes a description of the effects of these substances and also the signs and symptoms a person may experience when they withdraw from those substances. In the next section, health professionals are informed about how they can conduct an assessment of a person's substance use. This includes an explanation of the different types of screening tools available.

THE BIG PICTURE

Australia's plain packaging legislation is world first

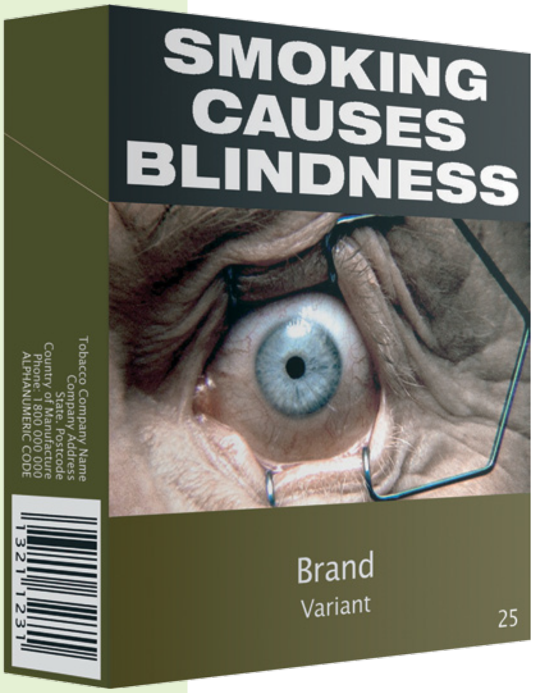
The Australian government's world-first legislation to require all tobacco to be sold in plain packaging received the Royal Assent on 1 December of 2011. The Tobacco Plain Packaging Act (2011) requires that all tobacco products sold in Australia from 1 December 2012 are in plain packaging. The legislation bans the use of logos, brand imagery, symbols, other images, colours and promotional text on tobacco products and tobacco product packaging. The packaging must be a standard drab dark brown colour in matt finish. The only thing on the packs to distinguish one brand from another will be the brand and product name in a standard colour, position, font size and style.

This new law aims to:

- reduce the attractiveness and appeal of tobacco products to consumers, particularly young people
- increase the noticeability and effectiveness of mandated health warnings
- reduce the ability of the retail packaging of tobacco products to mislead consumers about the harmful effects of smoking or using tobacco products.

These plain packaging laws will contribute to the Australian government's comprehensive package of efforts to reduce smoking rates as agreed by the Council of Australian Governments (COAG) in 2008. Through the National Healthcare Agreement, COAG set targets of reducing the adult daily smoking rate to 10 per cent by 2018, and halving the rate among Aboriginal and Torres Strait Islander people.

Source: © Commonwealth of Australia, 2 March 2012



Source: © Commonwealth of Australia

Assessment of substance use

People can present at any time to any health professional for help for a substance use problem; for instance, when they are intoxicated (e.g. in an emergency department) or experiencing symptoms of acute withdrawal. In circumstances such as these, it is important that the health professional undertake the following:

- conduct an accurate and comprehensive assessment, including a substance use history
  - complete a full medical screen for physical health problems
  - conduct a mental state exam and risk assessment
- provide short-term interventions to stabilise the presentation
- discuss ongoing issues related to substance use with the person
- make a referral to an appropriate drug and alcohol service.

The majority of people with alcohol and drug-related problems, however, will present to health professionals for reasons that may not appear to be directly connected to their underlying alcohol or drug problem; for example, a mental illness, heart disease or trauma.

It is important for the health professional to recognise the condition and provide appropriate care and treatment. Indeed, it is recommended that all people are screened or assessed for their substance use, with a more in-depth assessment conducted as required. The rationale for this approach is that it will increase the likelihood of the identification of underlying substance-use problems and will benefit the consumer by ensuring that:

- the care and treatment required for withdrawal or maintenance can be instigated; for example, the prompt implementation of treatment for symptoms of withdrawal
- the appropriate care and treatment are provided, increasing the likelihood of the person participating in and cooperating in the care and treatment for their comorbid health issue
- opportunities for health promotion and harm reduction interventions can be provided
- the person may be helped to gain insight into their behaviour and make informed choices regarding seeking further help to change their lifestyle.

As noted previously, a health professional may think a person does not 'look' like they have a substance use issue; however, 'looks' are not necessarily an indicator. All people need to be asked about substance use as part of a routine assessment. Likewise, it cannot be reiterated too often that health professionals must demonstrate empathy and adopt a non-judgemental or non-confrontational attitude. The person will only disclose their substance use to a health professional if they feel that they will not be viewed negatively and they will be provided with appropriate treatment.

Standardised substance screening tools

There are a number of standardised **screening instruments** that health professionals can use to help them to assess a person's substance use (see table 10.6, overleaf). These tools can be administered quickly as part of routine assessment and history taking. Urine drug screens can aid diagnosis and 'dip sticks' may be helpful in confirming illicit drug use. A more detailed analysis can be obtained by sending urine samples to the laboratory for screening. However, results will take several days and so may not assist the multidisciplinary team in developing initial treatment plans. The half-life and excretion of illicit drugs is variable; for instance, amphetamines are detectable in urine for up to 48 hours post-administration; cocaine for two to three days; and methadone for seven

screening instruments brief measures to help the health professional to identify if a person may require a more thorough assessment to nine days. Marijuana may be detected in the urine of heavy smokers up to six weeks after use. Note that while medical urine screens are calibrated to standardised cut-off levels, urine screens conducted for non-medical purposes may have different cut-off levels that will affect detection times.

The interpretation of urine screen results, particularly for cannabis, can be a complex issue. Consulting a drug and alcohol specialist to assist in interpreting results is recommended where possible.

TABLE 10.6 Examples of substance screening tools

Tool	Use
The AUDIT (Alcohol Use Disorders Identification Test)	Developed for use in primary care settings. It focuses on identifying people with hazardous drinking and mild dependence. Its sensitivity at picking up on mild dependence is offset by the time it takes to use (Saunders, Aasland, & Babor, 1993).
The CAGE	Simple and quick to use. It identifies dependent level use, but is less sensitive at picking up on non-dependent patterns of use. The acronym CAGE is taken from the following four questions asked to screen for alcohol-related problems: 1. Have you ever felt that you should **C**ut down on your drinking? 2. Have people **A**nnoyed you by criticising your drinking? 3. Have you ever felt **G**uilty about your drinking? 4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?
The PAT (Paddington Alcohol Test)	This test was designed for selective use with adults when there is suspicion of excessive alcohol use. Focuses on amount and frequency of alcohol consumption. The test was designed to be completed in hospitals (specifically emergency departments) within 60 seconds.
The DAST (Drug Abuse Screening Test)	This test specifically does *not* include alcohol use. It is a 20-question self-test, also available online, that helps a person to become more aware of their patterns of substance use. However, the language in the DAST uses terms such as 'abuse', with which some respondents may be uncomfortable.
Severity of Dependence Scale (SDS)	The SDS was devised to provide a short, easily administered scale that can be used to measure the degree of dependence experienced by users of different types of drugs. The SDS contains five items, all of which are explicitly concerned with psychological components of dependence. These items are specifically concerned with impaired control over drug taking and with preoccupation and anxieties about drug use.

Source: Adapted from Babor et al. (2007)

Once the health professional has identified that a substance use issue is likely, a more comprehensive alcohol or drug history needs to be obtained, as this will help identify whether the person may benefit from a specialist assessment and referral. Most health services in Australia utilise standardised substance assessment forms that begin by asking questions about legal substances such as tobacco, alcohol and prescribed medications. These forms will generally come with instructions so that all health professionals are able to provide them to a client. Alternatively, some health services in Australia have now established **drug and alcohol consultation liaison** services. These services are similar to the mental health consultation liaison services that are described at length in chapter 12. They provide a means by which health professionals can access specialist drug and alcohol workers to assist them in providing care and treatment to people with a substance use issue.

drug and alcohol consultation liaison drug and alcohol health services that are consultative in nature and delivered by specialist drug and alcohol health professionals in a range of generalist practice settings

Assessment of alcohol and drug use

Alcohol and drug use history taking includes comprehensive assessments that cover the substance use, general health, mental health and risk of the patient. Alcohol and drug history taking is to therefore be accompanied by a general medical exam, mental state exam, and a thorough risk assessment.

Health professionals must ensure that they document this information in the clinical records for future reference. The information can also be used to measure improvement or deterioration in the client's symptoms as time goes by. If the health professional is using specific screening tools, they are to be completed only as an accompaniment to the clinical interview and medical exam. The key elements of a detailed substance use history include the following:

- substance of choice (e.g. which substance does the person primarily seek/crave; what happens when this substance is not available)
- reasons for use (e.g. recreational, to cope, peer group pressure)
- trigger for use (e.g. any particular event or situation including emotional states that may trigger the urge for use)
- route of administration (e.g. oral, smoked, nasal, intravenous) or in the case of alcohol number of standard drinks per day
- when did the person last use (including amount used — question also for historical information like frequency and duration)
- periods of abstinence (if there have been times when the person has not used, include reasons why this period began/ended)
- previous experience of substance withdrawal, in particular whether the person has any history of seizures or delirium tremens
- signs of any symptoms of dependence or withdrawal
- any specific behavioural changes associated with use (e.g. criminal, suicidal, sexual, accidental)
- potential for suicide, homicide or accidental injury
- social situation — effects of substance on specific issues (e.g. childcare, employment, driving, work/school, relationships, and recreation).
- present or past contact with specialist treatment services
- the presence of behaviours associated with increased risk (e.g. sharing of needles, intoxication).

Referrals

When health professionals make a referral to a specialist drug and alcohol service, it is essential that the health professional goes on to support the person through the process of referral. This includes providing them with information about the service they are being referred to, ascertaining their preferred point of access to the service, and personally assisting with the transfer of care; for example, helping to make the initial appointment, clarifying any questions the person may have and providing the drug and alcohol service with sufficient referral information.

It is also necessary for health professionals to follow-up with a phone call to the person around the time of their first appointment and confirm with the drug and alcohol service whether the person has attended. This is important because transitions in care from one service to another are one of the most critical points where a person can be 'lost' in the system, giving rise to negative health outcomes (Mills et al., 2012).

While a person can often be referred on to a more appropriate service for care and treatment, there will also be times when health professionals are required to provide the treatment where they are. For example, while some health services in Australia provide bed-based services that are specific to detoxification and management of withdrawal, most people will be managed in their local area, either in a general hospital bed or in the community. For this reason, there is a need for all health professionals to understand the basic principles underlying the provision of care and treatment to a person with a substance use issue.

Caring for family members

When substance use becomes problematic for a person, the effect on family members can be devastating. The misuse of substances in society has many implications and there is often a range of repercussions for family members, as well as the person who is using the substance. Additionally, there have been times when family members were seen as the contributors or ones to blame for an individual's ongoing substance misuse behaviour. This is a particularly unhelpful approach to supporting both the person and the family. Often, family members are left bewildered and at a loss to know as to how to best support their family member to reduce or cease their substance misuse and regain their health and wellbeing.

Health professionals need to be aware that family members are likely to be affected in different ways by the substance use issues of the person. Family members may experience a sense of shame, guilt, blame, grief, anger or hopelessness. Health professionals need to support the family by listening, addressing any issues, providing information, and referring them to support services such as Al-Anon, Centrelink or community counselling services.

Support and education

The health professional needs to be aware that family members will require support and education to:

- manage their reactions to the use and misuse of substances by the person
- maintain their own health and wellbeing

- support the person with the substance use disorder but not the substance use behaviour (Straussner, 2012).

Sometimes the family members are at a loss as to how to put these principles into practice. Health professionals can help by, for example, suggesting the family member refrain from giving the person cash, but rather provide them with specific items that they may need; for example, food or clothes.

Support groups such as Al-Anon and Nar-Anon Family Group play an important role in assisting families to deal with the impact of substance misuse. It is essential that the health professional offer information to family members about how to access groups and education. Availability of programs will vary between states and territories, and health professionals are encouraged to identify those that are relevant to their local area.

Parents and children

People with a substance use disorder often have children. Health professionals need to be aware of the effects of substance use by parents on the children. Children will be affected by a parent with a substance use disorder (Conners-Burrow et al., 2013). For example, a parent with a substance use disorder may not be physically or emotionally available for their child. The parent's cognitive capacity and functioning may also be impaired as a result of the disorder, which places the child at risk. While the health professional must continue to demonstrate a non-judgemental attitude and support the person, there is also a need to intervene. All states and territories across Australia have child protection laws with which the health professional must comply.

Homelessness

A significant number of people with a substance use disorder may be homeless (Chamberlain & Johnson, 2011). This can cause concern for health professionals who are required to arrange follow-up appointments and possible ongoing treatment on discharge. Consideration needs to be given to contacting a social worker or government services that link individuals with homeless support agencies in the local community.

This section outlined the principles of providing care to a person with a substance use disorder, including engaging with the person and supporting them through the various stages of change in an ongoing process. The provision of care also involves supporting partners or carers, providing them with information and assistance as required. In the next section, motivational interviewing is explained. This is a therapeutic approach by which the health professional can engage with a person and influence them to think about change.

Understanding motivation

Providing care for people with problems that require a significant lifestyle change can be complex. The health professional may find that their recommendations regarding lifestyle change will go unheeded by the individual to whom they are offering the advice. Identifying the ideal treatment does little to improve outcomes for the individual if they decline the treatment.

To become an effective health professional, it is important to be aware of the contemporary models of change and the evidence-based strategies that increase the likelihood of the person adhering to treatment recommendations.

The following section explores the Cycle of Change model and motivational interventions that will enhance the health professional's effectiveness when working with people with a range of issues.

Cycle of Change

In the past, behaviour change was viewed as a one-step process: behaviour was either instituted or stopped. However, in the late 1970s and early 1980s, Prochaska and DiClemente (1982) developed a theory of behaviour change by breaking down the process into several stages comprising definitive cognitive and behavioural shifts. The 'Cycle of Change' model describes the six discrete stages (the original model contained five) through which an individual passes when making any behavioural or lifestyle change. Some health professionals may also know this model as the '**Transtheoretical Model of Change**', which is the clinical name of the model.

Transtheoretical Model of Change the clinical name and theory behind the 'Cycle of Change' model, which describes the six stages a person will move through when making change in their life

The six stages identified are:

1. precontemplation
2. contemplation
3. determination or preparation
4. action
5. maintenance
6. relapse and recycling (DiClemente, 2003).

Figure 10.5 illustrates the six stages of change, including the cyclic natures of these stages. In addition, each of the stages of change will now be described in more detail.

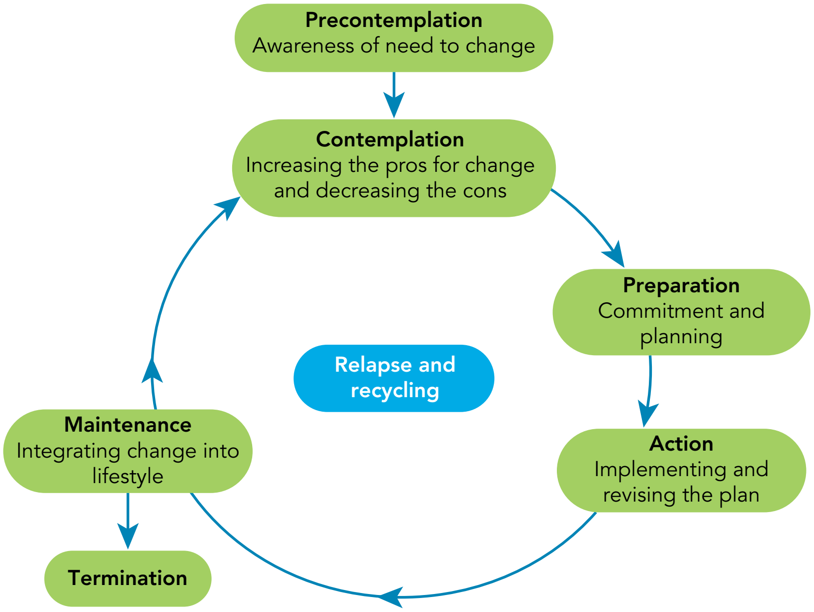


FIGURE 10.5 Cycle of Change model

Source: DiClemente (2003)

Precontemplation stage

The hallmark of the precontemplation stage is that the individual is not currently considering changing their behaviour. It may be that the person does not think that their behaviour needs to change, or that the thought of changing is too difficult. The person may fail to make a connection between their behaviour and the consequences. Some precontemplators are happy with their substance use, while others have tried to change so many times before that they become resigned to continued use and feel too hopeless to change.

When working with a person who is precontemplative, health professionals should first work on building a therapeutic alliance with the individual before working on strengthening the person's perceived importance of making a behaviour change by raising the person's consciousness that there is an issue with the current behaviour. Once the person recognises the importance of the behaviour change, the health professional can help build the person's **self-efficacy** or belief that it is possible to change.

self-efficacy a person's belief about their ability or capacity to accomplish a task or achieve a goal

Some useful strategies to help build self-efficacy include reminding the person about other achievements they have made in the past and letting them know that many people in the same situation struggle with similar issues and manage to make changes despite the difficulties. The health professional should always be aware that the term 'precontemplator' should never be used in a pejorative way. Everyone is precontemplative about many things. For example, one might be precontemplative about ceasing coffee consumption or saving for a winter's holiday in Antarctica.

Contemplation stage

In the contemplation stage, the person is ambivalent about changing their behaviour. They are seriously considering change, but they are torn between the desire to change and the difficulties of undertaking a change. Contemplators acknowledge some of the consequences of their behaviour.

The aim of the health professional in working with someone who is contemplating a health behaviour change is to facilitate an increase in **ambivalence**; exploring the person's reasons for change and what the risks of not changing are can do this. It is important to continue to support an individual's self-efficacy throughout this stage. When talking with an individual who mentions the possibility of change, it is useful to explore these thoughts in more detail.

ambivalence uncertainty or indecisiveness about an issue or course of action; it can also be described as being in two minds about doing something

Determination or preparation stage

Working with someone who has made a decision to change their behaviour is relatively straightforward. Firstly, the health professional can assist by helping the individual strengthen their commitment to undertake the change. Provide the person with reassurance that it is quite normal to still have some doubts. The health professional can help the person plan the necessary changes that will be required, exploring which issues will be the most difficult. It is important for the health professional to use their knowledge of strategies and resources to provide a variety of options and support the person to choose best strategies.

Action stage

The action stage is the first point where the health professional observes some objective behaviour change. For example, the person may have taken some small steps to change their behaviour or may have instituted a major behaviour change. The early period of any behaviour change is likely to be the most difficult, so it is important to continue to offer support through this period. Health professionals need to provide affirmations for the person such as 'You must be happy with all you've achieved so far' or 'You have really made some positive changes — you're achieving everything you said you would so far'. It is also important for the health professional to discuss which strategies have been working for the person and continue to offer a menu of options for other strategies. Some strategies can be particularly useful during the action stage including **distraction techniques** for dealing with urges to revert back to former behaviours.

distraction techniques a strategy used by a person to temporarily take their attention away from a strong emotion, compulsion or desire; it may involve an activity or refocusing of thoughts onto something else

Maintenance stage

In maintenance stage, the person recognises after several months of behaviour change, that it requires less effort to maintain the new behaviours. This can provide the person with a sense of confidence that they have successfully made a change. In this situation the health professional can encourage the person to remain vigilant in their efforts to avoid 'risky' situations, which might lead them back into their old behaviour patterns. It is also important to let the person know that ambivalence can creep back in to their mind at any time.

Relapse and recycling

It is not uncommon for people to lapse back into their former behaviour. This may be a minor slip (lapse) or a longer-term return to former behaviour. Most people who have been successful at undertaking a difficult lifestyle behavioural change have succeeded only after making several seemingly unsuccessful attempts.

It is extremely important that the health professional avoids making any statements that could be interpreted as demoralising for the person who may have had a lapse. Another danger in this situation is to minimise the potential consequences of a lapse. The best approach is to encourage the person to learn from their experience and develop strategies to avoid the same mistakes next time.

Understanding the transtheoretical model of behaviour or Cycle of Change provides health professionals with insight into how a person with a substance use issue can work towards achieving change. The process is ongoing and effective health professionals will support the person through the cycle as many times as it takes.

At the same time as providing support to the person, it is also important health professionals ensure they support the partners, carers or family members of the person. Substance use issues will impact on not only the person who is using the substance, but also those with whom the person lives or is in a relationship. Partners, carers and family members play a crucial role in supporting the person and helping them to achieve change. At the same time, they also require support from the health professional. Table 10.7 describes five different precontemplator subtypes identified by DiClemente (2003). It is important to distinguish between these subtypes in order to match the most appropriate intervention to the individual.

TABLE 10.7 Precontemplation subtypes

Type of resistance	Strategies
Revelling Those who are having too good a time to change.	• Stimulate concern about the negative consequences. • Raise doubt about their illusory sense of elevated self-efficacy. • Focus on how their behaviour affects others. • Shift focus from problematic issue.
Reluctant Those who are simply unwilling to consider change.	• Counter the hesitance by working through their concerns about changing. • Build confidence in their ability to change. • Use the support of individuals who have made similar changes.
Resigned Those who feel hopeless and helpless, may have a history of failed attempts and do not feel they can change.	• Provide hope. • Share success stories of similar individuals. • Evaluate prior attempts and suggest different strategies to use.
Rebellious Those who actively resist attempts to encourage change.	• Link autonomy and freedom to change. • Shift high-energy levels from rebellion to change. • Make sure they feel in charge of the change at all times. • Offer choices and options for managing their change.
Rationalising Rationalises why the addictive behaviour does not pose a problem. Appears to have all the answers.	• Continue to make a clear connection between behaviour and consequences. • Do not deride their reasons but try and work with them to your advantage. • Build confidence in their potential to change.

Source: Adapted from DiClemente (2003) and Clancy and Terry (2007)

IN PRACTICE

Integrated motivational assessment tool

This particular tool was devised by Clancy and Terry (2007) to assist health professionals to assess a client's motivation for receiving treatment interventions for both mental health and substance misuse disorders comorbidly (table 10.8, overleaf). It allows the health professional the ability to assess and subsequently focus on an issue that may be causing the greatest detriment to the client's health.

John is a 24-year-old male who is experiencing psychosis and is using cannabis on a a daily basis. When using this tool a health professional would try to elicit John's comprehension of the possible contributing factors of daily cannabis use to his psychosis. For example, John may believe that due to his psychosis it would be useful to take antipsychotic medication to deal with

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symptoms that he may experience (e.g. auditory hallucinations) therefore using this model it could be argued that John is in the action phase of the transtheoretical model when considering his mental health issues. However, when questioned about his cannabis use, John indicates that it does not affect or contribute to his psychosis, therefore it can be assumed when considering his substance misuse issues that he is a pre-contemplator. From this information the health professional would make an assessment of the impact of John's beliefs around his substance use and mental illness and therefore target behaviours and motivations that may have the most detrimental effect on health. In this example the health professional would most likely work with John with psycho-education on the effects of cannabis and its possible contribution to exacerbation of psychotic symptoms. The idea being that this may possibly motivate John to shift from a pre-contemplator to a contemplator in relation to his cannabis use and his mental illness.

TABLE 10.8 Integrated motivational assessment tool

		Motivation regarding AOD treatment				
		Pre-contemplation	**Contemplation**	**Preparation/ Determination**	**Action**	**Maintenance**
Motivation regarding psychiatric treatment	Pre-contemplation					
	Contemplation					
	Preparation/ Determination					
	Action					
	Maintenance					

Source: Queensland Health (2010)

Stages of treatment

The staged treatment model proposed by Mueser and colleagues (2003) for working with people who have comorbid mental health and substance use disorders provides a useful framework to guide health professionals as they work with complex issues. The model comprises four broad strategies for treatment that guide the clinician to provide interventions that are suited to the person's readiness to participate in treatment.

The main difference between the stage of treatment model and the Cycle of Change model, is that the Cycle of Change model describes where an individual is in relation to a behaviour change, while the stages of treatment model describes interventions that a clinician or a service may implement to suit the client.

The four stages of treatment in the model are:

- engagement
- persuasion
- active treatment
- relapse prevention.

Engagement

A person may be enrolled in treatment without being engaged in the treatment process. This often occurs when a person is strongly encouraged to seek treatment by a significant other. A client who is engaged in treatment feels that the service provider has something desirable to offer. Health professionals can engage people into treatment by firstly making the environment as pleasant as possible, focusing on the consumer's main issues and providing practical assistance to help the person. Being friendly and not focusing on rules also helps to engage the individual.

Applying pressure on a person to cease substance use before engagement has taken place often results in treatment dropout.

Persuasion

Once engaged, the person is usually more prepared listen to information. Motivational interviewing and psychoeducation are the strategies best suited to influencing the person to make lifestyle changes. If available, group therapy can assist in the persuasion stage.

Active treatment

People in the active treatment stage are prepared to listen to encouraging statements promoting the possibility of change. It is in active treatment stage that people begin to make some changes. Health professionals can ensure that the person assumes control of the change by offering a range of strategies from which the person can choose.

Relapse prevention

Clients with complex issues really benefit from support in helping them expand their recovery to making the most of their life. This is likely to be more successful with some assistance from the health professional. It is important to encourage the person to try new things, take some risks and maintain some vigilance to ensure the progress that has been achieved is maintained over time (Mueser, Noordsey, Drake, & Fox, 2003).

Motivational interviewing

In the past, health professionals would often use confrontational methods to try to convince people to change their behaviour. This is not helpful, as confrontation can be seen as pushing against the person's wishes until they relent. Motivational interviewing is a directive, client-centred counselling style that seeks to increase a person's ambivalence about making a behaviour change and helping the person see a resolution to their ambivalence. Miller and Rollnick (2013) suggest that the following styles and responses from health professionals have been shown to actually *increase resistance* among some clients.

- *Arguing for change* — where the health professional assumes a pro-change side of the argument only.
- *Assuming the expert role* — where the health professional implies that he or she 'has all the answers' (i.e. 'I know what is best for you').
- *Criticising the person* — shaming or blaming. While the underlying intent of this approach is to shock the person into change, it often ends with the opposite outcome, where a person becomes defensive about their behaviour and reinforces the self-doubt they may already have about their ability to change a behaviour.
- *Labelling* — the health professional needs to refrain from using pejorative and stigmatising labels when attempting to support someone in purposeful behaviour change. Terms such as 'substance abuser', 'junkie', 'druggie' and 'alcoholic' have no value or purpose in a therapeutic relationship. These terms can create barriers to engagement as the person may not view themselves within the context of this language, and the use of labels perpetuates negative beliefs about these individuals within health care settings and the wider community.
- *Hurrying* — it is important not to rush people. Behaviour patterns often take years to develop, so it does not make much sense to rush things when it comes to deciding whether or not a change is required or is possible. Using forceful tactics to push change along, risks getting ahead of the person's readiness to change and can increase resistance. It is also important not to rush into identifying the issues that require attention. Many people may not yet have articulated for themselves exactly what their issues are, and often benefit from a thoughtful, reflective approach to help them clarify the issues.
- *Claiming pre-eminence* — the health professional claims his/her goals and perspectives and these override those of the client (Miller & Rollnick, 2008).

At other times, health professionals have assumed that if they gave someone information about their experience of ill-health and any associated risks, it would be enough to bring about the required health behaviour change. In reality, however, achieving change is not that easy. There are many reasons why people do or do not achieve a desired health behaviour change. Some may believe that they are unable to make a change, while others may feel that the costs — physical, psychological and/or financial — are too great. Others again may not place the same value on the 'need' to make a change that the health professional does. Finally, there are those who see no need to change. A lack of motivation is discussed in the next section.

Rationale for motivational interviewing

Motivational interviewing (MI) is a counselling strategy or 'talking therapy' that aims to increase the individual's motivation for change through the dialogue maintained between the health professional and client. MI builds on the work of Prochaska & DiClemente's 'Cycle of Change' (1982) and the underlying processes of change. It was first described by Miller and Rollnick (1991, 2002, 2013) and has since demonstrated effectiveness across a variety of clinical settings (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010).

The rationale that underpins MI is simple:

- the health professional's **interpersonal style** can have an impact on a person's level of resistance towards change
- arguing with a person increases their resistance
- the more a person resists an idea, the less likely they are to change
- people who change, usually go through a period of increased ambivalence just prior to change.

MI is non-confrontational and assumes equal status of the person and the health professional. While the health professional takes the lead, the client plays an active role in the dialogue and consequent learning. Indeed, MI emphasises an individual's right to define their own problems and choose how to deal with them. Motivation and resistance are seen as products of the interaction between the health professional and the person. If the person becomes resistive, this indicates that the health professional has been moving too fast.

interpersonal style mannerisms or approaches used by a person when interacting with others, often stemming from personality and mood

Principles of motivational interviewing

The main principles of MI are:

- avoid argumentation
- express empathy
- support self-efficacy
- deploy discrepancy
- roll with resistance.

These principles are now described.

Avoid argumentation

Confronting or arguing with the person can be counterproductive even though you may feel the person is denying the consequences of their substance use. Argumentation will merely increase resistance and reduce the likelihood of the person listening. The use of confrontation has been shown to increase dropout rates. The 'I know best, listen to me' attitude of the health professional can have a negative impact on attempting to engage in a therapeutic relationship with the person. Arguing can lead to an increase in resistance. Rather than trying to 'break through' the denial, it is better to work around it. Remember the decision to change is the client's decision. No-one likes being told what to do. The aim is negotiation rather than conflict.

Express empathy

The use of empathy is a key aspect of MI. This goes beyond the health professional feeling compassion, instead relying on the health professional's ability to *express* and *articulate* empathy. Expressing empathy is critical to MI. Some examples of empathic statements are as follows.

- 'Things have been difficult for you lately.'
- 'It can be really challenging to maintain this lifestyle.'
- 'It must be hard to feel that everyone is against you.'

Empathy is different to sympathy or feeling sorry for the person. Empathy involves imagining how the person feels or perceives things. If the person believes the health professional is unable to see things from their perspective, they may feel as though they have not been listened to or understood, therefore they are less likely to ‘open up’. However, if the person perceives empathy from a health professional, they are more likely to accept gentle challenges and questioning around lifestyle issues and substance use beliefs. Expressing empathy facilitates engagement, which is the seed of a successful therapeutic relationship.

Support self-efficacy

Self-efficacy refers to an individual’s belief about whether change is possible. It is a person’s belief in their ability to succeed in specific situations (Bandura, 1997). A person’s sense of self-efficacy plays a key role in how a person approaches goals, tasks and challenges. Therefore, people with high self-efficacy who believe they can perform a task well are more likely to view difficult tasks as something that can be overcome or mastered, rather than avoided. It is a person’s sense of control that facilitates health behaviour change.

A good way for the health professional to build self-efficacy is to explore changes that the person has made in the past in other areas of their life. Some individuals may have made multiple attempts in the past to change their behaviour and now feel a sense of failure. If this is the case, remind them that the majority of people who have made long-term change in their lives have usually had several unsuccessful attempts prior to succeeding, and that it is normal for this to happen. It is also useful to elicit some knowledge about a previous unsuccessful attempt, to help the person to identify what led to the last relapse and define some strategies to avoid the same result. It can also be useful to ask the person how confident they feel in being able to undertake the change using a scale of one to ten (Miller & Rollnick, 2013).

Develop discrepancy

This principle involves the health professional generating a discrepancy between how the person sees their situation and how they would like it to be. This can be achieved by exploring goals and the barriers to achieving them. Another strategy for developing discrepancy is to ask the person how some of their behaviours fit with the way they like to be thought of by others. Sometimes the health professional may also notice some discrepancies in the person’s history; for example someone who has previously told the health professional that they have no problems associated with drinking, may later tell the health professional that they did something under the influence of alcohol about which they are not pleased. In this situation, the health professional might gently explore how this behaviour fits with their perception that they have no problem with drinking.

Roll with resistance

Resistance may be direct or indirect. It is neither a bad nor a good thing. The more a person resists, the less likely they are to change. Resistance is a signal to the health professional that they are moving too fast and that they have misinterpreted the person’s readiness to change.

For example, resistance may occur if the health professional begins to talk about possible changes a person could make before the person has recognised there is a need to change at all.

Some examples of behaviours that signal resistance include the following.

- *Interrupting* — the person interrupts the health professional when discussing issues.
- *Negating* — the person expresses unwillingness to accept responsibility, recognise problems, or listen to suggestions.
- *Ignoring* — the person ignores the health professional.
- *Arguing* — the person contests the accuracy, expertise or integrity of the health professional.

MI was designed to reduce the person's resistance and increase the likelihood of change through the following three fundamental approaches.

To 'roll' with the resistance, the health professional will work to achieve the following.

- *Collaboration rather than confrontation* — the MI relationship involves a partnership that recognises both parties as equal and honours the person's perspective and expertise. The atmosphere is conducive rather than coercive.
- *Evocation rather than education* — the motivation and resources to effect change are presumed to exist within the person. The health professional's role is to elicit from the person their reasons for change and the strategies and resources they might employ to achieve change, rather than 'enlighten' the person with their own knowledge, skills and insights.
- *Autonomy instead of authority* — the health professional affirms the person's right to choose and facilitates informed choice rather than telling the person what to do.

Challenging an individual's statements can increase resistance to change. Instead, the health professional needs to express interest in their wellbeing and emphasise the person's right to choice. Encourage the person to develop their own solutions to the problems that they themselves define.

The next section provides a brief overview of microskills. When utilising MI, the health professional will apply similar skills but with a slightly different focus.

Microskills

Miller and Rollnick (2013) suggest four useful **microskills** that can be used throughout the process of MI. The following, known as the 'four OARS', have been derived from person-centred counselling:

1. **O**pen questions
2. **A**ffirming
3. **R**eflective listening
4. **S**ummarising.

microskills in counselling terms, techniques that are used in the counselling situation (e.g. maintaining eye contact and using open-ended questions)

Open-ended questions

Open-ended questions are discussed briefly in chapter 7 in relation to the person with depression. When using the MI strategies, health professionals will use open-ended questions to avoid a pattern of asking questions that require only short answers from the client. Open-ended questions are those that invite long answers. They could include the following.

- 'Fill me in on . . .'
- 'Tell me about . . .'
- 'What are your concerns about . . . ?'
- 'Bring me up to speed on . . .'
- 'What do you think about . . . ?'

Open-ended questions are used to establish an atmosphere of acceptance and trust by allowing the person to do most of the talking. They provide an opportunity to guide the person in their exploration, elicit the desired information, and gain an understanding of their situation and ambivalence.

Affirming

Affirming refers to offering direct compliments and statements of appreciation and understanding to the client during the interview process. Examples include the following.

- 'You took a big step in coming here today.'
- 'That's a great suggestion.'
- 'You are clearly a very strong person. Most people would struggle to cope in that situation.'

Affirmation can be important in building rapport and reinforcing open exploration. The appropriate level and frequency of affirmation within the therapeutic relationship will vary across social contexts. It is important to appropriately affirm a person's strengths and efforts. Some health professionals recommend always encouraging the **internalising** affirmation statements (e.g. '*You* must be happy that you succeeded' rather than '*I'm* so happy you succeeded'). This provides an important means of helping the client to see the personal benefits of their changed behaviour.

internalising a technique used by the health professional to assist the client to see the personal benefits of their changed behaviour; it replaces externalising the reasons for change

Reflective listening

Reflective listening is probably one of the most important and challenging skills needed for MI. Reflective listening involves the health professional listening intently to the words and the feelings being expressed and reflecting them back to the person in the health professional's own words.

- 'You're angry with your mother.'
- 'You haven't always been like that.'
- 'And that's what worries you.'

This can be a mere substitution of the person's words, or, as the health professional gains more skill, they may make a guess at an unspoken meaning, or make an observation about how the person is feeling, or attempt the next sentence in the person's paragraph (known as continuing the paragraph). The depth of reflection increases with the level of the health professional's skilfulness. However, it is important to slightly understate what the person has said, particularly when a statement is emotionally loaded. The experts in MI aim for two to three reflections per open-ended question, so that in the early stages at least, a substantial portion of the health professional's responses are reflective listening statements. This can be quite a challenge and it can take several years to achieve this level of skill.

Summarising

Summary statements are a useful way of linking together and reinforcing the information discussed during MI. Periodic summaries also show the person that the health professional has been listening carefully and it prepares the person to elaborate further.

As noted, these communication skills are used through the process of the MI. They are a means by which the health professional can encourage the person to reflect on the issues they have raised and to continue the conversation. In the process of talking, the person will also be thinking about their situation, including their substance use and how it is impacting upon their lives. In the next section, some of the strategies related to the MI approach are outlined.

Motivational interviewing strategies

The principles and microskills for MI described in the previous pages allow any conversation with a person to be motivational. Miller and Rollnick (2013) have also developed a series of 'recipe style' interventions that any health professional can employ to encourage a person to consider the possibility of changing the status quo. These strategies all aim to have the person consider the advantages of changing, the disadvantages of not changing, viewing change in a more positive light and finally developing an intention to change.

Using the importance ruler

Miller and Rollnick (2013) utilise a scale from one to ten to obtain the person's self-rating of how important an issue is to them. The person is then asked how they would get from where they are on the scale to a higher number. This same scale is used to elicit the degree of confidence the person has in addressing the issue.

Typical day

The typical day strategy is a useful way to help engage with a person during the first couple of sessions. Knowing how a person spends their day and who they interact with can also provide some useful information for later MI sessions.

Instructions

The health professional explains to the person that they would like to develop a better understanding of how the person spends their time on most days. The health professional should ask them to think of a recent day that represents an 'average' day for them, and encourage the person to choose a specific day; for example, 'the day before yesterday', rather than talk about what they usually do 'most days'.

The health professional explains that they would like to spend ten minutes or so going through with the person exactly what they did on that day, from the moment they woke up to the moment they went to sleep. If the person seems to run through the day too quickly, the health professional can try to bring them back to half-hour intervals. It is important to stay on track. The health professional may be tempted to explore some issues that are raised, but instead it is best to acknowledge the problem if necessary, make a mental note of the issue and come back to it after the exercise is finished, or it can be raised in the next session. This has the added benefit of showing the health professional had a real interest in the conversation.

Try to make connections between mental state (i.e. mood, feelings) and substance use and medication adherence. At the end of the exercise, the health professional can summarise some of the major points and give positive feedback/affirmations where possible regarding positive behaviours — hobbies, family/friends contact, resourcefulness or problem solving.

Decisional balance

Many people accessing services expect their health professional to take a negative and paternalistic approach toward their substance use, sometimes interpreting this response as a personal value judgement. The decisional balance, which is one of the most frequently used motivational strategies, is ideally suited to individuals who are already displaying some ambivalence regarding their substance use and can be helpful in determining a person's readiness to change. For some people, the concept of being simultaneously in two minds about behaviour is new to them. The decisional balance and the double-sided summary provided at the end of the intervention can be an effective tool in increasing ambivalence.

Instructions

Begin by the health professional asking 'What do you like about your use of . . . ?' For individuals who have difficulty in articulating things they like about using, some health professionals will offer a menu of options for them to choose from. However, this needs to be done sparingly. The health professional needs to find out what this person likes about using, rather than what the health professional thinks the person might like about it. Summarise all of the good things the person has suggested.

Then the health professional needs to ask if there is another side to their using: 'What are some of the 'less good' things about using . . . ?' Again, the health professional may have to offer a menu of options or ask questions like 'How do your parents feel about your using . . . ?' It is then time to provide a double-sided, selective summary such as: 'You said some of the things you like about using were . . . and then you said that there was another side to it. You said some of the not so good things about using were . . .'

An advanced skill is to choose the appropriate amount of emphasis to place on each of the points being summarised, adding more weight to the not so good things. Finish by the health professional asking 'Now that you've gone through both sides of the equation, where does this leave you?' or 'How do you feel about your use of . . . now?' The health professional should not label the less-good things as 'bad' or 'problems' unless the person uses that terminology to describe them first.

Some individuals will respond well to writing these things down in two columns on a sheet of paper so that they can take it away and add to it later. This strategy needs to be used with caution for people with high levels of anxiety or for those who are not ready to deal with the pressure of increased ambivalence.

It is also best not to use this strategy with an individual who is currently tempted to use. As may be imagined, talking about the positives of substance use could trigger a person to want to use. Distraction is a better strategy to use with someone who is currently tempted to use rather than discussing the things they like about using.

Exploring goals and values

The health professional can assist the person to explore their goals and values as a reference point from which to compare the status quo. The health professional may ask them what would help them to live more in alignment with their values or achieve their goals, and also what might stand in the way.

As already noted, MI has been shown to be effective in helping people with substance use issues to make changes in their lives. In the next section, the use of MI with people with comorbid issues is discussed.

Motivational interviewing and comorbidity

When using MI with people who have mental health issues as well as substance use problems, the following points need to be considered.

- When using the decisional balance, if a person states that a substance reduces their symptoms of mental illness, explore this later in more detail with particular attention to timeframe. For example, using substances may make them feel great in the short term, but cause problems later.
- When a person begins a behaviour change, try to have as many people as possible provide the person with positive feedback (e.g. involve family and other health professionals).
- Do *not* use the decisional balance strategy with someone who is acutely depressed, as this may cause unnecessary distress.
- Do involve the family in care as much as possible. Educate family on the basics of non-confrontational interventions. Use information from family members to provide options when offering a menu of choices for the 'not so good things'.
- Always give consistent messages, including a unified 'recommended goal'. For people with both mental health and substance use issues, abstinence is the most appropriate recommendation. It is easy to recommend abstinence while accepting an individual's decision to continue to use. This does not mean you condone continued use.
- Harm minimisation information can easily be couched within broader abstinence recommendations. For example, a clinician may say something like 'the experts recommend that it's best not to smoke cannabis at all when you have schizophrenia, but if you do choose to smoke, it is dangerous (and illegal) to drive while under the influence'. Remember, abstinence may be a health professional's goal *of* treatment without being a prerequisite *for* treatment. Many people will never consider abstinence and still require support and treatment.

This section provides a brief explanation of MI, what it is, why it is used, and the strategies and techniques that are used as part of the MI process. Although MI has been shown to be effective in promoting change, there will often be occasions when health professionals are unable to maintain a therapeutic relationship with the person with a substance use issue for any length of time. In such cases, brief interventions have also been shown to be effective.

Brief interventions

Brief interventions present a framework for health professionals to provide standardised opportunistic interventions aimed at increasing the likelihood of behaviour change. Adopting a brief intervention focus acknowledges that the time and opportunities for health promotion and implementing behavioural change may be limited. Brief interventions have been shown to help reduce harmful substance use (Fischer, Donovan, Forceheimes, & Bogenschultz, 2012; Kilmas et al., 2013). Brief interventions aim to promote moderation or harm-free substance use and involve:

- assessment and identification
- advice
- counselling with education
- promotion of self-help.

The common elements of brief intervention have been summarised by the acronym FRAMES, which provides a framework that any health professional can use to address the need for personal change. The FRAMES approach to brief intervention is depicted in figure 10.6 (adapted from Miller & Sanchez, 1993).

Feedback	Feedback by the health professional on their assessment of the problem
Responsibility	Advise the person that the substance use is their responsibility
Advice	Give clear advice, both written and verbal, as to the reasons why there is a need to stop using the substance
Menu	Help the person to identify a range ('menu') of options or choices regarding their substance-using behaviour
Empathy	Be empathic, warm, understanding and encouraging about the person's ability to change
Self-efficacy	Encourage and reinforce the person's ability to achieve change by being self-reliant (e.g. avoid blaming others for their problems or failure to achieve an alcohol-free or substance-free lifestyle)

FIGURE 10.6 FRAMES approach to brief intervention

Source: Adapted from Miller and Sanchez (1993)

In order to ensure that the likelihood of change is maximised, people need to receive the appropriate level of specialist help when discharged from hospital. To achieve this, health professionals need to develop contacts and links with local government and non-government specialist alcohol and drug services. Much informal support, counselling, advice and treatment is provided by these organisations, particularly 'self-help' organisations such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), so it is necessary to know the local contacts and means of access or referral.

The stress–vulnerability model

Explaining how some individuals who use substances end up with mental health problems and others do not is best approached using a simple version of the stress–vulnerability model. This particular portrayal of the stress–vulnerability model is based on Mueser and colleagues (2003). The model also illustrates factors affecting the course of an illness.

The health professional can use this model to explain that every person has a degree of vulnerability to developing some illnesses. In fact, many illnesses run in families. These might be illnesses such as heart disease, diabetes or cancers.

Having a vulnerability to an illness does not mean that an individual will necessarily develop the illness. However, it does mean that the risk of developing the illness for that particular person is greater than for someone else in the community.

What can be helpful?

Figure 10.7 reveals that a healthy lifestyle can be helpful in reducing a person's chance of developing symptoms. Some helpful strategies include:

- positive relationships with friends and family
- having some meaningful activities and hobbies

- learning problem-solving strategies
- learning coping skills.

Taking medication as prescribed can also be helpful, but medication may not be for everyone. In fact, it can take some people with a mental health disorder a long time before they find a medication that works well for them. However, medication is one of the best tools we have to manage many illnesses.

What things are unhelpful?

Stress is unhelpful and can make mental health symptoms worse. While no person can avoid stress altogether, health professionals should note that stress can increase the likelihood that a person will become unwell. Using substances will also make a relapse of the person's mental health condition more likely.

Figure 10.7 illustrates the relationship between factors known to interact with an individual's biological vulnerability to developing symptoms of mental illness.

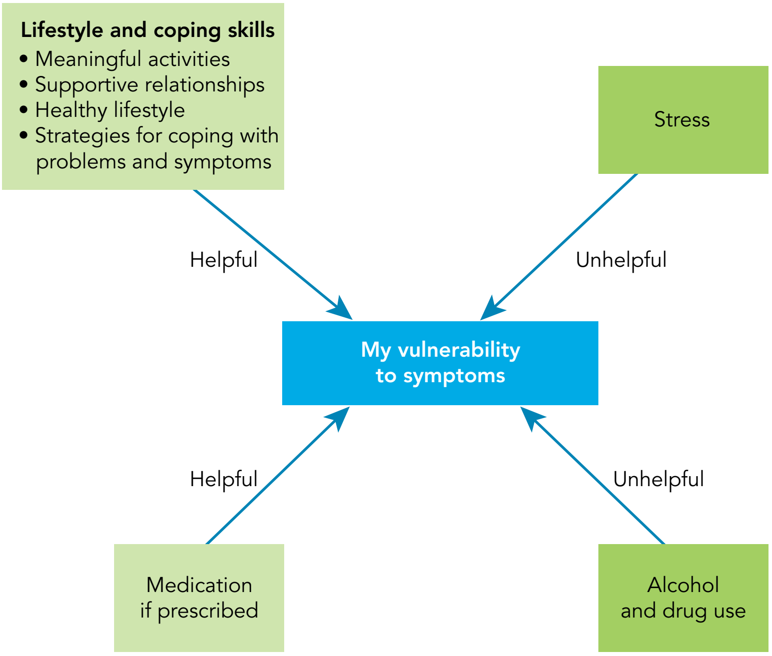

FIGURE 10.7 The stress–vulnerability model

Source: Based on Mueser, Noordsey, Drake, and Fox (2003)

SUMMARY

The focus of this chapter is caring for the person with a substance use disorder. The chapter commences with a background to the use of substances in Australia, including prevalence rates. It is noted that the vast majority of people in Australia use substances, from caffeine to alcohol. The adverse effects of using substances are described, together with the community attitudes towards people who use substances, especially illicit substances. The work currently being undertaken across Australia as part of the National Drug Strategy is also discussed.

Following this, comorbid mental health and substance use issues are considered. People with a mental illness have a higher rate of substance use issues; likewise, people with substance use issues will often have a comorbid mental health problem. It is important that health professionals are aware of the issues involved and ready to assist those at risk. The philosophy of harm minimisation is also considered, including the role of abstinence. Abstinence is the ultimate means of minimising harm; however, not all people will consider abstinence and they should not be excluded from care.

The different categories of substances are identified, including stimulants, depressants and hallucinogens. The major issue of alcohol misuse in Australia is also noted. It is critical that health professionals can recognise the signs and symptoms of alcohol withdrawal, as this condition is potentially life threatening. The best way for health professionals to manage opiate withdrawal is also described.

Information about the assessment of people for substance use and misuse is provided. This includes the provision of some simple screening tools for use by health professionals. The ongoing care of people with a substance use issue is framed within person-centred approaches, with strategies such as the transtheoretical model of Cycle of Change and stages of treatment explained. The chapter outlines the principles of motivational interviewing and brief interventions, and concludes with an overview of the stress–vulnerability model.

Issues related to excessive substance use are common in Australian society, and the consequences are seen frequently by health professionals in a variety of settings. Excessive substance use is a health issue and health professionals play a key role in providing care and treatment to people with a substance use disorder. The positive attitudes of health professionals is an important means by which people will be assisted to develop the motivation to change.

Review questions

1. What is the difference between substance use and substance misuse?
2. Describe the difference between 'dependence' and 'addiction'.
3. Describe the harm minimisation approach to substance use.
4. What are some of the adverse effects of substance use?
5. What serious complications can result from alcohol withdrawal?
6. What is meant by an 'integrated' health service delivery?
7. What is the difference between a stimulant, depressant and hallucinogen? Provide an example of each.
8. Outline some of the reasons that family members of people with a substance use disorder need support and education.
9. Name at least six opioid withdrawal symptoms.
10. Describe the 'AUDIT' assessment tool.
11. What are the six stages of the Transtheoretical Model of Change?
12. What are the main principles of motivational interviewing? When would you use this technique?

Discussion and debate

1. Discuss the difference between legalisation and decriminalisation of marijuana. List the pros and cons for each.
2. What do you think would be the benefits and challenges of requiring a person with a substance use disorder to receive treatment?
3. Think of a time you have tried to change your behaviour. How many attempts were required to alter your behaviour? What were the challenges?
4. List the essential elements of a substance use assessment. How can screening tools be used to enhance a health professionals understanding of a person's use?
5. Consider the strategies for building motivation in a person. Discuss how health professionals could best utilise these strategies.

Project activity

Access the online alcohol and drug database, the Australian Drug Information Network (www.adin.com.au). Click on the 'Help & Support Services' tab and explore the types of services that are available within your locality. Review the various detailed services available on this website for each of the main drug categories.

Websites

Al-Anon's purpose is to help families and friends of alcoholics recover from the effects of living with someone whose drinking is a problem: www.al-anon.alateen.org/australia

The Alcohol and Other Drugs Council of Australia is a non-government peak body that represents the interests of the alcohol and other drugs sector: www.adca.org.au

Australian National Council on Drugs is the principal advisory body to the government on drug policy and holds a crucial role in relaying the community's feelings regarding the development of policies and strategies: www.ancd.org.au

Drug & Alcohol Services South Australia offers a range of prevention, treatment, information, education and community-based services for all South Australians: www.dassa.sa.gov.au

DrugInfo Clearinghouse is a program of the Australian Drug Foundation that provides easy access to information about alcohol and other drugs, and drug prevention: www.druginfo.adf.org.au

The National Drug Research Institute conducts and disseminates high quality research that contributes to the primary prevention of drug use and the reduction of drug related harm in Australia: http://ndri.curtin.edu.au

The National Drugs Sector Information Service team is committed to supporting those who work to prevent or reduce the harm to individuals, families, communities and the nation caused by alcohol and other drugs. They do this by identifying and disseminating the evidence base; facilitating the application of best practice and focusing collections and services on the knowledge and information needs of alcohol and other drug professionals, practitioners and researchers: http://ndsis.adca.org.au

Quitsmoking is an Australian government initiative that provides information and support for people who are looking to quit smoking: www.quitnow.gov.au

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11

Caring for an older person with a mental illness

LEARNING OBJECTIVES

This chapter will:

- provide an overview of caring for the older person with a mental illness
- consider the notion of ageism
- outline the major aspects of assessing the older person
- describe dementia from a person-centred perspective
- differentiate between dementia and delirium
- clarify how to recognise depression in an older person.

Introduction

Australia has an ageing demographic and approximately 14 per cent, or 3.2 million people, of its population are over 65 years of age (Australian Bureau of Statistics [ABS], 2012). Of those people, 2.8 million are aged 65–84 years and a further 423 700 are aged 85 years and over (including 3500 over 100 years of age). This trend is common to all Western nations and is a result of sustained lower birth rates and increasing life expectancy. Australian health care in the twenty-first century thus needs to focus on ensuring there are adequate resources, including the delivery of primary health care services, for its ageing population (Freed, Sewell, Spike, Moran, & Brooks, 2012).

Many older people will live a healthy and independent life regardless of the myriad health conditions — including arthritis, osteoporosis, cancer, stroke and vascular disease — that may affect them (ABS, 2012). The Australian Institute of Health and Welfare (AIHW) indicates that among older Australians living in households in 2011–12, the most common long-term health conditions were short- and long-sightedness (affecting 35 per cent and 61 per cent of those aged 65 and over, respectively), arthritis (49%), hypertensive disease (38%) and deafness (35%) (AIHW, 2012). Anxiety and depression are particular risk issues. Likewise, dementia affects around 9 per cent of people over 65 and 30 per cent of those over 85 years of age (AIHW, 2012). It is estimated that one-third of those with dementia will experience moderate to severe behavioural and psychiatric symptoms.

These statistics suggest why the care of the older person is of particular importance to governments and health services across Australia. Likewise, it is essential that health professionals are aware of the main principles related to providing care to and supporting the needs of the older person who has mental health issues, and their families.

The focus of this chapter is the older person who is experiencing symptoms of mental illness. The chapter begins by extending the discussion around 'care' to consider the quite specific needs of older people. Notions of ageism are also discussed. Following this, approaches to the assessment of the older person are described. The importance of providing person-centred care using a biopsychosocial approach is highlighted. Assessment tools such as the mini mental state examination and Addenbrooke's cognitive examination are explained. The essential aspects of caring for an older person with depression are described. The chapter finishes by clarifying the difference between dementia and delirium, and how health professionals can best provide care to older people who are experiencing symptoms of each of these conditions.

Caring for older people

The meaning of care and caring, and the principles related to the provision of care and caring, are discussed at length in chapter 1. In this section, the discussion is extended to consider caring for the older person. This includes a reiteration of the essential nature of the relationship between the health professional and the person when providing care, and the importance of knowing the older person as an individual.

Notions of caring imply at least two related ideas. The first idea is that to care for another involves health professionals in a relationship with themselves as a health professional and also with the person they are caring for. That is, in order to be able to form a relationship with another person and to provide care, health professionals need to be able to take care of themselves first. Essentially they need to be able to practice what they will then preach. The second idea is that this caring relationship is an active, not a passive, engagement. While caring may be anchored in emotionality, it is not limited to it (Jaworska, 2007). It demands action. To care for someone suggests, at the very least, to actively elevate their interests and wellbeing to a position of primacy. It also involves recognition of the individual being cared for. In other words, and as Stein-Padbury (2013) suggests, when caring is directed to living things, this caring must consider the very nature of those living things, as well as their way of life, needs and desires, and their reality.

It is this 'reality of the other' that drives and sustains the task of caring for the older person who has mental health issues. The health professional's approach to caring is based upon a recognition of who this older person is. Their approach is also consistent with a comprehensive consideration of the individual, including a **biopsychosocial understanding** of the 'other' (see chapter 2). This suggests a number of themes. One is that older people are not a **homogeneous group**. Like any group of individuals, each person is unique in their aims, goals, beliefs, interests, experiences and personality.

Another theme is that effective health professionals do not **pathologise** ageing. Depression, anxiety, dementia, suicide and myriad other mental illnesses are not the inevitable consequence of ageing. Also, it is important to recognise that the older person can be easily excluded from discussions about health care resource allocation, policy initiatives and even their own treatment regimes. It may be the case that not only are the elderly disadvantaged by their age and the way society views 'being old', but those who have a mental illness may be additionally disadvantaged by the added stigma attached to anyone with mental health problems (Aberdeen & Bye, 2011).

biopsychosocial understanding an approach that considers the biological, psychological and social dimensions of a person's experience

homogeneous group a group with the same or similar characteristics, preferences, needs and lifestyle

pathologise the tendency for health professionals to place the ordinary human reactions, responses, thoughts, feelings and behaviours of various stages of life into a biomedical frame, label what is happening as a 'condition', and prescribe treatment

Further, in keeping with the requirement to apprehend the reality of the other, the health professional is urged to see and understand the older person in context. That is, the health professional is encouraged to view the person in terms of their emotional, psychological, physical, sexual and spiritual totality, rather than see them simply as an illness, a diagnosis or as a collection of symptoms. There is a need to acknowledge the meaning of their lives in a truly integrated and comprehensive way (McKay, McDonald, Lie, & McGowan, 2012).

Health professionals must also take care to listen to the meaning that is being placed on an experience or event by the other person, rather than place their own interpretation on that experience or event. Understanding the experiences of the older person is brought into sharp focus with the problem of delirium. Failure to observe, understand, acknowledge or hear the voice of the older person who has a delirium can have tragic consequences for both the person with a delirium and the health professional, for in the older person with a pre-existing dementia or an already debilitated medical state, an untreated delirium can be fatal.

The impact of ageism

It is surely a paradox that in a society which, demographically speaking, is characterised by increasing numbers of older people, ageism is not more of an issue. Regardless of the current demographics, the phenomenon of discriminating against people based upon their chronological age, first described by Butler (1969), survives and remains a powerful force for shaping perceptions and thus influencing behaviours.

Ageism has a well-established pedigree. Growing old has long been seen as an affliction associated with a deterioration in both mental and physical functioning. The ageing process has been described in terms such as 'wise', 'slow', '**senile**', 'ill', 'infirm', 'forgetful', 'frail' and 'decrepit' (Levy, Slade, Murphy, & Gill, 2012). In western literature, older people have often been convenient caricatures. In William Shakespeare's *As You Like It*, Jacques bemoans the inevitable conclusion to the 'strange and eventful history' that is life's journey, which ends in '. . . mere oblivion; sans teeth, sans eyes, sans taste, sans everything' (Act 11, scene 7). Aged character depiction often lurches uneasily from sad and pathetic, as in the folly of Shakespeare's *King Lear*, to downright evil and repulsive, as with Dickens's Scrooge; '. . . a squeezing, wrenching, grasping, scraping, clutching, covetous old sinner . . . [who] . . . carried his own low temperature always about with him' (Hearn, 2004).

senile a state where the person may exhibit memory loss or unclear cognitive or mental impairment that is sometimes associated with ageing

In more recent times, perhaps due in part to mass electronic media, the distinction between being young and being old has come into sharp focus. There appears to be a clear juxtaposition between the (idealised) images of youth, interwoven with cultural ideas and ideals of beauty, sexuality, achievement, strength, vigour and technological sophistication, with a perception, even a fear or revulsion, of the older person with wrinkled, sagging and blotched skin, hunched over and with ponderous mobility, frail and arthritically welded to that icon of ageing — the walking frame. It is not surprising that in recent times there has been an emergent image of the older person who contributes nothing to society yet remains a burden on economic resources such as medical care, pensions and various welfare programs that drain public monies from more worthwhile endeavours. Despite some attempts at changing attitudes and stereotypes to encourage a recognition of positive ageing, there seems to be a pervasive attitude that sees the older person as somehow not belonging — as a burden to the taxpayer, a drain on social and economic development and thus, and inevitably, somehow as less of a person (van den Jeuvel, 2012).

UPON REFLECTION

Impact of negative attitudes towards ageing on recovery

It is clear that the negative attitudes of a health professional can have an impact on the way in which they relate to and provide assistance for a patient. Reflection and appropriate clinical supervision are key aspects of a health professional's ability to understand their own values and how they may impact on the provision of care.

Questions

1. Do you think that a person's own view of their age would impact on their ability to recover from physical illness? Why?
2. What impact would the attitudes of a health professional have on an older person's recovery?
3. How do you think society's attitudes towards ageing affects the development of health care services?

Culture and attitudes

Cultural beliefs are enduring and can easily influence the way health professionals in general engage the older person. In the technologically developed West, discussions about ageing so often appear to focus on the medical and moral challenges it presents. For example, ageing is often viewed as a process defined by deterioration in a whole range of physical abilities, attributes and aspects, with the task for the older person being to age 'successfully'. Notions of healthy or positive ageing carry the underlying message that one can get ageing wrong; one can fail at it; one can let the side down; or that one can cost the community (the taxpayer) precious resources. To fail at ageing is to court moral censure, and so the older person is required to lift their game and not 'let the side down'.

A combination of ageist social values and an increasing tendency to medicalise ageing sees the ageing process often couched in terms of **cognitive decline** (Abeerdeen & Bye, 2012). Health professionals need to avoid viewing ageing for only its negative elements such as dementia, mental illness, depression and anxiety, and the malfunction, deterioration and breakdown of various bodily organs and systems. Rather, ageing can be reframed to incorporate positive elements — including notions of wisdom, experience, and a 'third (or golden) age', which presents the older person with many new opportunities.

Oliver (2008) notes a pervasive ageism among health professionals in the way the older person is so easily labelled in pejorative terms like '**social admission**' and '**acopia**'. He suggests that terms such as these reflect the social judgements of health professionals, rather than any attempt to identify actual physical or psychological disease processes, and they also allow physicians to avoid taking seriously the concerns of the older person. It is recognised that health professionals have a tendency to shy away from caring for older people with a mental illness (Singleton & Douglas, 2012; Walsh & Shutes, 2013). This view is reinforced by US research, which reveals that graduate health professionals continue to rank working with older people as their least preferred career choice (Twanley, 2013). In a disturbing trend towards minimising the experience of suffering in the aged, Ludwick, O'Toole and Meehan (2012) note evidence that suggests that the negative attitudes held by health workers can lead to the favouring of physical or chemical restraints over behavioural management in the older person with behavioural difficulties. This practice continues to occur despite the increasing evidence against the use of restraints with vulnerable populations, or calls for the minimisation of their use.

cognitive decline deterioration or decline in abilities such as memory, reasoning, judgement, planning, decision making, language and other aspects of mental or intellectual functioning

social admission a label often used to describe a patient who has been admitted to hospital to address social needs, rather than a biomedical condition; usually negative in connotation

acopia a label often used to describe someone who has a low level of coping skills or finds it difficult to cope with life's experiences; usually negative connotation

Discrimination

Discrimination has many faces. One may be a simple negative attitude towards the older person based upon a fear or dread of ageing (Bishop, Roden, Bolton, & Wynn, 2008) and mortality. Another may be the tendency to see the older person as a member of a subgroup primarily defined in terms of their deficits (Horta, 2010). A further act of discrimination includes the practice of seeing all older people — that is, everyone over 65 years — as a member of a homogeneous collection of individuals (van den Heuvel, 2012) with identical needs, wants, ambitions, fears, beliefs and values. Such perceptions are not uncommon. Indeed ageism is so pervasive that even older people themselves will endorse ageist attitudes and behaviours toward themselves and also other older persons (Bryant et al., 2012).

This suggests the first challenge for the health professional working with the older person: to see each individual within the context of their own lives and their own meanings, and to set aside their own preconceived ideas about what should be and what should not be; what is and what is not; and who is deserving of care and who is not. Social images of older people seem to oscillate between the cranky, irritable, cantankerous and intolerant 'grumpy old men' and 'grumpy old women' (there are even television shows by those names), and someone who is a cross between Santa Claus and Agatha Christie's Miss Marple — without any distinctive personality; shapeless and invisible; always pleasant to small children and dogs; without ambition, beliefs, voice or opinion; and decidedly asexual. Yet the health professional will be confronted with older people who have a mental illness or dementia, who have sexual relationships, who live quite independently, or who are gay or lesbian. Realities such as these may challenge the professional's preconceived ideas of what it means to be old; and yet the responsibility of the health professional is to acknowledge the uniqueness of the individual person (Lachman & Agrigoroaei, 2010). It may be that the health professional's first step toward confronting ageism lies in an honest and thorough examination of their own attitudes and values.

Assessing the older person

The assessment process begins with listening to the story of the person. At one level this 'listening' is just that: listening to the older person's perspective. A person's life is often understood as a series of narratives (Bruner, 2004) — that is, stories about who we are and who we have been, and how we have come to this particular point. Just listening to the words of the other person as they tell their particular story — whether it is a story of dementia, depression, suicidal thoughts, chronic mental health issues, grief or loss — is a powerful way for the health professional to build a rapport based upon the existence of the older person as a person. If the ability to confront one's own preconceived ideas about ageing is the first skill of the health professional, then the ability to listen without judgement is the second.

A biopsychosocial approach

On a deeper level, this listening takes on a more profound form of knowing. This is the biopsychosocial assessment (Engel, 1977), which is discussed in earlier chapters. In the past, health professionals have tended to debate the relative merits of nature versus nurture, mind versus body, and biology versus environment when it comes to the understanding of cause and process of mental illness (McKay et al., 2012). Our current perspective, however, is that there is no easy distinction to be made; that people are a complex interaction of relationships and interrelationships; that there is an interplay between environment and biology; and that mind and body are, in fact, inseparable (Adams, Poole, & Richardson, 2006; Garland & Howard, 2009; Richardson & Barusch, 2006). As Engel (1977) wrote:

> To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician's role and the health care system. This requires a biopsychosocial model (p. 132).

The biopsychosocial model is predicated upon the realisation of the interaction between biology, psychology and sociology; or, to put it another way, an interaction between our physical selves, our mental and emotional selves and the sorts of relationships people have with others in their lives. In terms of the assessment process, the health professional works from the biopsychocial and person-centred approaches described in chapter 2. In this chapter, these two approaches are combined to be called the **biopsychosocial person-centred approach** to assessment and care. The additional term, 'person-centred', reminds the professional that the person and the care of the person is the rationale for undertaking any form of assessment.

It is clear from figure 11.1 that not only is the person a complex interaction of diverse influences, but also that these influences cannot be easily compartmentalised. That is, variables such as 'depression' can easily fit within all three parts of the model. The same applies to most of the dimensions identified — each has psychological, sociological and biological impacts and implications. The model is thus a flexible conceptual learning tool for health professionals who may be challenged by notions of the biopsychosocial person-centred approach.

biopsychosocial person-centred approach an approach that understands the person as a biological, social and psychological being, with the person defined in terms of their relationships and interrelationships at the centre of the matrix of care

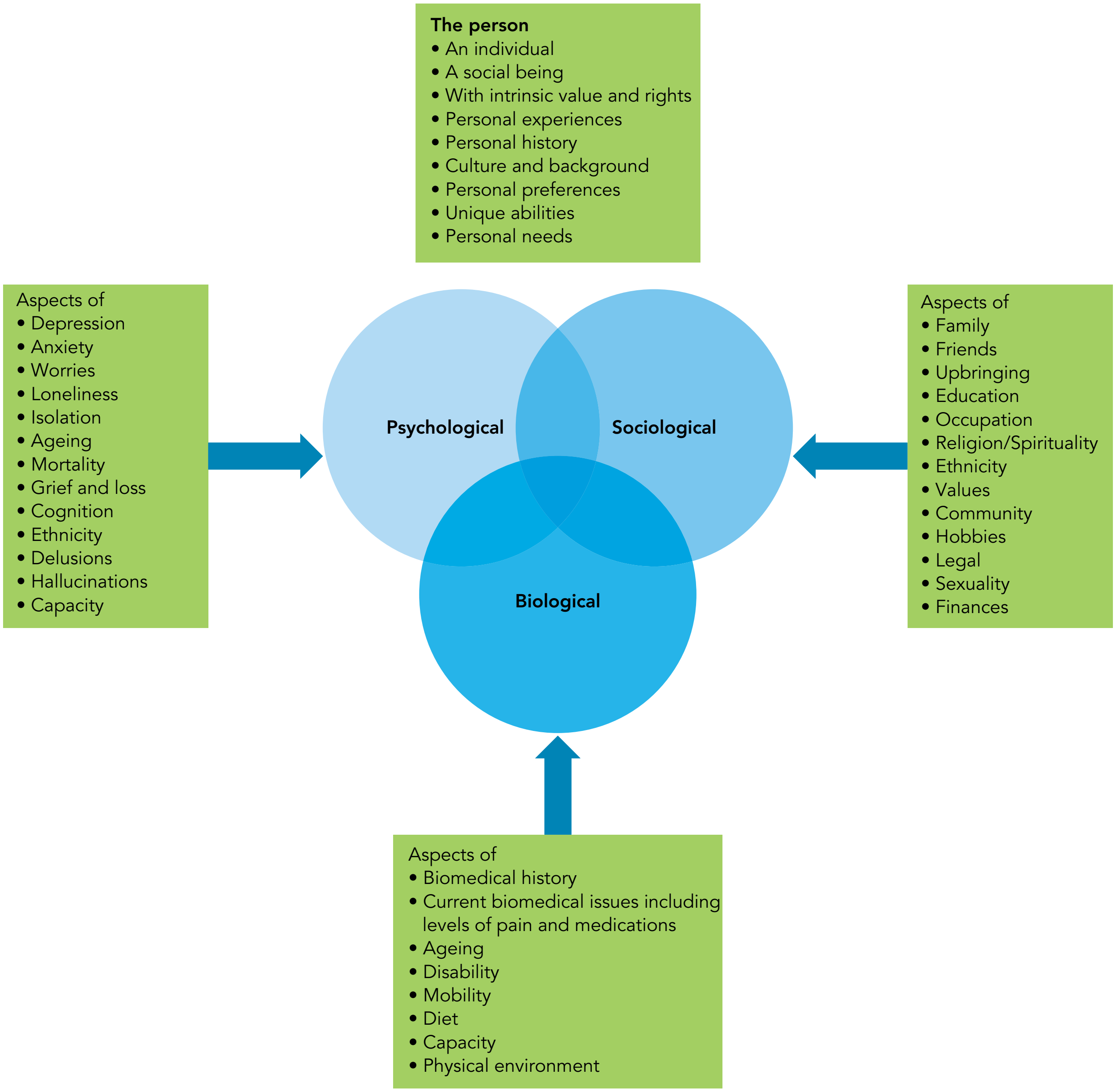

FIGURE 11.1 The biopsychosocial person-centred model

The health professional who adopts the person-centred approach, recognises that 'personhood is a status or standing which is bestowed upon one human being by others, in the context of relationships and social being [which] implies recognition, respect and trust' (Kitwood, 1977, p. 8). This suggests that the individual's social being is primary — a position not uncommon with philosophers from Aristotle to Marx. It may be suggested that the relationship between the person's social being and their psychological and physical self is one of *primus inter pares* or first amongst equals. Still, however this relationship is conceptualised, the health professional is called upon to think of the person not only as a biological creature but also as a social being. What does this mean in practice? Questions such as these are discussed in the next section.

Knowing the person

Knowing a person is a complex process that can be difficult to quantify or qualify. In the health context, it means that the health professional must know the totality of the person and not seek to reduce the older person to a collection of symptoms, an artefact of medical pathology, or a deviation from how older people are often portrayed in society. It means that a systematic approach to knowing the person begins with an understanding of the personal experiences and history of the individual, their relationships with others, the significant events in their lives and the meanings they place on their experiences.

Knowing the older person also means that treatment is collaborative. The idea of 'collaboration' is usually couched within the context of members of the multidisciplinary team working in harmony. This is certainly crucial for optimal outcomes. However, even this form of collaboration is dependent upon a more basic form of engagement: the collaboration of the professional with the older person. The health professional works *with* the older person and does not impose a set of judgements or treatment options *upon* that person.

IN PRACTICE

Getting to know the older person

Beverley is an older person who presents to the local emergency department of a metropolitan public hospital. She is a 76-year-old woman who has been brought in by ambulance from a nearby small rural town (population 3500), after seeing her GP to report increasing chest pains. Beverley lives alone in a unit complex and does not have any children; and her husband of 55 years recently passed away (six months ago) from prostate cancer. At triage, she describes an increasing feeling of tightness in the chest, chest pain, some shortness of breath and generally getting tired easily. She reports feeling lethargic and constantly worn out which, she says, is quite out of character for her. She has been an active and fit woman for most of her life and she does not smoke or drink. Having worked as a primary school teacher for most of her adult life, Beverley reports that she rarely took time off for illness and even now states that she does not understand what all the fuss is about. After a discussion with the triage nurse, she also reveals that she has developed a cough and has been having some recent difficulties with concentrating and remembering things. In addition, she has had increasing nights of restlessness and broken sleep. Some nights after she wakes — often around 2 am — she finds it very hard to get back to sleep, but she puts this down to the recent change in weather. She assures the nurse and then the doctor that there is really nothing wrong with her and certainly nothing worth worrying about.

Questions

1 What symptoms might suggest Beverley has a physical illness?
2 What symptoms might suggest that there is a mental health problem?
3 What questions would you ask to find out more about Beverley?

Thinking biopsychosocially

One way of understanding the biopsychosocial approach is to think of the various options the health professional may have in a case such as that described in the previous 'In practice' feature. The health professional may take a strictly *biological* approach and ask questions such as the following.

- 'Is this woman physically unwell?'
- 'Does she have congestive cardiac failure?'
- 'Is it possible she has a dementia?'

If this is the pathway of investigations then other questions might be asked, as follows.

- 'Does she have a history of coronary artery disease or heart attack?'
- 'Is there any longstanding hypertension or kidney disease?'
- 'Is there a cardiac history in her family?'

The health professional may also conduct a variety of investigations such as checking for an abnormal (weak or rapid) pulse, an enlarged liver, fluid retention and so on. Follow-up tests may involve a chest X-ray, blood tests, an electrocardiogram, a urinalysis, and even an exercise stress test. As a dementia screen, the health professional may do a simple mini mental state exam (MMS) or an Addenbrooke's cognitive examination (ACE), which are two simple pencil-and-paper tests for cognitive functioning that might indicate the presence of dementia or some form of cognitive impairment.

To be more thorough, however, the health professional might want to embrace a biopsychosocial approach to the assessment. In terms of the person's psychological needs, the health professional may explore the mental health, emotional or behavioural causes for the person presenting to the heath service for assistance, as follows.

- What is the mood and affect of the person?
- Do they report feelings of depression or anxiety (see chapter 7)?
- What are their thoughts and behaviours?
- What are their perceptions?

The health professional is aware that both depression and anxiety often go together, and, in the older person, this may display as a somatic presentation. The health professional will also explore thoughts of self-harm, asking questions such as the following.

- 'Do you have future plans?'
- 'How have you coped with problems in the past?'

- 'Is there a personal or family history of depression, anxiety, self-harm or even suicide?'
- 'What do you worry about?'
- 'What is your usual sleeping pattern?'

The health professional then asks questions of a more *sociological* nature. They will take the time to get to know their client as a person. This will involve taking a personal history and ascertaining aspects of their life, such as:

- why they live alone
- where they have moved from
- whether they are married, single, widowed or divorced
- what social supports they have
- what family they have
- what their financial situation is
- their educational and occupational background, and so on.

This list is by no means exhaustive but, following on from the previous 'In practice' example, a picture soon emerges that reveals a situation far more complex than was first presented:

From a biopsychosocial approach, a picture soon emerges that reveals a situation far more complex.

> The psychosocial investigation reveals that Mrs Beverley Smith is recently widowed, her husband dying six months previously from a long illness. Three months ago her dog died and since then she has been feeling increasingly low and miserable. Both her GP and friends have noticed that Beverley has been staying home a lot, has not been caring for herself like she used to and has been making comments that she would 'be better off dead'. It is revealed that she was convinced by friends to move from her home of 25 years to a smaller and more managable unit. However, things have not worked out as planned. Beverley now lives in a 1-bedroom unit attached to a medium-sized complex; she seldom sees her neighbours and often sleeps all day and stays up late at night. Beverley has recently detached from her friends, does not know the neighbourhood, and finds it hard to get on with her life after her husband's death. What may at first have seemed like a cardiac illness or an impending dementia may now seem like depression and issues of grief, loss, meaning and self-worth.

The biopsychosocial approach described is instructive; it suggests that it is imperative for the health professional to know what is happening with the person beyond the physical symptoms that the person may immediately present. It may be that the older person is not willing to immediately divulge sensitive personal material. It may also be that to talk of depression is at odds with their views on resilience and self-esteem. The older person may feel ashamed to suggest they have a mental illness, or they may not, in fact, know they have a mental illness. If the health professional — in this case, the GP — is younger, then the older person may feel uncomfortable about revealing intimate aspects of their lives. Only after they have established a rapport and feel that it is safe to talk may they be willing to divulge relevant information.

'Knowing the person' is at the heart of an assessment of the older person. To focus on one aspect of an assessment is to perhaps miss out on vital information and subsequently implement incorrect treatment. The importance of biology cannot be denied; however, it must be seen through the prism of an enduring psychosocial reality of meaning, context, history and relationships.

Cognitive assessment

In order to provide optimal outcomes for the older person, the health professional is called upon to holistically conceptualise their world. This is itself an undertaking that requires great sensitivity, empathy and effort, and demands the health professional know the totality of the older person. In the following section, the major mental health issues that confront the older person are explored. The answer is the same, whether discussing dementia, depression or delirium: in order to deliver care that reflects best practice, the health professional is called upon to actively know the person for whom they are caring. So far, the chapter has discussed assessment in an informal sense. Some time will now be spent in briefly commenting on a more formal approach to assessment.

The assessment and diagnosis of a mental illness is a sophisticated process that requires a specialist such as a **psychogeriatrician** or **geriatrician**. This does not mean, however, that health professionals cannot conduct or participate in a structured assessment process. In fact, it is crucial that both these professional groups are aware of appropriate assessment processes, not only to inform their own engagement with the older person, but also to alert other members of the multidisciplinary team.

psychogeriatrician a medical specialist in mental illness of old age

geriatrician a medical specialist in the physical care of the elderly

Mini mental state exam (MMSE)

One assessment tool is the **mini mental state exam (MMSE)**, a quick and effective pencil-and-paper test that provides a reliable instrument for dementia screening and identifying delirium in the older person (Folstein, Folstein, & McHugh, 1975). It includes asking the person to count backward by 7s from 100, to identify common objects (e.g. a pen, a watch), to spell simple words backward, to write a sentence, and to demonstrate that they are oriented to day, month and year, as well as town and country. Although there are limitations to this tool — for example, it is not sensitive to mild cognitive impairment, does not provide diagnostic certainty, and does not account for low education level, poor literacy, cultural diversity and lack of English proficiency (Clark et al., 1999; Espino, Lichtenstein, Palmer, & Hazuda, 2001; MacKenzie, Copp, Sha, & Goodwin, 1996) — it remains an effective instrument for the health professional to make valid assessments of the older person's cognitive ability. Another important drawback for the health professional to remember is that the MMSE is not sensitive to persons with an executive function disturbance such as a frontotemporal dementia. In this case, the health professional may utilise the **Addenbrooke's cognitive examination (ACE)**.

mini mental state exam (MMSE) a brief psychological test that enables a health professional to assess a person for and/or differentiate between a dementia, delirium psychosis and affective disorders

Addenbrooke's cognitive examination (ACE) a self-reporting tool for assessing dementia, including the different types of dementia; the tool takes five minutes to complete and test memory

Addenbrooke's cognitive examination (ACE)

The ACE, as it has come to be known, is an effective screening tool 'sensitive to the early stages of dementia, and capable of differentiating subtypes of dementia including Alzheimer's disease, frontotemporal dementia, progressive supranuclear palsy and other parkinsonian syndromes' (Mioshi, Dawson, Mitchell, Arnold, & Hodges, 2006, p. 1078). The tool is used to identify frontotemporal dementia; however, an issue for health professionals is that the ACE may take up to half an hour to administer and, for the very old or frail, this may be tiring. Even so, like the MMSE, it is easy to administer and is based on asking the person a series of questions, the answers to which are then written down by the examiner, and a number of pencil-and-paper tasks completed by the subject.

Mental state exam (MSE)

A final formal assessment tool to consider is the mental state exam (MSE). The MSE is described in detail in chapter 2. The advantage of the MSE is that it can be done while the person is being interviewed. It is a subjective assessment of the person's mental state and allows the skilled health professional to make judgements about a person's appearance, behaviour, mood, affect, speech, cognitions, thought patterns and level of consciousness, largely through a face-to-face conversation with the person. The MSE needs to ensure that 'risk' (including content of thought) is comprehensively assessed to ensure that the older person being reviewed is not at risk of suicide.

It is wise to remember that the MSE has at least two caveats. First, successfully administering the MSE requires a great degree of skill and experience. Health professionals unfamiliar with the MSE are advised to seek training and education to become proficient at it rather than simply reading about it. If a less experienced health professional is required to complete the MSE, then it is strongly advised that they seek confirmation of the MSE outcome from a more experienced colleague before implementing any treatments or interventions.

Second, it is important to remember that all effective assessments of older persons depend in large part upon an attitude the health professional has toward them, rather than the tools they use. That attitude has been described in terms of a biopsychosocial person-centred approach, which is based upon an engagement with the person that is antecedent to any particular assessment tool. This approach, which is based on listening to the person, being in touch with the person's reality, hearing the person's experiences and acknowledging the person's meaning, is the bedrock of any assessment of value. Implicit here is also an understanding of the health professional's own values and attitudes toward the elderly and ageing. Without these skills and attitudes, more formal assessments will be of little use.

Dementia

Dementia is a syndrome associated with a variety of diseases, characterised by a chronic and progressive cognitive decline that involves disturbances of brain function such as memory, thinking, comprehension, abstract thought, language and judgement (AIHW, 2012). This cognitive decline reveals itself through increasing functional deficits such as memory loss, confusion, language disturbance, an increasing inability to self-care, disturbances of executive function, psychiatric pathology (depression and anxiety being the most common) and medical co-morbidities.

dementia a chronic, irreversible, neurological disorder that sees a progressive deterioration in a person's cognitive, mental and physical abilities

The trajectory of dementia is one of increasing cognitive deficits involving what are called 'challenging behaviours', or behavioural and psychological symptoms of dementia (BPSD), that can include wandering, pacing, hoarding, verbal and physical aggression, screaming, repetitive vocalisations, delusions and hallucinations, sexual disinhibition and faecal smearing. Typically dementia ends in permanent dependence in all aspects of care and, ultimately, death.

Dementia and ageing

The greatest risk factor for dementia is increasing age, although younger onset dementia, which occurs before age 65 years, is becoming more frequent. In 2011 it was estimated that there were approximately 23 900 people under the age of 65 with the diagnosis of dementia (AIHW, 2012). Dementia in the elderly, however, remains the most challenging problem confronting the older person, their families and those health professionals who care for them. The rates of dementia, in both Australia and worldwide, are having and will continue to have, a major impact on personal, local and national wellbeing. According to Australian Institute of Health and Welfare (2012, p. ix) the following observations can be made about dementia in Australia.

- An estimated 298 000 Australians had dementia in 2011, of whom 62 per cent were women, 74 per cent were aged 75 and over, and 70 per cent lived in the community.
- Based on projections of population ageing and growth, the number of people with dementia will reach almost 400 000 by 2020. This figure is likely to triple between 2011 and 2050, to reach around 900 000 by 2050.
- Dementia was the third leading cause of death in 2010 (accounting for 6 per cent of all deaths), with an average of 25 people dying from dementia every day that year.
- Twice as many women as men die from dementia.
- Some of the increase in number of deaths due to dementia can be attributed to population ageing and growth, but some may be due to changes in how dementia is recorded on death certificates. Dementia was recorded as the underlying or additional cause of 14 per cent of deaths in 2010.
- Dementia is estimated to be the fourth leading cause of overall burden of disease, and the third leading cause of disability burden. For people aged 65 and over, dementia was the second leading cause of overall burden of disease and the leading cause of disability burden — accounting for a sixth of the total disability burden in older Australians.
- An estimated 552 000 GP attendances (0.5%) in 2010–11 involved the management of dementia.
- In 2009–10, dementia was a diagnosis for 83 226 (1 in every 100) hospitalisations, and was the principal diagnosis for 12 286 (1 in every 1000).
- In 2009–10, 392 796 (0.2%) government-subsidised prescriptions were dementia specific.
- Total direct health and aged-care system expenditure on people with dementia was at least $4.9 billion in 2009–10, of which about $2.0 billion was directly attributable to dementia. Of this, $1.1 billion was for permanent residents in residential aged-care facilities and $408.0 million was for community aged-care services.
- In 2009, people with dementia aged 65 and over had a substantially higher average number of health conditions (5.4) than all people in that age group (2.9).
- In 2009–10, 53 per cent of permanent residents in residential aged-care facilities had dementia. Residents with dementia were more likely than those without dementia to require high care (87% versus 63%).
- Estimates suggest that, in 2011, there were around 200 000 informal carers of people with dementia living in the community. Co-resident primary carers of people with dementia were almost twice as likely as all co-resident primary carers to provide 40 or more hours of care per week (81% versus 42%).

That the greatest risk factor for dementia is advancing age can be seen in table 11.1. The implications of this are profound. The number of people aged 65 years and over is projected to more than double between 2010 and 2050 (from about 3 million to 7.5 million), while the number of people aged 85 years and over will quadruple (from less than half a million to about 1.6 million) (AIHW, 2011). This has major implications for resource allocation directed towards the care of the person with dementia, for support services, institutional placements, medical and psychiatric interventions, the training and education of carers, and for the inevitable cost of dementia in terms of lost productivity and absenteeism of employees who stay at home to care for a family member (Alzheimer's Australia, 2007). As dementia will impact most upon the elderly (65+) 'a substantial challenge to our society will be the management of ageing-associated chronic diseases and the minimisation of any resultant disability in older people' (Murray, Ames, & Moore, 2009, p. 216).

TABLE 11.1 Estimated number of people with dementia, by age and sex, 2011

	Rate (%)			Number		
Age group (years)	**Males**	**Females**	**Persons**	**Males**	**Females**	**Persons**
0–64	0.1	0.1	0.1	12 600	11 300	23 900
65–74	3.1	3.4	3.2	25 200	28 900	54 100
75–84	8.8	10.4	9.7	39 800	57 500	97 400
85 and over	24.4	32.2	29.5	35 600	87 000	122 600
Total 65 and over	7.1	10.3	8.8	100 700	173 400	274 100
Total	**1.0**	**1.6**	**1.3**	**113 300**	**184 700**	**298 000**

Source: AIHW (2012, p. 14)

Types of dementia

A number of diseases can be identified under the umbrella of dementia. Most common is Alzheimer's disease, which accounts for approximately two-thirds of all cases (76%), and vascular dementia (10%), which accounts for about a quarter of cases. Together these two conditions account for over 86 per cent of all cases of dementia in Australia (AIHW, 2011). Other major forms of dementia include Lewy body dementia (up to 5 per cent of cases), and frontotemporal dementia (5–10 per cent of cases) although, in those people below age 60 years, frontotemporal dementia may be as common as Alzheimer's disease (AIHW, 2012; American Psychiatric Association [APA], 2013).

Less common types of dementia include:

- dementia in Parkinson's disease
- alcohol-induced dementia
- drug-related dementia
- head injury dementia
- dementia in Huntington's disease
- dementia that develops as a result of human immunodeficiency virus (HIV), or Creutzfeldt-Jakob disease (APA, 2013).

In all, there are thought to be at least 100 different causes of dementia (AIHW, 2012). Table 11.2 identifies the major forms of dementia in terms of clinical course, associated behavioural presentations typically associated with each type of dementia, possible causes and some associated or relevant issues.

TABLE 11.2 Clinical course and features of the major forms of dementia

Type of dementia	Clinical course and common associated behavioural displays	Possible causes	Associated issues
Alzheimer's disease	• Gradual onset • Progressive decline • Increasing deficits in memory, recognition of people and objects, ability to self-care, naming familiar people/objects, calculation, visuo-spatial skills and language • Deterioration of social skills • Emotional unpredictability • Emergence of challenging behaviours such as depression, agitation, aggression and sexually inappropriate behaviour • Late in the illness immobility and mutism appear with death from systemic infections related to incapacity	Presence of 'plaques' (protein deposits and dead cells) outside brain cells and 'tangles' (protein deposits) inside brain cells that impair functioning and lead to cell death	*Protective factors* include: • regular exercise • intellectual and social activities • higher education • moderate alcohol use *Risk factors* include: • old age • family history of Alzheimer's disease • head injury • smoking hypertension • poor diet
Vascular dementia	• Slow and steady deterioration or 'step-wise' decline related to type of neurological insults (repeated mini-strokes or a single major event) • Impaired executive function • Difficulty completing tasks, slowed thinking, poor problem solving, limited ability to focus while memory remains relatively intact • Apathy, depression, mood swings, impulsive aggression may be present • Gait disturbances common, frequent falls	Multiple discrete infarcts, strategic single infarcts or diffuse subcortical white matter disease	*Risk factors* include: • hypertension • stroke • cardiovascular disease • diabetes • excessive alcohol use • smoking • overweight • sedentary lifestyle
Fronto-temporal dementia	• Insidious onset with gradual deterioration • Three variants identified: (i) behavioural — neglect of hygiene and grooming, lack of social tact, sexual disinhibition, apathy, hyperorality (ii) progressive non-fluent aphasia — loss of ability to speak or to speak logically, reduced output of speech (iii) semantic — loss of meaning or understanding of words	Possible mutation in tau protein gene on chromosome 17	• Occurs early (45–65 years) • 50 per cent have a family history with first-degree relatives
Lewy body disease	• Gradual onset • Progressive decline • Fluctuating cognitions • Recurrent visual hallucinations • Parkinsonism features (rigidity, bradykinesia, unsteady gait and postural instability) • Frequent falls • Night-time behavioural disturbances • Apathy, depression and paranoid ideas may be present • Visuo-spatial disturbance	Presence of abnormal structures (Lewy bodies), which cause death of nerve cells	Contraindication of anti-psychotics in treatment of delusions and visual disturbances raises difficult care issues

Assessment of dementia

The formal diagnosis of dementia is typically performed by a specialist such as a psychiatrist, geriatrician or psychogeriatrician. But that does not mean that other health professionals have no role to play. Certainly all health professionals are likely to encounter, in their day-to-day practice, individuals who present with dementia-like symptoms such as a decline in memory, reasoning and communication, a reduction in the ability to successfully undertake everyday tasks of living, and increasing confusion and changes in mood. In such circumstances, when dementia is suspected, it is important for the person to be seen by a specialist to rule out other possible causes of the presentation. For example, forgetfulness, attention difficulties, getting words wrong and slowed thinking processes can be an indication of early stage dementia or an indication of depression. The formal process of diagnosing dementia may include the use of scans or pencil-and-paper tests such as the MMSE and ACE.

Dementia can be thought of as a chronic, irreversible, neurological disorder. An important aspect of the condition is that it shows an ongoing deterioration from previous levels of functioning. In the absence of any other diagnosis, a gradual deterioration over time in the person's cognitive ability will suggest a dementia. This alerts the health professional to an understanding of the importance of being aware of the person's current level of functioning so that information regarding any deterioration can be documented and passed on to those who will ultimately make the diagnosis.

Ethical and legal considerations

Ethical considerations that are specific to people with a mental illness are discussed in chapter 3. The discussion in this section relates more specifically to the older person. This is because the existence of medical and psychiatric **comorbidities** makes the disease process exceedingly difficult to categorise. Questions that could be asked by the health professionals include the following.

comorbidity the simultaneous presence of two health conditions, illnesses or disorders

- Is dementia a mental health problem with physical overlays or a physical problem with mental health overlays?
- Does this distinction really matter?

In any case, the disease process sees increasing deterioration in the person's mental and physical abilities. This in itself raises complex issues such as the person's ability to care for themselves and make what might be called 'best interest decisions' with regard to their own wellbeing. Again, this gives rise to complex issues of autonomy, self-determination and capacity. It would seem, then, that in addition to all the skills of engagement the health professional requires, an understanding of ethical and legal contexts is vital. In particular, the professional needs to be aware that capacity — that is, the ability of an individual to make best interest judgements — is a domain-specific rather than a general global construct (Berglund, 2012; Freegard & Isted, 2012). What this means in reality is that while the person with dementia may not have capacity in certain specific areas, such as the ability to trade in stocks and shares or to buy and sell property, or even to understand why they do not have the capacity to consent to treatment, they may very well have the capacity to make judgements about where they live and who they spend time with and what makes them happy and sad.

For this reason, health professionals need to be wary about a **paternalism** that denies a voice of any kind to the person with dementia, and they need also to educate families and other care givers that a diagnosis of dementia does not mean that the person has no ability at all to make any decisions whatsoever about their lives and how they live their lives. The assessment of whether or not someone has the capacity to make decisions about their lives must be approached on a case-by-case and situation-by-situation context (Draper, 2011; Phillips, Pond, & Goode, 2011; Seeher, Withall, & Brodaty, 2011) rather than an 'all or none' ability.

paternalism attitudes or actions by people in positions of power (e.g. government, health professional) that subordinates should be controlled for their own good

Dementia and medication

As dementia is typically described and conceptualised as a biomedical problem, there is a tendency to respond to challenging behaviours — for example, verbal and physical aggression, restlessness, screaming, sexual disinhibition — with antipsychotics. Such an approach is problematic on a number of accounts.

First, antipsychotics do not change the dementia-related behaviours of the person in any meaningful way. Many behaviours derive from the actual experience of dementia or the environment in which the person with dementia is located, rather than resulting from any obvious psychosis. Behaviours that do not respond to antipsychotics include anxiety, depressed mood, hoarding, restlessness, screaming, sexual disinhibition, shadowing, swearing, wandering and the agitation and restlessness that is often seen in the late afternoons or early evenings that may be described by carers as 'sundowning' (National Prescribing Service Limited [NPS], 2008). Moreover, evidence suggests that even in situations where antipsychotics may be indicated, such as for treatment of severe aggression, agitation or psychotic symptoms, the effect is at best a minor positive (NPS, 2007).

Second, the introduction of antipsychotics can result in a whole variety of new behaviours that emerge as part of adverse reactions and side effects. Such responses may include cardiovascular problems, uncontrollable movements, sleepiness, urinary symptoms, gait disturbance and dry mouth (Shekelle et al., 2007). When present, these will increase the burden of care and markedly reduce the quality of life of the person with dementia.

Third, there are some severe and life-threatening responses to antipsychotics of which the health professional must be aware. These reactions include delirium, cardio-toxicity and stroke (European Medicines Agency, 2009; NPS, 2008). The health professional must be alert to the impact these medications can have on the person with dementia and respond accordingly. For the allied health professional who has no medical background, ignorance of drug side effects and adverse interactions does not absolve them from an ethical or clinical responsibility.

This section provided an overview of dementia, its prevalence in Australia and risk factors. The most common ways of assessing dementia were outlined, as well as the legal and ethical considerations for health professionals. The care and treatment for people with dementia was also described. The next section explains the issues related to depression in the older person.

Depression in older people

The central features of depression are lowered mood, and a loss of interest in life and formerly enjoyed activities (Barry, Abou, Simen, & Gill, 2012). Yet, in the older person, for a variety of reasons, depression may not be acknowledged by the individual or easily identified by the health professional (Choi, Kunik, & Wilson, 2013). This may be because the older person has little understanding of depression, or may see it as a weakness or a moral failure rather than a treatable condition. They may not be open to reflecting psychologically on their wellbeing or feelings, and may be reluctant to make an appointment to see a health professional for anything other than clearly identifiable physical ailments. Thus, depression in the elderly is often missed.

What constitutes depression?

Depression and its signs and symptoms are detailed in chapter 7. The following discussion is aimed at adding some quite specific points relating to the older person.

In the past, epidemiologists have tended to define depression in terms of a strict diagnostic criteria for a **major depressive episode**, which indicates rates in the older person lower than other populations (Barry, Abou, Simen, & Gill, 2012). Yet the number of older people who present with depressive symptoms that fall short of fulfilling such a rigid criteria suggest much higher rates. Once again, this identifies the limitations of a strict biomedical approach to mental illness. Symptoms of depression, such as despair, sadness, feelings of failure and low self-worth, can be powerfully debilitating. To the person who experiences such feelings, whether or not they qualify for a diagnosis of major depressive episode is probably not uppermost on their minds. To the health professional, the biopsychosocial person-centred approach demands a focus on the person and the way they experience and interpret their lives rather than on any rigid diagnostic criteria.

major depressive episode
a group of symptoms used to identify depression as a serious clinical mental illness involving profoundly debilitating symptoms, which may include a potential for self-harm or suicide

As noted in chapter 7, depression itself is to be distinguished from 'feeling down' or 'upset' or 'having the blues'. While everyone has periods in their lives when they feel sad, miserable or low, perhaps in response to a tragedy or loss, such feelings typically fade as the person comes to terms with the event. Loss and grief are, after all, a normal part of human life and health professionals need to ensure that they do not pathologise common human reactions to stressful situations (see chapter 5). With depression, however, concerns emerge when such feelings are intense in nature and 'have a prolonged course, when they interfere with psychosocial functioning, and when they cluster with other symptoms' (Sands, 2001, p. 171). This may include a threat of self-harm and/or suicide.

Depression, at whatever age it is encountered, displays a complex interaction of experiences across a number of dimensions — biological, psychological and social. Not all people who are depressed display these feelings and not all feelings are displayed with the same intensity. Also, the symptoms described do not fit neatly into each respective dimension. Indeed, it is impossible to make clear-cut distinctions between the different dimensions of the symptoms. Decreased libido, for example, may be a biological response to depression but it has psychological consequences for the person in terms of self-worth and self-esteem, and social consequences in terms of relationships with partners. A similar comment could be made about sleep disturbance such as early morning wakening, another biological indicator of major depression. In the early hours of the morning, after the person with depression wakes, they may lie in bed and ruminate on negative self-thoughts about how they have wasted their life and how others might be 'better off' without them. Such attitudes may undermine an already vulnerable mental state and render acts of self-harm more likely. Thus depression is an interaction of a variety of different elements and, consequently, needs to be approached as such.

What does depression look like?

Whereas in the younger person depression may present as a clear sadness, low mood, **nihilistic thoughts** and feelings, social withdrawal and loss of interest in life (see chapter 7), in the older person there is a tendency towards a display of both somatic symptoms and cognitive impairment. In the older person there may also be a significant element of anxiety; a restless, irritable, agitated quality to their affect. In fact, there is a high degree of co-morbid prevalence between depression and anxiety, with some studies suggesting almost 50 per cent of older people with a major depressive disorder also having an anxiety disorder (Beekman et al., 2000).

nihilistic thoughts
negative thoughts that the world or a person's body, mind or self is utterly worthless or does not exist

The older person may present to a health professional with a variety of physical complaints, aches and pains, and chronic unexplained physical symptoms, which may be seen as warranting further medical investigation. They may also present with a degree of cognitive impairment suggestive of an underlying dementia (Salive, 2012). Given that older people with depression are likely to present with somatic symptoms or cognitive impairment, depression can easily be missed.

Symptoms of depression in the older person may include:

- somatic complaints, aches and pains, reports of feeling unwell
- difficulty with memory and concentration
- lack of energy, but may feel restless, anxious and irritable
- sleep disturbance
- loss of appetite
- a tendency to ruminate and worry
- loss of pleasure and interest in life
- feeling unworthy or a burden on others
- thoughts that life is pointless or not worth living.

Effective health professionals will familiarise themselves with these symptoms and use them as a benchmark to assess an older person who seems to be struggling with a low mood or loss of interest in life.

Knowing and engaging with the person

When engaging the older person who may have depression, the standard principle for the health professional remains the same: first, know and effectively engage with the person. The health professional needs to take time to establish a rapport with the person, listen to their story and ask questions. It may be that they require some form of relationship or rapport with the health professional before they will 'open up' to them. Assessment of another's mental state is an intimate process — and needs to be treated accordingly. A general rule of thumb is, when meeting the older person on the first occasion, it is best to concentrate on getting to know them. Listen to the story of their life and experiences, and focus on understanding them; validate their accomplishments and the strategies used to overcome adversity. In this way, an assessment is already taking place. The thoughtful health professional will, in many cases, be able to discern whether or not the person is depressed by simply engaging in conversation.

Assessment of depression

There are at least two ways the health professional may assess for depression in the older person. The first is to rely on one of the many assessment tools available. A number of these are listed in chapter 7. For the older person, perhaps the most common or useful scale is the geriatric depression scale (Yesavage et al., 1983). This tool is described in more detail in the following section.

For those older people who may have a depression in a pre-existing dementia, another useful tool is the Cornell scale for depression in dementia (CSDD) (Alexopoulos, Abrams, Young, & Shamoian, 1988). The CSDD is designed for the assessment of depression in older people with dementia who are able to communicate their basic needs. The tool differentiates between the diagnostic categories and severity of depression. Scores are determined by a combination of prior observation and two interviews: 20 minutes with the carer and ten minutes with the person with dementia.

There is much discussion in the literature about the efficacy of screening tools in terms of their validity and reliability, ease of use, and appropriateness with the older population (Bagby, Ryder, Schuller, & Marshall, 2004; Smalbrugge et al., 2008; Strober & Arnett, 2009; Trivedi, 2009). Health professionals who are interested in this area of health care are encouraged to read more about assessment tools in a specialised text. The focus of this chapter and, therefore, this discussion is to familiarise health professionals with notions of depression as a 'lived experience' of the older person. Moreover, there is a danger in relying on specific tools to measure and assess the experience of others. While assessment tools have their place, they can never substitute for the relationship between one person and another.

Geriatric Depression Scale (GDS)

The **Geriatric Depression Scale (GDS)** (Yesavage et al., 1983) is widely used as a tool to diagnose depression in the older person. The GDS certainly has its place in the assessment process. It is easy to administer and score, requiring only a yes or no response. Respondents, however, seldom give simple yes/no answers to questions; rather they tend to expand, ponder, reflect upon their circumstances, perhaps even explain or justify their answers, and this can provide valuable insights into their mental and emotional state. It can also begin a discussion between the health professional and the older person and in this way break down the barriers between both, facilitating a free exchange of shared understating and thus build a relationship of warmth and trust.

Geriatric Depression Scale (GDS) a series of 30 questions requiring a yes/no response that gives a rating of the presence or absence of depression

Patient Name:______________________________ Date:______________________

GERIATRIC DEPRESSION SCALE (GDS)

Instructions: Please circle the best answer for how you felt **over the past week**.

1. Are you basically satisfied with your life?	Yes	No
2. Have you dropped many of your activities and interests?	Yes	No
3. Do you feel that your life is empty?	Yes	No
4. Do you often get bored?	Yes	No
5. Are you hopeful about the future?	Yes	No
6. Are you bothered by thoughts you can't get out of your head?	Yes	No
7. Are you in good spirits most of the time?	Yes	No
8. Are you afraid that something bad is going to happen to you?	Yes	No
9. Do you feel happy most of the time?	Yes	No
10. Do you often feel helpless?	Yes	No
11. Do you often get restless and fidgety?	Yes	No
12. Do you prefer to stay at home, rather than going out and doing new things?	Yes	No
13. Do you frequently worry about the future?	Yes	No
14. Do you feel you have more problems with memory than most?	Yes	No
15. Do you think it is wonderful to be alive now?	Yes	No
16. Do you often feel downhearted and blue?	Yes	No
17. Do you feel pretty worthless the way you are now?	Yes	No
18. Do you worry a lot about the past?	Yes	No
19. Do you find life very exciting?	Yes	No
20. Is it hard for you to get started on new projects?	Yes	No
21. Do you feel full of energy?	Yes	No
22. Do you feel that your situation is hopeless?	Yes	No
23. Do you think that most people are better off than you are?	Yes	No
24. Do you frequently get upset over little things?	Yes	No
25. Do you frequently feel like crying?	Yes	No
26. Do you have trouble concentrating?	Yes	No
27. Do you enjoy getting up in the morning?	Yes	No
28. Do you prefer to avoid social gatherings?	Yes	No
29. Is it easy for you to make decisions?	Yes	No
30. Is your mind as clear as is used to be?	Yes	No

Scoring for the Geriatric Depression Scale (GDS)

In scoring the Geriatric Depression Scale, each item is scored 0 or 1 depending upon whether the item is worded positively or negatively. The total score on the scale ranges from 0 to 30.

For items 2–4, 6, 8, 10–14, 16–18, 20, 22–26, 28 the scoring is:

- Yes = 1
- No = 0

Items 1, 5, 7, 9, 15, 19, 21, 27, 29, 30 are reverse scored as follows:

- No = 1
- Yes = 0

FIGURE 11.2 Geriatric Depression Scale (GDS)

Source: Yesavage (1983)

UPON REFLECTION

Assessing depression in older people

The GDS is the most commonly used screening tool for older people with possible depression. Review the GDS in figure 11.2, specifically focusing on the content of the questions.

Questions

1. How is this depression screening tool different to other screening tools for depression?
2. Would you do this scale in isolation? If not what else would need to be conducted?
3. As a health professional how can you ensure that the older person provides accurate responses to the 30 items?

Of course, there are drawbacks to the GDS. For example, it places minimal emphasis on somatic issues, which may be common in the older person where depression is masked by numerous medical complaints, and it has no items related to sexuality. This latter fact may sometimes be a positive as such discussion may offend or upset the older person. Also, it does not provide any rating as to the severity of depression, nor does it describe or assess risk of self-harm or suicide. These issues need to be approached directly by the health professional.

The interview and clinical judgement

The most effective way to assess for depression is by interviewing the older person. Interviewing skills, however, are not innate. Rather, they are learned. Moreover, it can take some years for health professionals to gain the experience, confidence and expertise required to effectively engage an older person, establish a non-threatening environment and build a relationship that enables the older person to talk. Even so, interviewing skills are well worth developing. Further, it must be understood that this assessment and interview process is one that requires collaboration between health professionals who are skilled and educated in working with the elderly, especially those with mental illness (Elder, Evans, & Nizette, 2013).

Depression is an emotion, a subjective feeling that a person has about themselves and their world, and the health professional accesses these feelings by making a personal connection with the older person. Human beings are social creatures who engage others in relationships based on trust, empathy and shared understandings. Although there is something artificial and distancing in attempting to quantify the emotional world of the older person, this does not mean that the relationship between the health professional and older person is unstructured. There are signposts along the way that alert the health professional to the older person's distress and helps make sense of what the older person is experiencing.

Some areas are crucial in alerting the health professional to depression in the older person who may not want to admit such an experience. These areas or signposts include:

- sleep disturbance
- changes in appetite

- feeling tired or worn out
- loss of interest in things formerly enjoyed
- motor activity that may be described as either agitated or reduced
- poor concentration and attention span
- a sense of poor self-esteem or failure
- the prominence of physical complaints that may not have an underlying clear diagnosis (Salive, 2012).

These feelings are accessed by listening to the older person tell their story, by asking them directly, by observation, and by asking those around them who know them.

Risk factors

The health professional also needs to be alert to the various psychological, social and biological risk factors for depression in the elderly. Social isolation and loneliness, bereavement, low socio-economic status, being a carer and being female are prominent factors. Other indicators include chronic illness, including cerebrovascular disease, stroke, Parkinson's disease, Alzheimer's disease, diabetes, hypothyroidism and hyperthyroidism, and also previous episodes of depression or anxiety (Baldwin, 2008; Funnell, 2010; Mitchell & Subramaniam, 2005).

There is a high prevalence of depression among residents in aged care facilities. Rates vary, depending upon the different studies, with some suggesting rates as high as 45 per cent (Almeida, Alfonso, & Pirkis, 2011). Older people with physical co-morbidities — such as stroke, heart disease, diabetes and chronic pain — are also at higher risk of depression (Fiske, Wetherall, & Gatz, 2009). Other high-risk groups include:

There is a high prevalence of depression among residents in aged care facilities.

- those with dementia — with up to 20 per cent of those diagnosed with Alzheimer's disease having depression (AIHW, 2012)
- older people who are carers for family members who have a chronic illness (Baldwin, 2008)
- older people in hospitals
- older women, who are more likely than older men to experience depression and anxiety disorders (Slade et al., 2009).

It is important that the health professional who works with older people is able to recognise the signs and symptoms and intervene, as appropriate.

Suicide

Old age suicide is a complex area and, like depression itself, suicidal ideation is not easily identified. Moreover, a death is not recorded as a suicide until it is identified as such by a coroner. Social, ethical and religious factors are thus likely to impact on such decision making as the legal identification of suicide will have profound implications for the family. In Western societies in general, the emphasis tends to be on suicide in the young — another possible expression of ageism — yet rates of suicide in the elderly, especially elderly males, are comparable to rates in younger males (Harwood, Hawton, & Hope, 2006) with rates of suicide completion in the elderly being higher than any other age groups worldwide (O'Connell, Chin, Cunningham, & Lawlor, 2004; Rodda et al., 2008).

With regard to both depression and suicide, the health professional needs to be aware of the various assumptions about older people that may accompany such problems. Depression, despair, hopelessness and suicide are not an inevitable conclusion to the ageing process. Rather, they are mental health problems that can be treated. Factors that may predispose the older person to suicide include a history of depression or other psychiatric illness, loss of spouse or partner, increased social isolation or a lack of social supports, living alone, loss of autonomy — as in moving into an aged-care facility — or having a number of chronic physical ailments. Again, health professionals are encouraged to take a comprehensive or biopsychosocial person-centred approach, rather than stereotype or pre-judge the person based on either preconceived values or ideas of what depression is or what it is like to be an older person.

THE BIG PICTURE

Challenges of the twenty-first century

Australia's population has been ageing steadily and it has been estimated that the proportion of people aged 65 and over will reach 20 per cent (or 4.9 million people) by 2025. In light of this trend, it is clear that government policy will require a consistent and comprehensive approach to managing the issues that will arise from the changing age composition of Australia's population. These issues bring with them at least two major challenges, and include the development of an appropriate evidence base and consideration of the development of appropriate health care services.

The first challenge is to develop a clear and 'real world' evidence base for the effective treatments of the range of issues affecting older Australians (e.g. cancer, depression and dementia). Older patients are underrepresented in clinical trials because they are often receiving concurrent medications, have coexisting medical problems or are simply outside of the age cut-off — clearly leaving us with a significant deficit in knowledge of older persons. Data and evidence specifically relating to the efficacy of the range of possible and potential treatments and interventions for the elderly are needed because age at diagnosis is a critical factor that significantly modifies prognosis.

For example, some cancers may become more aggressive in the elderly when compared to younger cohorts; consequently, effective or optimal treatments can be different in the two age populations. Further, these treatments may have different side effects or consequences that are not clearly understood by medical practitioners and this may affect significant decisions made relating to the end-of-life care requirements.

The second challenge is to develop responsive and effective health systems that are capable of managing the expected rise in demand, and also the increased severity of illness in older people. Further, this system will need to provide access to high-quality care and effective new technologies (depending on the outcome of the first challenge). A two-tiered health system — where affluent, younger patients obtain effective and up-to-date treatments in the private sector and vulnerable and older patients obtain care in the public sector, with varied funding arrangements — is not considered tolerable by many.

It will be a difficult task for the future health care system to provide effective and evidence based treatments to older persons in rural and remote regions of Australia. In Australia today, effective (and costly) treatments for a range of chronic illnesses are generally provided only in major metropolitan areas; however, as the rural/remote population ages, the provision of care in these areas will need to be reviewed. For example, a direct correlation between distance and cancer treatment services and patients' use of that treatment has been observed, with patients less likely to access specialist treatment when longer distances are involved.

Source: Adapted from Martin, Coory, and Baade (2012)

This section provided information on depression and suicide in the older person, as well as an explanation of how the health professional can best support the older person who has a depression. The next section discusses 'delirium', highlighting the vital importance of the health professional being able to identify a delirium, which can be a life-threatening condition.

Delirium

Delirium may be described as a sudden deterioration in mental functioning in response to an underlying medical cause. It is a common presentation in the older person, particularly in those in hospitals and residential care. However, delirium also presents a risk to the individual in the community who is frail, has a chronic illness or who has a pre-existing dementia. It is important that all health professionals who work with older people have a detailed understanding of delirium, partially because delirium in the elderly can be life threatening, but also because a delirium has the ability to impact negatively on the quality of life of the older person. For example, a delirium will almost certainly make any pre-existing condition, such as dementia or a mental health condition, much worse, and will thus inevitably place an extra burden on carers. If identified and responded to quickly, delirium can be reversed and much pain and suffering can be reduced. However, if it is left untreated, the person may die.

Assessment of delirium

The formal diagnosis of a delirium is made by the medical specialist and is based on the results of a variety of assessments such as blood chemistry, erythrocyte sedimentation rate, electrocardiogram, chest X-ray and urinalysis. However, the most effective way of identifying a delirium is through observing a change in the person's behaviour. In fact *any change in the person's usual behaviour must alert the health professional to the possibility that a delirium may be present*. This of course demands a knowledge of the person's usual behaviour in order to identify any recent change, and so reminds the health professional of the importance of knowing the person.

In addition to the heath professional observing or identifying changed behaviours, there are also a number of practical tests the health professional can perform to make a reasonable judgement about the presence of delirium. The MMSE is a reliable way of detecting a delirium. Does the person show a sudden deterioration in their ability to perform the test? Do they suddenly present as disoriented? Is their attention span suddenly affected? If the health professional does not have either access to or experience with the MMSE, a simple cognitive exercise may be performed. This may involve asking the person to count backwards from ten, or to say the months of the year backwards, or asking them to give their name and address, or to identify the day of the week, the month of the year or the season. If the result of such an exercise reveals that an older person is *suddenly* unable to perform such basic mental tasks, then a delirium should be assumed and action taken immediately to have a detailed medical assessment.

Characteristics of a delirium

There are a number of central features of a delirium that the health professional needs to commit to memory. These are identified in table 11.3 — namely, an acute onset, fluctuating presentation, problems with attention and concentration, disordered thinking and alterations in consciousness.

TABLE 11.3 Characteristics of a delirium

Feature of delirium	Assessment
1. Acute onset and fluctuating course	Is there an acute change in mental status from the person's baseline? Does the abnormal behaviour tend to come and go or increase and decrease in severity?
2. Inattention	Does the person have difficulty focusing attention? For example, are they distracted or having difficulty keeping track of what is being said?
3. Disorganised thinking	Is the person's thinking disorganised or incoherent, rambling or irrelevant, unclear or illogical, or unpredictable?
4. Altered level of consciousness	Overall is the person lethargic (drowsy, easily aroused), stuporous (difficult to arouse), comatose (unable to be aroused) or hypervigilant (hyperalert)?

Source: Royal Australian College of General Practitioners (2004, p. 24)

The typical onset of delirium is hours or days, different from the slow insidious onset of dementia or depression. Also, the condition tends to fluctuate; that is, the person may present as well in the morning, yet confused and muddled in the afternoon, or appear better in the evening and have a restless, agitated and disturbed night. This suggests the importance of health professionals talking to each other about an older person's presentation and also talking to carers such as non-professional institutional carers or the family carer. Further, delirium is characterised by:

- impaired attention
- increased distractibility
- thinking that is muddled, chaotic and confused.

In dementia, and indeed in depression, this is not typically the case, certainly at the outset. Sleep is usually disturbed in delirium, while in dementia it is not. The person with delirium may also have visual disturbances and mood swings. Fear, anger, irritability or even euphoria may all be present, but the central theme remains the same: have these behaviours and presentations only recently emerged? If so, the health professional must assume a delirium and act with haste to have medical assessment arranged.

Issues for the health professional may emerge when the person has a pre-existing dementia that is moderate to severe, making a **differential diagnosis** difficult. Here, again, the most important advice is to be aware of any recent change in the person's behaviour. It is far better to assume a delirium might exist and to act accordingly than to assume no delirium and not act. The consequences of missing a delirium for the person may be profound.

differential diagnosis being able to identify which diagnosis, from a number of possible competing diagnoses, is correct

Those health professionals who work with the older person who is in hospital, or is expected to be hospitalised, or who is in or about to go into residential care, need to remember that between 10 and 15 per cent of older patients who are admitted to hospital present with delirium and up to 40 per cent may develop it during their stay in residential care (Clinical Epidemiology and Health Service Evaluation Unit, 2006). In other words, both hospitals and residential care are locations where delirium is liable to be prominent.

Types of delirium

There are three identified types of delirium:

1. hyperactive
2. hypoactive
3. a mixed presentation, which involves features of both.

In hyperactive delirium, the person can present as agitated, restless, over-active and hyper-alert. They may be uncharacteristically verbally aggressive, loud, threatening and chaotic in their presentation and they may engage in random acts of confused and pointless activity. This type of delirium is easy to identify, perhaps because it is so disruptive and challenging to carers. The hypoactive presentation, on the other hand, can easily be missed because the person may be withdrawn, insular, isolative, and quiet with little motor activity. In the hustle and bustle of medical wards, or in the understaffed and poorly trained aged-care sector, it is easy to miss such presentations. Consequently, the outcomes are much worse for this subgroup. In the mixed form of delirium, there are elements of both.

UPON REFLECTION

Distinguishing between dementia and delirium

Many health professionals are unsure of the difference between dementia and delirium, or delirium and mental illness generally. If they observe an older person with symptoms of a delirium they automatically label them as 'demented' or 'mad'.

Questions

1. What factors may have led to this attitude in health professionals?
2. Why is it important that health professionals can pick the difference between a delirium and dementia?
3. As a health professional, what can you do to ensure that you can identify the difference between a delirium and dementia, and delirium or other mental illness?

Risk factors

While there are a large number of possible causes of delirium, the health professional needs to be alert to the most obvious. Five of the most common risk factors are:

1. infections — often urinary tract or chest infections, but any infection whether local (e.g. spider bite, ingrown toenails) or systemic (pneumonia) can trigger a delirium
2. medications — particularly benzodiazepines, corticosteroids, opioids, non-steroidal anti-inflammatory drugs, psychoactive drugs and drugs with anti-cholinergic activity; in general, the higher the number of medications a person is on, the greater the risk of delirium. Check for behavioural change following medications introduced or withdrawn
3. trauma — such as falls or head injury. In the older person, fractures of any kind (but particularly neck of femur) can cause a delirium
4. disorders of heart and lungs
5. dehydration and constipation.

The health professional also needs to be alert to the variety of risk factors for delirium in the older person. Old age is the most obvious. Added to this is cognitive impairment such as a dementia; indeed, the older person with a pre-existing dementia is five times more likely to develop a delirium (Royal College of Psychiatrists, 2005). In addition, severe illness, physical frailty, visual impairment, polypharmacy, existing infection and surgery are all important risk factors (British Geriatrics Society and Royal College of Physicians, 2006). Risk factors themselves are a complex dynamic. Inouye and Charpentier (1996) outline the relationship between predisposing and precipitating factors: the former are existing vulnerabilities such as dementia, age and increasing frailty, whereas the latter identify acute adverse events such as infection, surgery or fall with a resultant fracture. In particularly old and frail persons, it may only take a relatively minor event to trigger an episode of a delirium.

Responding to a delirium

The care of the person with delirium identifies a regime that has altered little over the past decade. Because a delirium is potentially life threatening, it is essential that all health professionals understand what is meant by 'delirium' and how to recognise the condition.

The principles of care remain to reduce stimulation; maintain hydration; provide support, reassurance and compassionate intervention to both person and family; reorientate the individual; and facilitate familiar friends and family to remain with the person while ensuring compliance with prescribed medical treatment (Elder, Evans and Nizette, 2013; Rossom, Anderson, Greer, MacDonald, Rutks, & Tacklind, 2011). Measures to achieve these principles of care include:

- maintaining fluid balance, nutrition, elimination and general comfort
- monitoring with regard to changes in vital signs, behaviour and mental status
- providing a quiet, well-lit room with moderate levels of stimulation, while, at night, a dim night light is important in case the person wakes and is frightened or confused
- maintaining orientation through the provision of clocks, calendars, family photos and other personal possessions
- ensuring paid health carers clearly identify themselves. Ideally, the number of different paid health carers must be kept to a minimum. Enlist the support of family members wherever possible
- providing education, support and reassurance to family members
- encouraging family members to stay with the person when possible.

By recognising a delirium, and providing appropriate treatment, health professionals will be well-placed to provide the best possible care to the older person and support the improvement of their health outcomes.

SUMMARY

The care of the older person with a mental health problem is an invitation to advocate for the welfare of another human being. Like all meaningful relationships, the provision of this care begins with knowing the person. To know the person demands that the health professional is open to the story of the other and connects with them, their history, their meaning, their values and also their experiences. Knowing the person requires going beyond diagnoses, signs and symptoms and biomedical explanations and interpretations, to discover the meaning of a life that defies simplistic definition. Knowing another person also means that the health professional must be aware of their own values, meanings and style of interacting — that is, be aware of what it is the health professional brings to the relationship.

This chapter considers the extent of what it means to care for the older person who occupies a world that is in many ways very different to the one inhabited by the health professional. In no small way, the reality of ageism is the first barrier that must be overcome to enter this world. This chapter suggests that a powerful way of both entering and understanding this world is through the biopsychosocial person-centred perspective that sees the older person as very much more than simply a defective or broken-down medical organism, but rather views (or connects with) the person as a valid individual in whatever context they are located. This, in turn, recognises that context — social, personal, historical — is crucial. Through this approach, dementia can be understood as a social construct as much as (or more than) a medical one, and depression and suicide can be seen as, again, a social and personal experience. Perhaps the most powerful example of knowing the person emerges with a discussion of delirium, where knowing and not knowing may in fact be the difference between life and death. Delirium is a salutary lesson for all those who work with the older person.

Often it is assumed that, as health professionals, the care provided to people represents a kind of linear relationship. That is, the health professional does the caring and the person they are helping is the recipient; the beneficiary of care. In reality, however, it is both the health professional and the person who bring uniqueness to the relationship, drawn from their own experiences, values and beliefs, and their own stories. As the health professional impacts upon the person, so the person impacts upon the health professional. The health professional needs to be open to know the person — not as a 'patient' or 'client'; not as a person who has a mental illness, a dementia, a depression or a delirium. They need to know them as a person: a person with a past and with relationships; with ambitions, sadnesses, joys and triumphs; with an individual perception of what the complexity of human life means to them. To know the person means knowing them for who they are; not as some mirror image of the health professional, but as a valid and dynamic human being in their own right. From there, and only there, can the caring process begin.

Review questions

1 What is meant by 'ageism'?
2 How can discrimination of the elderly affect healthcare delivery?
3 What challenges does the Australian health care system face in the coming years, as the population grows older?
4 What are the drawbacks of the mini mental state examination (MMSE) when it comes to diagnosing dementia in the older person?
5 Describe ways in which a health professional can build rapport with an older person.
6 Describe the four main types of dementia.
7 What is the single most important risk factor for dementia?
8 What are the risk factors for depression in an older person?
9 What is the Geriatric Depression Scale (GDS)? Describe it.
10 When using a screening tool with the elderly, what else needs to be done to ensure a comprehensive assessment?
11 Identify the most important management tools for the treatment of the behaviours and psychological symptoms of dementia.
12 What is the difference between dementia and a delirium?

Discussion and debate

1. Discuss the possible negative attitudes that a health professional may have in relation to older people and how this could impact on the provision of care. List ways in which these negative attitudes can be recognised and managed so that appropriate health care is provided.
2. Suicide in the older person is an issue that is attracting increasing attention in the media. However, in a society that has limited resources, it could be argued that the taxpayer's dollars are better spent on addressing issues of self-harm in young people. The older person has already lived their life. What do you think?
3. 'It is normal for the older person to get depressed. People around them are dying and they are coming to the end of their life.' Discuss.
4. Person-focused approaches to care are labour intensive. Discuss how the health professional can realistically provide biopsychosocial person-centred care in the current health system in Australia.
5. Discuss the clinical difference between dementia and delirium and provide appropriate ways in which a health professional can manage each situation.

Project activity

Using the provided case study on page 490 (Beverley) complete the following.

1. Discuss how you would form an appropriate rapport with her.
2. Reflect on what attitudes (negative and positive) that you have towards Beverley and discuss how these may impact on the care that you could apply.
3. Complete and rate the GDS as you think she may respond.
4. Complete a suicide risk assessment for Beverly, listing the key issues that are causing you concern and discuss how you could reduce her risk.
5. Based on your responses to the first four questions devise an appropriate care plan for Beverley.

Websites

Alzheimers Australia is a national organisation committed to the prevention of dementia, while valuing and supporting people living with dementia: www.alzheimers.org.au

The Australian and New Zealand Society for Geriatric Medicine (ANZSGM) is a professional society for geriatricians and other medical practitioners who have an interest in improving the medical care of older people: www.anzsgm.org

FRONTIER Research is investigating the neurological, psychological and biological basis of brain function in frontotemporal dementia and healthy ageing: www.ftdrg.org

The Fronto Temporal Dementia Forum provides a place for safe and secure communications for people who have been diagnosed with or care for loved ones with frontotemporal dementia: http://ftdsupportforum.com

Healthinsite is an Australian government initiative that provides an internet gateway to access a wide range of up-to-date and reliable information on health and wellbeing. It includes a wide range of information about supporting the mental health of the older person: www.healthinsite.gov.au

Mental Health Foundation of Australia provides links to information about mental health and services, including those provided to older people: www.mentalhealthvic.org.au

Psychogeriatric Nurses Association Australia (Inc.) is an avenue for personal and professional communication between psychogeriatric nurses. This site encourages the dissemination of knowledge, skills and ideas: www.pgna.org.au

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12

Approaches to mental health service delivery

LEARNING OBJECTIVES

This chapter will:

- consider current approaches to the delivery of mental health services in Australia
- discuss the importance of primary health care services for people with a mental illness, including health promotion and illness prevention
- describe a range of early intervention and early treatment services for young people
- summarise the important role of consumer and carer networks and organisations in the planning, development and implementation of services
- outline a range of secondary mental health services, including the role of mental health consultation liaison teams in hospitals
- explain the main characteristics of services provided by the tertiary health sector, including forensic mental health services
- discuss the major challenges for those accessing dual disability services.

Introduction

The mental health services provided in Australia today are much different to those that were available prior to deinstitutionalisation. Since the 1980s, the number, type, range and settings of services provided to young people, adults, older people, individuals, families, groups and communities have expanded significantly. It is important that health professionals are aware of the many services available, as this will enable them to open up diverse service options for people affected by mental health issues.

This chapter describes some of the main mental health services available in Australia, with a focus on the primary, secondary and tertiary contexts. Such a division is in many ways arbitrary, since a large number of services span the primary, secondary and tertiary sectors. Also, the way in which each of the services operates will often differ between jurisdictions. Even so, this division is a useful means of organising the services, as it provides a way of considering their scope and function.

The chapter commences with an examination of the importance of our national strategies related to mental health promotion, mental illness prevention and early intervention. This is followed by an outline of a variety of secondary health services, including consultation liaison services, community mental health teams, inpatient services, child and adolescent mental health services, and older persons mental health services. Two examples of tertiary sector mental health services are then described, including forensic mental health services and dual disability services.

Approaches to mental health service delivery in Australia

In Australia, over $6.3 billion, or $287 per Australian, was spent to provide mental health-related services in 2009–10 (Australian Institute of Health and Welfare [AIHW], 2012). Moreover, state and territory expenditure for specialised mental health services has increased by an annual average of 5.4 per cent over the 5 years to 2009–10 in direct response to the increase in need and also demand for these services (AIHW, 2012).

Conventionally, policy makers and service providers worldwide classify mental health services according to a system developed in the 1990s by the US Institute of Medicine (Mrazek & Haggerty, 1994; see also Hage & Romano, 2010). As shown in figure 12.1, health services are provided on a continuum that begins with illness prevention; and moves on to early intervention, then treatment and continuing care. There is an expectation that health promotion will underpin all services regardless of where they fall on the spectrum of interventions.

The mental health services delivered in Australia today fall across this spectrum. It is important to highlight this as many health professionals are unaware of the wide-ranging nature of available health services. For example, health professionals who work in the secondary and tertiary sectors, such as hospitals, may have limited understanding of the health services provided outside of the hospital setting. Similarly, some health professionals may view services that are delivered in the community as lower in status than the services delivered in the acute hospitals, where there is a large concentration of services. Such attitudes suggest a lack understanding of the importance of primary health care services and initiatives, and the improved health outcomes and cost efficiencies these services and initiatives have generated.

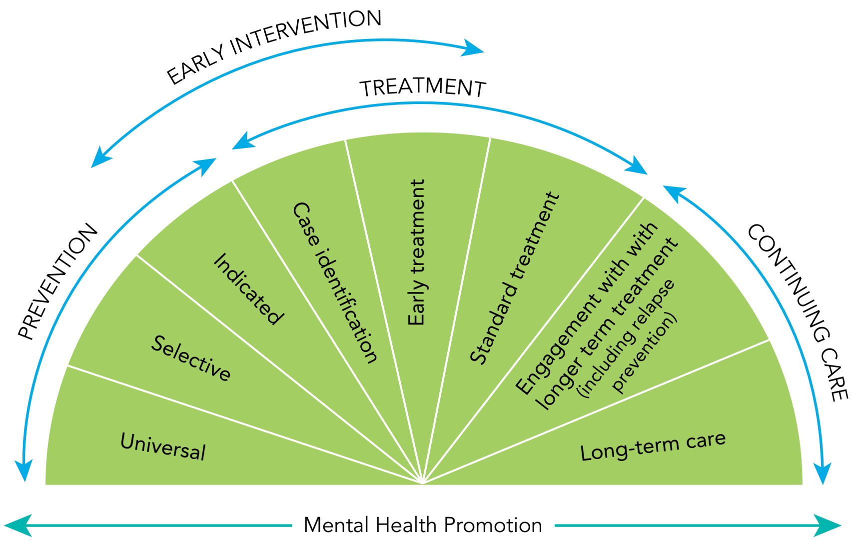


FIGURE 12.1 The spectrum of interventions for mental health problems and mental disorders

Source: Rickwood (2005), adapted from Mrazek and Haggerty (1994)

UPON REFLECTION

Resourcing health services: An ethical dilemma?

The spectrum of interventions outlined in figure 12.1 is relevant to all health services, not just mental health services.

1. Where would the greatest number of people be located on this spectrum? Why is this so?
2. Where are the most number of services located on this spectrum? Why is this so?
3. How ethical is this resourcing? Explain your reasoning.

National standards for services

As noted in chapter 1, the **National Mental Health Strategy** was developed by the Australian government to guide the development, planning, implementation and delivery of mental health services by state or territory governments across the nation. The National Mental Health Strategy comprises a National Policy (now in its second iteration), National Plan (now in its fourth iteration), a Statement of Rights and Responsibilities,

National Mental Health Strategy the national long-term approach guiding the development, planning, implementation and delivery of mental health services in Australia, produced and articulated by the Australian government in collaboration with key stakeholders and also various national health care agreements. According to the Department of Health (www.health.gov.au), the specific aims of the National Mental Health Strategy are to:

- promote the mental health of the Australian community
- prevent the development of mental disorder
- reduce the impact of mental disorders on individuals, families and the community
- ensure the rights of people with a mental illness.

These aims are achieved through a variety of mental health organisations and services located across Australia, with the quality of these organisations and services guided by the National Standards for Mental Health Services (Australian Government, 2010).

The **National Standards for Mental Health Services**, which are an essential component of the National Mental Health Strategy, were originally developed in 1997 and revised in 2010 to ensure currency and relevance. Today, there are ten national standards. The key principles that inform these ten standards include the following.

- Mental health services are to promote an optimal quality of life and to support sustained Recovery for people with mental illness.
- Participation by consumers and carers is integral to the development, planning, delivery and evaluation of mental health services.
- Treatment, care and support must be tailored to meet the specific needs of the individual consumer and impose the least personal restriction on the rights and choices of the consumer.
- Consumers should be involved in all decisions regarding their treatment and care and, as far as possible, have the opportunity to choose their treatment and the setting in which it is accessed.
- Consumers have the right to have their nominated carer(s) involved in all aspects of their care.
- The roles, needs and requirements of carers, which are different from and separate to those of consumers, must also be supported (Australian Government, 2010, p. 5).

National Standards for Mental Health Services an Australian government document that describes ten standards for mental health services that must be met by all organisations who provide these services in Australia

All of the services described in this chapter are framed by these principles. In addition, the services must align with the general reforms currently in progress for all health services across Australia (e.g. Council of Australian Governments, 2011). This means that mental health services must have a primary health care focus, promote social inclusion, and enable people and communities to be self-supporting.

State or territory variations

It would be difficult to list all of the many and diverse services that operate in Australia across the continuum illustrated in figure 12.1. This difficulty is compounded by the Australian health system, with its multiple layers at the national, state or territory, and local levels. For example, similar service types may have a quite different structure or appearance in Western Australia when compared to those in New South Wales or Tasmania. Likewise, services provided in capital cities will be different to similar service types provided in rural Australia. Certainly, and as already noted, all services will conform to the National Standards and a range of national strategies, plans and priorities. Even so, the descriptions provided in this chapter are broad in nature to allow for jurisdictional and local differences; the descriptions aim to give health professionals a starting point to explore further as required.

Primary health care services

As described in chapter 1, primary health care focuses on health rather than illness, prevention rather than cure, and communities rather than hospitals (National Health and Hospitals Reform Committee, 2009; Primary Health Care Working Group, 2009). Primary health care services are often viewed as the first point of contact for someone experiencing mental health issues. Generally, no referral is needed to access these services. It is important to note that they also provide resources and information to promote healthy lifestyles within communities, by communities, and to support communities (Rickwood, 2011). This means that primary healthcare services aim to support consumers to take ownership of the services they receive.

Mental health promotion and disease prevention

The World Health Organization's *Ottawa charter for health promotion* (1986) was described in chapter 4. This Charter presented a plan for action to enable 'health for all' by 2000, which included addressing the social determinants of health, such as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. The *Jakarta declaration* (1997) built on the *Ottawa declaration* and identified urgency for further investment in health, especially for disadvantaged groups such as women, children, older people, indigenous populations, those living in poverty and other marginalised populations. The key components of these two documents include strategies to safeguard health and improve the outcomes of individuals, communities and larger population groups, across the lifespan. These strategies provide direction for Australian policy on the delivery of primary health care services.

Darren Greentree has used his experience of depression after the loss of his wife to cardiomyopathy to help people in the country cope with their anxieties during recent times of drought.

The place of **health promotion** and **illness prevention** is central to the delivery of all health services across Australia (Australian Government, 2011; Council of Australian Governments, 2008; Walker & Rowling, 2007). The aims and objectives of related activities include building on existing strengths to reduce the extent and severity of ill-health. Health promotion and illness prevention activities are the responsibility of all health professionals — not just those who are involved in research, policy development, community action and program activity.

Mental health promotion and **mental illness prevention** activities are a subset of mainstream health promotion and illness prevention. They are also an integral part of the mental health continuum identified in figure 12.1, with services aimed at enhancing the capacity of individuals and communities to understand and respond appropriately to people with mental health issues (Wand, 2011; Pollett, 2007). As with health promotion generally, mental health promotion is about improving the quality of life and potential for health, rather than alleviating symptoms or improving the deficits caused by ill-health. Similarly, mental illness prevention involves the action or activities that are required to develop the social and emotional environments that support the best possible levels of mental health and wellbeing of populations, communities and individuals; and to prevent the development of mental health issues (Hiscock et al., 2012; Woodhouse, 2010).

According to the World Health Organization (2002), there are three different ways to approaching the prevention of mental illness:

1 universal prevention, which targets general populations

2 selective prevention, which targets individuals or subgroups whose risk of developing a mental disorder is greater than the general population

3 indicated prevention, which targets individuals at high risk of mental health issues and places less emphasis on assessing or addressing environmental influences or community values.

These three approaches are the first in the range of interventions depicted in figure 12.1.

Another way of conceptualising the promotion of the mental health and wellbeing of populations, communities and individuals is provided in figure 12.2. This flowchart illustrates the broad contextual principles and other factors involved in mental health promotion and illness prevention activities, regardless of location, social and economic determinants. For example, the flowchart identifies the importance of whole-of-community engagement to the success of mental health promotion and illness prevention approaches. For this engagement to occur, however, there needs to be a major philosophical shift in the way health services are provided and resources are allocated. Perhaps most notably, the greatest proportion of health-related resources is currently directed towards secondary and tertiary health services (in particular, hospitals). Yet, the health needs of the majority of people fall into the primary health care category.

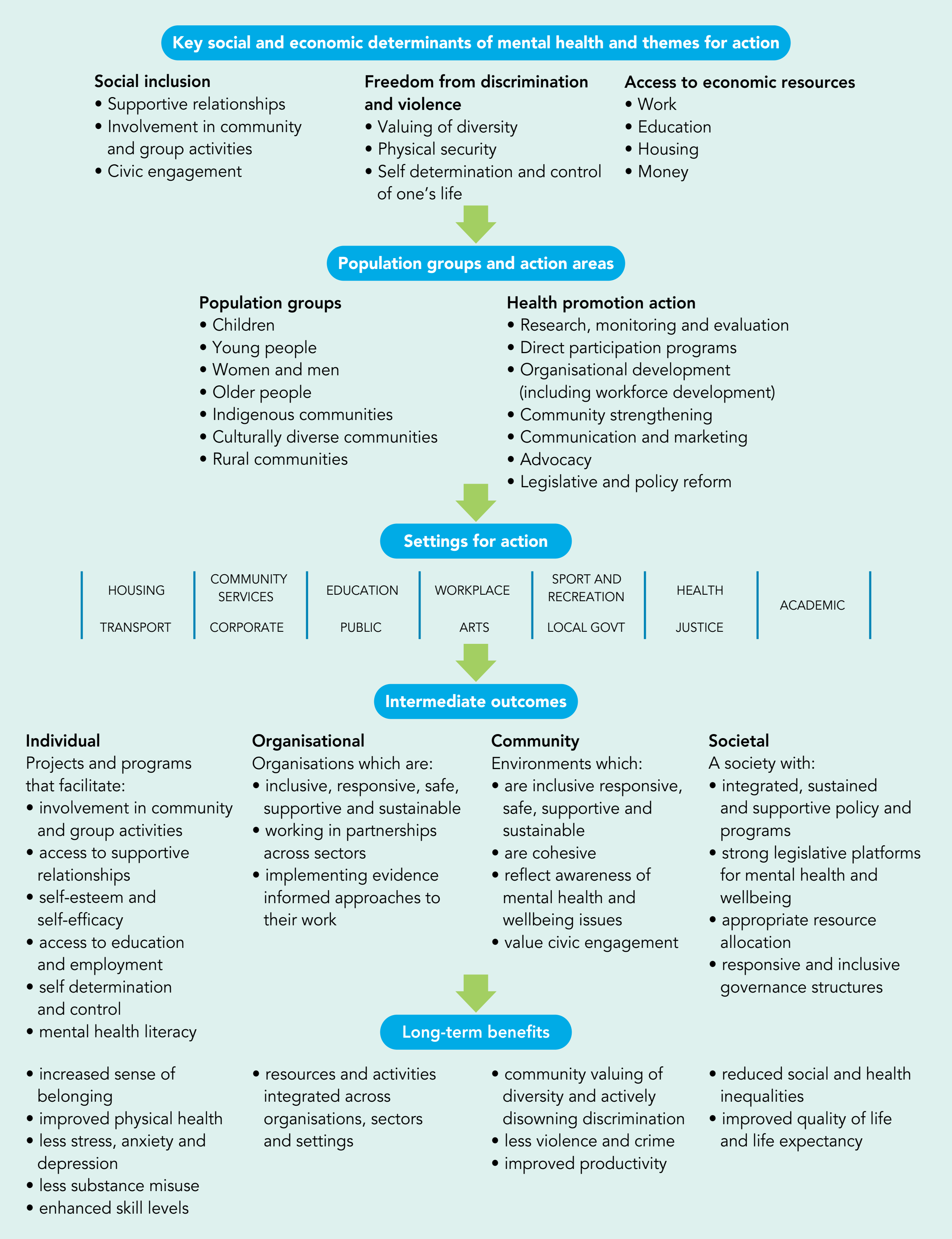
True equity of service delivery and better mental health outcomes will only ever be achieved when there is a balanced allocation of resources across the entire spectrum of health service delivery (Mrazek & Haggerty, 1994; Tenbensel, Eagle, & Ashton, 2012).

health promotion the process of enabling people to increase control over their health, to improve their health

illness prevention the measures taken to prevent the occurrence of disease, such as risk factor reduction, arresting the progress of disease or reducing the consequences of the diseases once established

mental health promotion process or actions aimed at maximising mental health and promoting social and emotional wellbeing across entire populations, for groups and individuals

mental illness prevention activities that occur before the initial onset of a mental health issue, aimed at preventing the development of that mental health issue



Key social and economic determinants of mental health and themes for action

Social inclusion
- Supportive relationships
- Involvement in community and group activities
- Civic engagement

Freedom from discrimination and violence
- Valuing of diversity
- Physical security
- Self determination and control of one's life

Access to economic resources
- Work
- Education
- Housing
- Money

Population groups and action areas

Population groups
- Children
- Young people
- Women and men
- Older people
- Indigenous communities
- Culturally diverse communities
- Rural communities

Health promotion action
- Research, monitoring and evaluation
- Direct participation programs
- Organisational development (including workforce development)
- Community strengthening
- Communication and marketing
- Advocacy
- Legislative and policy reform

Settings for action

HOUSING	COMMUNITY SERVICES	EDUCATION	WORKPLACE	SPORT AND RECREATION	HEALTH	ACADEMIC
TRANSPORT	CORPORATE	PUBLIC	ARTS	LOCAL GOVT	JUSTICE	

Intermediate outcomes

Individual
Projects and programs that facilitate:
- involvement in community and group activities
- access to supportive relationships
- self-esteem and self-efficacy
- access to education and employment
- self determination and control
- mental health literacy

Organisational
Organisations which are:
- inclusive, responsive, safe, supportive and sustainable
- working in partnerships across sectors
- implementing evidence informed approaches to their work

Community
Environments which:
- are inclusive responsive, safe, supportive and sustainable
- are cohesive
- reflect awareness of mental health and wellbeing issues
- value civic engagement

Societal
A society with:
- integrated, sustained and supportive policy and programs
- strong legislative platforms for mental health and wellbeing
- appropriate resource allocation
- responsive and inclusive governance structures

Long-term benefits

- increased sense of belonging
- improved physical health
- less stress, anxiety and depression
- less substance misuse
- enhanced skill levels

- resources and activities integrated across organisations, sectors and settings

- community valuing of diversity and actively disowning discrimination
- less violence and crime
- improved productivity

- reduced social and health inequalities
- improved quality of life and life expectancy

FIGURE 12.2 VicHealth 2005 Framework for the Promotion of Mental Health and Wellbeing

Source: Keleher and Armstrong (2005)

THE BIG PICTURE

Men's Shed movement

In Australia, males are four times more likely than females to take their own lives, with suicide the tenth leading cause of death for males (Australian Bureau of Statistics [ABS], 2013). This trend is of great concern to health authorities, who are supporting the development and implementation of a number of primary health care programs to address the problem.

The Men's Shed movement is a prime example of one such primary health care initiative. Men's sheds have long figured in the Australian culture; and the Men's Shed movement has used this cultural icon as a means of attracting men and providing them with a place to go to participate in a variety of meaningful community activities and also support one another.

Traditionally, there has been little encouragement for men to take an interest in their own health and wellbeing. Unlike women, men tend to be more reluctant to discuss their emotions and less likely to ask for help. Probably because of this, many men are less healthy than women — they drink more, take more risks and experience more isolation, loneliness and depression. Relationship breakdown, loss of access to children following divorce, retrenchment or early retirement, and physical or mental illness are just some of the problems that men find hard to deal with on their own.

The Australian Men's Shed Association considers good health to be the result of many factors, including feeling good about oneself, being productive and valuable to one's community, connecting to friends, and maintaining an active body and an active mind. The organisation maintains that a Men's Shed membership:

> gives a man that safe and busy environment where he can find many of these things in an atmosphere of old-fashioned mateship. And, importantly, there is no pressure. Men can just come and have a yarn and a cuppa if that is all they're looking for.

The movement embraces men from all backgrounds — what they all have in common is spare time with which they would like to do something meaningful. A Men's Shed should have:

> a coordinator who has both the technical and social skills to develop a safe and happy environment where men are welcome to work a project of their choice in their own time and where the only 'must' is to observe safe working practices. All in a spirit of mateship.

> Because men tend to speak up about their problems, both the health system and our modern society have not prioritised them until recently. It's time for a change and the Men's Shed movement is one of the most powerful tools we have in helping men to once again become valued and valuable members of our community.
>
> *Source:* Adapted from Australian Men's Shed Association (2012)

An important aspect of mental health promotion and illness prevention is working to minimise risk factors for developing mental illness, and building or supporting the protective factors that prevent mental illness. All health professionals, regardless of where they work, need an understanding of these risk and protective factors so they can identify the potential for mental health issues to develop; and work with individual, families, groups or communities to build resilience (see chapter 1). Risk and protective factors are the focus of the next section of this chapter.

Risk and protective factors

There are many different factors that contribute to a person developing a mental health issue. For example, while people with depression are thought to have a disruption that affects their neurotransmitters (including serotonin, noradrenaline and dopamine; see chapter 7), other factors are also involved. Such factors include genetics, age, gender, illness, stress, personality and exposure to traumatic events (Telford, McCarthy-Jones, Corcoran, & Rowse, 2012). The causes of depression, then, are multifactorial.

Traditionally, a number of distinctions have been made between the factors that influence health and illness, with these distinctions based on the relationship between causes and health outcomes. A **cause** is an external agent that results in ill-health. For example, soldiers in a combat zone who experience highly stressful and traumatic situations may develop post-traumatic stress disorder (PTSD). The cause of the PTSD for this population group, then, is combat-related stress — while the outcome is a mental-health problem.

cause in health, an agent or event that results in an illness or disorder; the illness or disorder is a direct consequence of the cause

Causes can also be linked to the determinants of health. A **determinant** is a factor that operates at the social, community or systems level to affect the likelihood that a person will develop a particular health condition (World Health Organization [WHO], 2011). For example, the social determinants of health, as discussed in chapter 4, include peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. In light of these determinants, it is often argued that certain population groups — such as refugees, survivors of natural disasters, or those who have experienced large-scale social upheaval, injustice or economic inequity — are more likely to develop health issues, including mental health issues (Guscott, Guscott, Malingambi, & Parker, 2007; Ranse & Lenson, 2012; Schweitzer, Vromans, & Asic-Kobe, 2011).

determinant a factor that operates at the social, community or systems level to affect the likelihood that people will develop a particular health condition

Significantly, not everyone who experiences a traumatic event will go on to develop a mental health problem. For example, less than 10 per cent of people who are exposed to highly stressful or traumatic events go on to develop PTSD (Breslau, 2009). This raises important questions about the reasons some people develop mental health issues, while others who are exposed to similar experiences or events do not develop the same issues. Answers to these questions in part lie with a person's risk and protective factors.

UPON REFLECTION

Whose problem is it?

People who come to Australia as refugees or asylum seekers have often experienced high levels of trauma prior to and during migration. This is a significant risk factor that can contribute to the refugees or asylum seekers going on to develop mental health issues. In addition, refugees and asylum seekers have few social supports upon arrival, and often no family in Australia. This is another risk factor and suggests why the health outcomes of refugees and asylum seekers are lower than the mainstream population.

Questions

1. Some people would say that all refugees and asylum seekers should have the equitable opportunity to enjoy good health in Australia, regardless of visa status or financial means. Do you agree? Why?
2. If you were responsible for planning and developing health services for newly arrived refugees or asylum seekers, what would be your top five priorities? Why?
3. As an individual health professional providing health care to a newly arrived refugee or asylum seeker, what would be your top five priorities? Why?

Risk factors and **protective factors** are similar to the determinants of health, but operate at the level of individuals or groups. Risk factors increase the likelihood that an individual or group of people will develop a disorder; protective factors reduce the likelihood of developing a disorder. This may account for why one person may develop health issues when exposed to particular events or experiences, while another person who has been exposed to the same events or experiences does not. Table 12.1 provides examples of the protective factors that may reduce the likelihood of a person developing mental health problems. The influence of these protective factors may be reduced by the person's risk factors, which are also outlined in table 12.1.

It is worth reiterating that although risk factors are associated with poorer mental health outcomes, it should not always be assumed that people who have experienced or identify with one or more of these factors will develop a mental health issue. Some people will not be affected by risk factors; for others, a so-called risk factor may actually serve as a protective factor. For this reason, the risk factors in the following table must be viewed as a guide only. They do not take into consideration the notion of **resilience**, which was discussed in chapter 1. Nor does the list consider how health professionals can work with individuals or groups to strengthen their ability to cope with stress or manage their life experiences.

It is also important to examine the degree to which the determinants of health, together with the protective and risk factors identified in tables 12.1, lie outside the control of health professionals. This lack of control does not negate the importance of health promotion and illness prevention activities; however, it does highlight the complexity of the situation. It also highlights the need for a long-term sustained effort to improve the various determinants of health. Finally, this lack of control points to the importance of early intervention strategies, which the health professional is most certainly able to influence.

risk factors factors that increase the likelihood that an individual or group of people will develop a condition or illness; they are measured in terms of consequence and likelihood

protective factors factors that decrease the likelihood that an individual or group of people will develop a condition or illness; they are measured in terms of consequence and likelihood

resilience the psychological and emotional strengths, assets, stamina and endurance of a person to adapt to changed circumstances

TABLE 12.1 Protective factors and risk factors for mental health and wellbeing

Protective factors

- **Arts** and cultural engagement
- **Childhood: positive early childhood** experiences, maternal attachment
- **Cultural identity**
- **Diversity:** welcomed / shared / valued
- **Education:** accessible
- **Environments:** safe
- **Empathy**
- **Empowerment** and self determination
- **Family:** resilience, parenting competence, positive relationship with parents and / or other family members
- **Food:** accessible, quality
- **Housing:** affordable, accessible
- **Income:** safe, accessible employment and work conditions
- **Personal** resilience and social skills
- **Physical health**
- **Respect**
- **Social participation:** supportive relationships, involvement in group and community activity and networks
- **Sport and Recreation:** participation and access
- **Transport:** accessible and affordable
- **Services:** accessible quality health and social services
- **Spirituality**

Risk factors

- **Alcohol and drugs:** access and abuse
- **Disadvantage:** social and economic
- **Displacement:** refugee and asylum-seeker status
- **Disability:** Discrimination and stigma
- **Education:** lack of access
- **Environments:** unsafe, overcrowded, poorly resourced
- **Family:** fragmentation, dysfunction and child neglect, post-natal depression
- **Food:** inadequate and inaccessible
- **Genetics**
- **Homelessness**
- **Isolation** and exclusion: social and geographic
- **Natural and human-made disasters**
- **Peer rejection**
- **Political repression**
- **Physical illness**
- **Physical inactivity**
- **Poverty:** social and economic
- **Racism**
- **Unemployment:** poor employment conditions and insecure employment
- **Violence:** interpersonal, intimate and collective; war and torture
- **Work:** stress and strain

Source: The Melbourne Charter was the outcome of a worldwide discussion initiated by the organisers and participants of the Global Consortium for the Advancement of Promotion and Prevention in Mental Health (GCAPP) conference 'From Margins to Mainstream: 5th World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders' in Melbourne, Australia, September 2008. Reproduced with permission from VicHealth.

Early intervention

Early intervention occurs when there is early recognition of a mental health issue, and the person affected is provided with timely and appropriate treatment and support (McGorry, 2012). The focus of early intervention is not just the individual who is experiencing the issue or problem, but also the individual's family or significant others.

early intervention strategies that target individuals who are displaying the early signs and symptoms of a health issue

To ensure a person or group of people is provided with appropriate early interventions, all health professionals need to be aware of and able to recognise early warning signs or symptoms. In general, the early warning signs or symptoms of a mental health issue are:

- fewer than those required to diagnose a disorder
- present for a shorter period of time than is required to diagnose a disorder
- less intense and disruptive than those of a diagnosable disorder (Morriss, Vinjamuri, Faizal, Bolton, & McCarthy, 2013; Mrazek & Haggerty, 1994; Puiatti, Mudda, Giordano, & Mayora, 2011).

The more common early warning signs for conditions that occur across the lifespan — such as depression, anxiety or psychosis — include changes in feelings, thinking and behaviour. Table 12.2 (overleaf) provides a list of the more common early warning signs.

TABLE 12.2 Common early warning signs for mental health issues

Changes in feelings	Changes in thinking	Changes in behaviour
• Feeling anxious or worried • Feeling tense or restless • Feeling irritable or quick to become aggressive • Feeling depressed or unhappy • Feeling unsafe or threatened • Feeling paranoid (e.g. thinking that others are talking about you)	• Difficulty concentrating or remembering things • Difficulty making decisions • Thoughts racing, slowing down or jumbled/confused • Thinking very negative, pessimistic thoughts • Hearing voices not coming from other people • Thinking about harming yourself • Dwelling on past events	• Isolating from others, not wanting to go outside • Increased or decreased appetite • Increased or decreased sleep • Increased risk taking/ dangerous behaviour (e.g. alcohol or illicit drug use) • Increase in emotional outbursts (e.g. crying, laughing or yelling) • Reduced energy levels and motivation to participate in activities and interests • Difficulty looking after personal appearance and living environment

Source: Adapted from O'Sullivan and Gilbert (2003)

The origins of these early warning signs are mostly non-specific. They can be caused by or be symptomatic of a number of different health conditions. Early warning signs may also be transitory in nature. This means they can be very difficult to identify. Even so, people who develop a mental illness often report prior changes in their thoughts, behaviour or their physical being, however non-specific in nature.

In psychosis, early warning signs or an 'at risk mental state' are sometimes called the 'prodromal period'. This is a retrospective concept, because until there is an established psychotic illness, the prodromal period does not exist! Some people describe the prodromal period as a time when 'something is not quite right' (McFarlane, Cornblatt, & Carter, 2012). Symptoms include changes in perception, beliefs, cognition, mood, affect and behaviour. Because these signs and symptoms are non-specific, it is important that health professionals remain aware that any change, however subtle, is worth noting and referring the person for a full assessment. Early intervention will support achievement of the best possible outcomes for the person.

Some people who experience early warning signs are reluctant to use conventional health services such as general practitioners (GPs) or the emergency department of a hospital if they think they have a mental health problem (Jackson & McGorry, 2009). Alternatively, some people may present to a service complaining of trouble sleeping, tiredness or chest pain. They may not be aware of an underlying mental health issue, or they may feel uncomfortable talking about their concerns and will use related issues as a 'cry for help'. Reasons for such reluctance in reporting these kinds of problems may be the social stigma that is associated with mental illness or the self-stigma some people attach to the symptoms (see chapter 1). This suggests why many early intervention services have been integrated into the community as 'just another health service' and located in a place where people live or work or learn.

IN PRACTICE

Identifying risk factors and early warning signs

Carl is a 21-year-old single male who lives with his parents on the family farm in Western Australia. He is your cousin and he has decided to spend a few days with you to get away from his parents. You notice some changes in Carl's mood and behaviour since the last time you saw him. For example, Carl seems very moody.

After a few drinks one evening, Carl opens up and tells you that he has some personal problems. The girl he had been going out with since high school has recently ended their relationship. He also tells you that he has very few friends back home as they have all left to find jobs in the city, so now he just stays home and drinks alone. He knows his parents care about him; however, sometimes it seems as if all they do is nag him about his drinking and tell him to forget about his ex-girlfriend, which he doesn't want to do. So now he does most of his drinking in the paddock as he drives around in his ute shooting feral animals that are damaging the family's crops.

You start to wonder if you should be concerned about Carl and what he is experiencing.

Questions

1. What are the risk and protective factors for Carl?
2. What are the early warning signs for Carl?
3. What are some of the primary health care services or resources that Carl could access, in the short term and medium term, to help him through this difficult time?

Early intervention services for young people

The best approaches to preventing or minimising the impact of mental health issues across the lifespan will commence with children and adolescents. Mental health problems in young people can have far-reaching effects on the physical wellbeing, as well as educational, psychological and social development, of individuals (Leach & Butterworth, 2012). Children who are healthy, physically and mentally, are better able to:

- learn
- experience stronger relationships with teachers,family members and peers
- negotiate challenges, including the transition into adolescence and then adulthood
- achieve long-term education and career goals
- enjoy a better quality of life.

If the early signs or symptoms are ignored, there is the potential for mental health issues to become more serious, with the young person developing a mental illness.

When working with children and adolescents, it is especially important that a holistic and comprehensive approach is taken. This is because the social determinants of health have a much greater potential to affect the health outcomes of children. For example, adolescents with mental health issues are less likely to complete secondary school and go on to further study and employment (Browne & Waghorn, 2010). Children and adolescents with mental health issues are also more likely to develop long-term mental health problems and physical health issues (McCloughen, Foster, Huws-Thomas, & Delgado, 2012). These outcomes, in turn, can have a huge impact on families, friends and the community as a whole. It is important, then, to ensure all services and professionals co-operate, including early childhood services, social services, schools, parents and families, and health services. This will enable the young person to be supported more effectively.

Research into risk and protective factors reveals that there are a number of groups of young people with particular mental health needs who are at an increased risk of developing mental health issues. Additional attention and support for these groups can potentially prevent mental health problems from developing in the long term. These groups include:

- children and young people from Aboriginal and Torres Strait Islander cultures
- children affected by significantly adverse life events such as severe trauma, loss or grief
- children of parents with a mental illness.

Children of parents with a mental illness are particularly at risk. Services provided to this group are described later in this chapter.

Also of concern is the data suggesting that only 25 per cent of young people with mental health problems actually access services (Purcell, et al. 2011). Moreover, for many young people there is a long delay between when they first experience symptoms and when they actually receive help. Because most young people don't regularly visit or necessarily feel comfortable with conventional medical or community health services, they are also harder to reach. For this reason, the government is concentrating on setting up services that are custom-made for young people, such as headspace and KidsMatter. A number of these services are outlined in figure 12.3.

FIGURE 12.3 Early intervention services for young people

- **headspace** (www.headspace.org.au) provides mental health wellbeing support, information and services to people aged 12–25 years and their families. There are a large number of headspace 'shop fronts' across Australia, staffed by youth-friendly health professionals who can help people with general health concerns; provide general counselling, education, employment and other services; and offer alcohol and other drug services. headspace also offers online information and services
- The **KidsMatter** mental health initiative (www.kidsmatter.edu.au) is a school-based mental health promotion, illness prevention and early intervention program developed for use in primary schools across Australia. KidsMatter activities include:
  - promoting social and emotional learning in the school communities
  - working authentically with parents, carers and families
  - providing support for students who may be experiencing mental health difficulties.

The school structure offers a systematic means of identifying children at highest risk or who are already showing early warning signs, then intervening early and engaging the children in early treatment. Schools are also uniquely placed to provide information and support to parents and families regarding their child's mental health and wellbeing.

- **MindMatters** (www.mindmatters.edu.au) is an extension of the KidsMatter program, and is a national resource and professional development program designed to promote and protect the mental health and social and emotional wellbeing of secondary students and members of the school community.
- **MoodGYM** (https://moodgym.anu.edu.au) is an online, interactive program offering a range of modules to help people to gauge how they feel, understand why they feel the way they do, change the way they think, know what makes them upset and be assertive. People may use MoodGYM at home and at their own pace. MoodGYM has achieved many positive outcomes and provides an important means through which young people with mental health concerns can access primary health care support (Calear, Christensen, Mackinnon, & Griffiths, 2012).
- **Orygen Youth Health (OYH)** (http://oyh.org.au) is a Melbourne-based youth mental health organisation. It comprises three main components: a specialised youth mental health clinical service, a research centre, and an integrated training and communications program.

  OYH provides clinical services to young people aged 15–25 with mental health issues who are located in the western and north-western areas of Melbourne. Its services include inpatient, acute, outreach, case management, psychosocial programs, peer and family support (e.g. Schell, Cotton, & Luxmoore, 2012). OYH also leads research to better understand the biological, psychological and social factors that influence onset, remission and relapse of mental illnesses, to discover better ways to prevent and/or mitigate the impact of mental disorders for young people (e.g. Nelson, Thompson, & Yung, 2012).
- **Reach Out** (http://au.reachout.com) is a web-based service aimed at people aged 14–25 years, and run by the Inspire Foundation (www.inspire.org.au). Members of the Foundation also travel around Australia speaking to young people.

The examples in figure 12.3 highlight how diverse primary health care mental health services can be. Important providers of services for young people, in particular, include schools and universities, employment agencies and social services (e.g. Centrelink). For this reason, it is important that all professionals who work in these diverse areas are aware of the early warning signs, how to identify them, and how to provide appropriate and timely interventions. Similarly, it is essential that mental health services across Australia continue to develop partnerships and build connections with non-government and community service organisations; departments of housing, education, disabilities and community services; and the ambulance and police services. This will enable diverse service providers to work together towards a common goal.

Children of parents with a mental illness

In Australia, over a million children have at least one parent with a mental illness (Maybery, Reupert, & Patrick, 2009). These children face many challenges that can impact negatively on their development and wellbeing (Murphy, Peters, Jackson, & Wilkes, 2011).

A number of services and programs have now been set up to support children of parents with a mental illness in Australia (Reupert & Maybery, 2009). Many of these services and programs are funded under the national Children of Parents with a Mental Illness (COPMI) initiative.

The main aim of the COPMI initiative is to develop information to support children of parents with a mental illness; together with the parents, their partners, carers, family and friends who support children of parents with a mental illness. With knowledge about mental health and illness, available services, and how to access these services, children and significant others are more able to negotiate the health system and make informed choices (Reupert & Maybery, 2010). The information generated by the COPMI initiative complements online training courses also developed for professionals who support families either individually or through community services and programs. In addition, the COPMI initiative employs mental health professionals — together with community support groups, educators, service organisations and the media — to produce resources that aim to:

- build resilience and foster better mental health outcomes for children of parents with a mental illness (Pakenham & Fraser, 2008)
- reduce stigma associated with parental mental illness
- help friends, family and workers in a range of settings respond to the needs of the children and their families
- respond to the needs of the children and their families where a parent has a mental illness (COPMI, 2012).

These resources are developed under the guidance of people with experience living in families where there is mental illness, supported by leading researchers and service providers in the mental health field.

Mental health literacy

A significant part of mental health promotion and illness prevention is **mental health literacy**. This term is described briefly in chapters 1 and 4, and involves increasing the awareness or knowledge of mental health issues in individuals and communities (Jorm, 2012). Important aspects of mental health literacy are:

- raising community awareness of the social and emotional wellbeing of communities, and how this can be affected by issues related to mental health and ill-health
- providing information on mental health and ill-health, including risk factors, self-treatment and where to go for professional help
- promoting attitudes that improve recognition and appropriate help-seeking
- assisting with community recognition of specific disorders.

mental health literacy the knowledge and understanding about mental health and illness that assists people to recognise, manage or prevent mental health issues

Activities designed to improve mental health literacy include the ongoing education of people of all ages and a continuous flow of information between service providers and community organisations (Reavley, McCann, & Jorm, 2012).

An important initiative that has worked effectively to increase the mental health literacy of various populations across Australia is the Mental Health First Aid (MHFA) course (www.mhfa.com.au). This program was developed in Australia by Professor Tony Jorm and Betty Kitchener to help people provide first-response support to someone with a mental health issue. The course has been rolled out across Australia and has also been taken up internationally (Jorm & Kitchener, 2011;

Kitchener & Jorm, 2006, 2008; Terry, 2009). Outcomes of the MHFA program include an increase in mental health knowledge, reduction in mental health stigma and, most importantly, an increase in the community support provided to people with mental health issues (Kitchener & Jorm, 2006; Hart, Jorm, Paxton, & Cvetkovski, 2012).

The program has a number of aims, many of which are similar to those of conventional First Aid courses. For example, aims of the MHFA program include preserving life when the person is a danger to themselves or others; helping to prevent a mental health problem from becoming a mental illness; promoting the Recovery approach to achieving good mental health; providing comfort to a person experiencing mental distress; and providing skills to help people deal with a mental health crisis. Mental health crises may involve situations in which a person is feeling suicidal, is having a panic attack, has had a recent traumatic experience, is acutely psychotic and perceived to be threatening violence, or has taken an overdose of medication or some other substance. Actions to take are listed under the acronym ALGEE:

- **A**ssess risk of suicide or harm
- **L**isten non-judgmentally
- **G**ive reassurance and information
- **E**ncourage person to get appropriate professional help
- **E**ncourage self-help strategies (Mental Health First Aid, 2009).

A number of population group-specific MHFA courses are also available, including culturally and linguistically modified courses, Aboriginal and Torres Strait Islander courses for urban and rural Indigenous community members, and courses suitable for adults working with adolescents. Increasingly, MHFA training is recommended to those who are employed in occupations where there is a greater potential for contact with people with mental health problems. This includes generalist health professionals such as counsellors, dieticians or nutritionists, GPs, Indigenous health workers, nurses or midwives, occupational therapists, paramedics, physiotherapists, psychologists or social workers. More information about MHFA courses can be found at www.mhfa.com.au.

Mental health literacy for health professionals

In addition to undertaking a MHFA course, health professionals who work in generalist health services have many other options available to them to learn more about mental health and mental illness. Another national government initiative that supports the development of knowledge about mental health and illness for the Mental Health Professionals Online Development (MHPOD) program. MHPOD is a learning resource for health professionals and draws on the research evidence-base for mental health treatment, care and contemporary practice. The program aims to support health professionals regardless of where they are located, by improving access to evidence-based educational programs. Practitioners, consumers, carers and educators across the country have contributed to MHPOD, which can be found at www.mhpod.gov.au.

Early treatment

When framed by an early intervention approach, early treatment has an emphasis that is different from more conventional mental health treatment. Early treatment focuses more on the determinants of an individual's mental state. This involves identifying ways of reducing the impact of the person's risk factors and supporting or strengthening the person's protective factors (see table 12.1 on p. 527). For this reason, it is unlikely that early intervention or treatment will be provided as a one-off or short-term activity. Mental health issues often develop over time and are episodic or recurring. Consequently, early treatment services must have a long-term perspective.

Early treatment, like early intervention, is not usually delivered by mental health professionals or mental health services. Rather, early treatment is provided by general health services, educational institutions, housing or employment services, or not-for-profit organisations (see 'Not-for-profit organisations' later in this chapter). Strategies include teaching the person coping skills and building on personal strengths. Of particular importance is improving access to social support and developing a sense of connectedness within the community to enhance resilience (Jackson & McGorry, 2009). Early treatment may also involve referral to specialist mental health services; but, again, the focus of this referral will be to strengthen protective factors rather than the provision of conventional treatment.

Another aim of early treatment is to improve the knowledge of mental health and illness in a person who is showing the early signs and symptoms of mental illness. Informed people are more able to make informed choices about their health. In addition, awareness of the signs and symptoms of a mental health problem, and what these signs and symptoms may indicate, can provide a person with reason to seek help earlier and thereby improve outcomes. Likewise, it is important to provide information and support to families or carers, as they spend more time with the person than the health professional and so will have a close interest in the choices that are made by the person. This is discussed further in the next section.

Consumer and carer networks

Consumer and carer participation in the planning, implementation and delivery of health services is now an expectation of governments across Australia, so it is not surprising the consumer and carer networks have a strong profile. As noted in chapter 1, a **consumer** is a person who is currently using or has previously used a mental health service (Australian Government, 2010). The term 'consumer' was developed as part of the consumer movement with a view to empowering people with a mental illness, and connotes ideas of choice for individuals in the treatment or services they utilise.

A **carer** is a person whose life is affected by the consumer's experience of mental illness, or who has chosen a caring role with or for the consumer (Australian Government, 2010). A carer may also be a member of the consumer's family, a legal guardian, or other person who is significant to the consumer.

consumer a person who is currently using or has previously used a mental health service

carer a person who is affected by symptoms of mental illness by virtue of a close relationship or a caring role with a consumer

Consumers and carers often have quite different voices and needs. Consequently, health professionals need to listen and respond to the stories and experiences of both parties. The health professional spends a comparatively short length of time with the consumer. In contrast, the consumer spends a considerable length of time with their carers, partners, family members, friends or community members. Moreover, the relationship between a consumer and carer can have a significant impact on health outcomes. For example, consumers and carers often share and negotiate a lifestyle between them. The role of the carer in the Recovery journey of the consumer, then, is central.

Even so, many carers will feel that they lack the skills or capacity to adequately support the person who is exhibiting symptoms of mental illness (Gavrilova, et al., 2009). It is the responsibility of the health professional, then, to provide support and information to carers, and also suggest pathways to assist them to develop the skills they need. The type of support and information the health professional provides to the carer will depend very much on the needs and preferences of the carers.

It is also important that health professionals support the mental health of the carer. Caring — especially long-term caring — can be very stressful. More than that, caring for a person with a chronic illness, such as a mental illness, is a risk factor for carers, who may go on to develop a mental health problem of their own if they are not adequately supported. If the person who is caring for the consumer at home becomes unwell or develops a stress-related illness, the consumer will be affected, often detrimentally. For this reason, the delivery of comprehensive health care by a health professional to a consumer will also include supporting or assisting the carer.

Consumer and carer networks and/or support groups operate in all states and territories. Health professionals are encouraged to provide the contact details for these groups to both consumers and carers. For example, organisations such as Carers Australia (www.carersaustralia.com.au) or the Association of Relatives and Friends of the Emotionally and Mentally Ill (ARAFEMI) in Victoria (www.arafemi.org.au), work to support consumers and carers in Recovery and empowerment, with services such as home-based and intensive outreach services, Recovery care programs, and flexible respite options.

A different — but just as important — organisation is the National Mental Health Consumer and Carer Forum (www.nmhccf.org.au), which provides the means for consumers and carers to actively participate in the development of mental health policy and service development in Australia. The aim of this forum is to:

- utilise the lived experience of its members and their unique expertise in mental health, to identify what does and does not work in the mental health sector
- identify important and innovative ways to bring about positive change within the mental health system
- be a powerful, respected, combined national voice for mental health consumers and carers.

The organisation provides consumers and carers with a united and national conduit through which they can create a more responsive system that will improve their quality of life.

Not-for-profit organisations

There are many thousands of **not-for-profit organisations (NPOs)** operating across Australia, and the large majority of these organisations provide an important means of supporting people in their communities. These organisations' activities include community and capacity building, the promotion of social inclusion, and also activities more specifically related to mental health promotion and illness presentation (Boyle, Donald, Dean, Conrad, & Mutch, 2007; Smith & Bateman, 2011). Lifeline is a well-known example of an NPO in Australia that provides easily accessible primary-level mental health services. In particular, Lifeline (www.lifeline.org.au) offers a range of mental health services, including a 24-hour 7-days-a-week telephone service that is staffed by trained volunteer telephone counsellors who take calls from people with concerns,

not-for-profit organisations (NPOs) voluntary sector organisations that seek to promote and/or represent the interests of members and also the community worries, or mental health issues, from anywhere in Australia. Lifeline answers around 450 000 calls per year from people needing emotional support. All health professionals are advised to remember the Lifeline telephone number: 13 11 14.

community managed organisations (CMOs) organisations that provide services to the community and are administered or operated by the community

Community managed organisations (CMOs) are NPOs that play a central role in supporting the mental health of individuals, families and communities. CMOs are administered, managed and operated independently of the government. They may include charitable, religious or social organisations, clubs or other associations. The core purpose of these CMOs is the welfare or wellbeing of the community. This is reflected in the nature of the activities undertaken by the CMOs, which contribute to supporting or building the capacity of communities. For example, Rotary International is a worldwide movement that has clubs located in districts or communities throughout Australia, where members work to 'make the world a better place'. Local Rotary programs and projects are diverse, and include bushfire recovery projects to support communities to rebuild after experiencing natural disaster as well as fundraising for health-related organisations such as the Royal Flying Doctor Service and the McGrath Foundation, the breast cancer support charity. Membership of a CMO is usually open to the general public, subject to the conditions of membership for the organisation (Australian Government 2012).

CMOs include the religious or faith-based organisations located across Australia. For example, the Salvation Army (www.salvos.org.au) is a Christian, non-government organisation that offers a wide range of front-line and support services across the lifespan. These services include aged care, children's services, youth services, community services, court and prison services, crisis and support accommodation, disability services, emergency services, employment services, financial counselling, professional counselling, Recovery services and support for those who may be feeling suicidal.

Another important resource provided by faith-based organisations is the individual leaders and outreach or other workers associated with the local church, mosque, synagogue, temple and so on. Many of these leaders and workers have been trained in counselling and are able to provide ongoing personal or social support to those in need.

Alternatively, community clubs that are not faith-based, such as Rotary, Lions or Apex, also provide a means by which communities are able to support communities and, in the process, the health of those communities.

non-government organisations (NGOs) organisations that provide services to the communities and population groups that are administered or operated by non-government bodies

Non-government organisations (NGOs) are similar to CMOs in that they are operated independently. Generally, however, NGOs have a wider focus — although, again, the purpose and function of NGOs varies widely. Examples of NGOs include service organisations that provide human rights advocacy or group social welfare initiatives, relief responses and natural disaster responses. NGOs can also serve as a 'check-and-balance' for governments to minimise the possibility of corruption or discrimination. Alternatively, they may be the means by which government initiatives are rolled out. NGOs are generally more global in orientation than CMOs (Australian Government, 2012).

In Australia, many of the services provided by CMOs and NGOs are supported financially by the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), which provides disability support funding. This source of funding is typically augmented by additional resources from state or territory mental health budgets. CMOs across Australia are now receiving an increasingly large proportion of the mental health budget, as they are viewed as able to provide services more efficiently than the public health care system.

In response to this increase in government funding, a coalition of community mental health peak bodies in all Australian states and territories has been established. Community Mental Health Australia (CMHA) was established in 2007 to represent more than 800 CMOs and NGOs located across Australia (CMHA, 2012). The primary goals of CMHA are to build a viable and sustainable community managed mental health sector and to promote the value and outcomes delivered by community managed mental health services based on a philosophy of Recovery and social inclusion. The types of Recovery-oriented services provided by CMOs include, but are in not limited to:

- housing, accommodation and residential support (e.g. Housing and Accommodation Support Initiative (HASI), which is a partnership program funded by the NSW Government and NGOs such as the Richmond Fellowship that links government housing with specialist support for people with mental illness)
- day-to-day supported living (e.g. Schizophrenia Fellowship, Uniting Care)
- activities of daily living and employment (Clubhouse)
- respite care for families and consumers (e.g. Carers Australia)
- generic counselling services (e.g. Anglicare, Centacare, Relationships Australia)
- Post and Antenatal Depression Association (PANDA)
- Personal Helpers and Mentors Program (PHaMS)
- step-up/step-down facilities as an alternative to inpatient admission or for a period of transition after hospital discharge, with clinical input from the local community-based clinical service (e.g. Centacare, Mental Illness Fellowship of Australia).

Although services such as these generally provide social and emotional interventions rather than clinical treatment, some CMOs and NGOs also provide consumers access to specialist mental health clinical care, usually through GPs, Better Access Initiatives, the Mental Health Nurse Incentive Program, or public mental health services. Some of these services are described in the following sections.

Better Access to Mental Health Initiative

The Better Access to Mental Health Care Initiative (Better Access Initiative) provides easily accessible and relatively inexpensive focused psychological interventions to people with mild-to-moderate mental health problems. The Better Access Initiative was established by the Australian government as a primary healthcare option for people with short-term mental health issues. Treatment received under this initiative is subsidised by Medicare Australia, which is the national government agency that delivers a range of health-related payments and services to the Australian community. The Better Access Initiative is provided by allied health workers, including psychologists, clinical psychologists and social workers. The majority of people who access services funded under the Better Access Initiative have a mood or behavioural disorder rather than chronic symptoms of mental illness The initiative has been utilised far beyond expectations since its implementation, demonstrating the need and demand for this type of service in the community (Littlefield & Giese, 2008).

To access a service via this initiative, a person must be referred to the allied health worker by a GP, psychiatrist or paediatrician, who will complete a detailed mental health assessment and prepare a mental health treatment plan. Eligible people can generally receive up to 12 individual or group therapy services in any one calendar year.

While long-term outcomes of the initiative have still to be rigorously evaluated, the results so far suggest that this initiative is an important means by which people can readily access specialist mental health support and interventions. More information about the Better Access to Mental Health Care Initiative can be found on the Department of Health website (www.health.gov.au) or the Australian Psychological Society website (www.psychology.org.au).

Mental Health Nurse Incentive Program

The provision of effective community-based support for people with chronic or severe mental illness can often reduce their need for acute hospital services and lead to improved health outcomes and reduced costs of care (Australian College of Mental Health Nurses [ACMHN], 2009; Hurley et al., 2014; Meenan & Robertson, 2013). People with chronic or severe mental illness are at particular risk because they are often unable to access a range of support services, including accommodation and employment services, social support networks and services that monitor their physical health. The Mental Health Nurse Incentive Program (MHNIP) is a primary health care initiative that provides community-based support to people with chronic or severe symptoms of mental illness.

Funded by the Australian government, the MHNIP enables specialist mental health nurses to care for people with a severe mental illness outside of the public health care system. Registered nurses (RNs) who provide this program may be employed at community-based general practices, private psychiatry services, or other organisations such as Medicare Locals (ACMHN, 2009). Alternatively, some mental health nurses have established their own private practices and, after receiving a referrals and plans from a GP or psychiatrist, can provide services autonomously.

RNs employed by the MHNIP are specialised RNs who must be credentialed by the ACMHN as mental health nurses (see chapter 1). The ACMHN, which is the peak professional mental health nursing organisation in Australia, provides a Credential for Practice Program that requires individual RNs to meet a predetermined set of standards before they can be credentialed as a specialist mental health nurse.

The services provided by RNs working under the MHNIP include:

- periodic reviews of mental state
- management and monitoring of medications
- person-centred therapeutic interventions
- monitoring of physical health status
- provision of health promotion information
- home visits
- care coordination, which includes improving the person's links to other health professionals and service providers.

More information about the MHNIP can be found on the Medicare website.

Nurse practitioners

Nurse practitioners are RNs with the education and extensive experience required to perform in an advanced and extended role. The title 'nurse practitioner', like 'registered nurse', 'enrolled nurse' and 'midwife', is protected by national legislation. Only those authorised or endorsed by the Nursing and Midwifery Board of Australia (NMBA), which forms part of the Australian Health Practitioner Regulation Agency (AHPRA), can call themselves a **nurse practitioner** (NP).

nurse practitioner a registered nurse with relevant postgraduate qualifications and extensive experience in a specialty field, who practises autonomously in an advanced and extended role

The scope of practice of a NP extends beyond that of the RN. This includes, but is not limited to, conducting comprehensive health assessments; making direct referrals to other health professionals; prescribing, titrating and ceasing medications; and ordering diagnostic investigations. The NP role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care that supports and complements other health professionals and services. The scope of practice of the NP is determined by their specialty area of practice. For example, the NP with a mental health specialty will provide services to people with mental health issues.

In November 2010, national legislation was enacted that allowed NPs access to the PBS (Pharmaceutical Benefits Scheme) and MBS (Medical Benefits Scheme) through Medicare. This was heralded as an historical landmark in health reform and an important step in the delivery of primary health care services to people with a mental illness by expert mental health professionals. NPs are now at liberty to see consumers and their carers in private practice, and bulk bill through Medicare. Likewise, the cost of medications that NPs prescribe can be claimed through Medicare.

Online services

The age of information and technology has witnessed an explosion in the development of digital and other online health services, including mental health services. These primary sector health care services are easily accessed by people, regardless of their location, and require no referral.

There are many examples of Australia-based online services, and many more online services that can be accessed across the globe. This includes both government-funded services or initiatives, and also services set up by private providers, including online counselling, psychotherapy and mental health information services.

The following list identifies just two of the more commonly known government-funded Australia-based services.

- *beyondblue* (www.beyondblue.org.au) — an Australian initiative that can be accessed via the internet. As well as providing national leadership on mental health issues, *beyondblue* also offers web-based support and outreach programs, and a telephone information line.
- Black Dog Institute (www.blackdoginstitute.org.au) — an educational, research, clinical and community-oriented facility offering specialist expertise in mood disorders, including depression and bipolar disorder. The institute is attached to the Prince of Wales Hospital in New South Wales and is affiliated with the University of New South Wales.

These examples illustrate how organisations across Australia are working together to raise awareness about mental health issues, provide information to specific and general population groups, and work to change attitudes in the community.

Practice nurses

Practice nurses are sometimes confused with nurse practitioners because of the similarities in the name, but practice nurses undertake a much different role in the primary health care context. A **practice nurse** can be an RN or enrolled nurse (EN) who is employed by a GP — that is, a medical practitioner — to provide primary health care to all people across the lifespan. The role of a practice nurse will vary according to the population profile of the general practice, the general practice structure and employment arrangements. The nurse may provide direct clinical care or play a pivotal role in health promotion, illness prevention and health maintenance through the provision of evidence-based information and education to individuals, groups and communities. This requires a broad knowledge of resources available within the community and health sectors to facilitate care to individuals/groups and the skills to communicate and educate (www.anf.org.au). This work also requires the nurse to work collaboratively with other members of the multidisciplinary team — internal and external to the general practice — and to promote health services that are focused on individuals as well as groups.

practice nurse a registered or enrolled nurse (RN or EN) who is employed by a general practitioner (GP) to provide nursing services to people who attend the general practice

UPON REFLECTION

Too many options?

The benefits of having a wide range of primary health care services available for people with mental health issues is that there is a wide range of options available and these choices are easily accessible.

A challenge of having a wide range of primary health care services is that some people may feel uncertain about which service is best for them.

Questions

1 Who is responsible for helping people with mental health issues, and their carers or family members, to navigate the many service options available?

2 How can health professionals who are busy working in the secondary or tertiary health sectors stay abreast of the many primary health care services that are now available?

Secondary health care services

The delivery of mental health care at the secondary level is complex, and varies across the states and territories as well as the urban, rural and remote contexts (Mental Health Council of Australia, 2010). As noted in chapter 1, a person can generally access secondary sector health services only when they are referred by a health professional. The obvious exception to this is self-presentation to a hospital emergency department. This section provides an overview of a selection of secondary sector mental health services, which comprise:

- child and adolescent mental health services
- community mental health teams
- consumer and carer consultants
- inpatient services
- mental health consultation liaison services
- perinatal mental health services
- older persons' mental health services.

It is important that all health professionals are aware of how these services operate, so they can provide appropriate advice or referral when necessary. As already noted, the details of how these services operate will vary from jurisdiction to jurisdiction. For this reason, it is recommended that health professionals obtain additional information about these services in their local area.

Child and adolescent mental health services

According to the Australian government, around 15 per cent of all children and adolescents (those aged up to seventeen years) have a mental disorder (Rivers, 2009; Sawyer et al., 2000). There are now a range of secondary sector child and adolescent mental health services (CAMHS) across Australia to meet the needs of these consumers. Many of these services are related to the early intervention and treatment services, previously described in this chapter under 'Primary health care services'. In addition to those already described, there are a number of quite specific services available for children and adolescents who require ongoing treatment and care.

CAMHS that are funded by public mental health services have a more secondary and tertiary focus, often requiring a referral from a health professional such as a GP, RN or a school counsellor before a full assessment can be conducted and appropriate interventions recommended. CAMHS focus on providing assessment and treatment for children and young people less than 18 years of age who are experiencing mental health issues.

The mental health issues experienced by children and adolescents are similar to those experienced by adults, and may include depression, anxiety and phobias, early onset psychosis, bipolar affective disorder, suicidal thoughts and behaviours, self-harming behaviours, behaviour and conduct disorders, and eating disorders. Also important is the early intervention and treatment provided for children with conditions on the autism spectrum — however, it needs to be noted that funding arrangements for these conditions lie outside of the mental health budget in Australia, so there is a somewhat artificial boundary limiting the services provided by CAMHS to young people who have been given this diagnosis. It is recommended that health professionals assist parents or carers of children with a disorder that lies on the autism spectrum by referring them to the appropriate services.

CAMHS teams are generally multidisciplinary and, in addition to assessment and treatment, provide the following:

- individual and family counselling
- outreach or drop-in services, which young people attend for individual or group therapy
- consultation liaison with other services, including GPs
- family and carer support
- adolescent therapeutic and educational day programs
- residential programs for young people who are either stepping down from inpatient mental health care, or stepping up from community care to more intense care that is not inpatient care
- community education and training
- perinatal consultation for parents.

Through these services, CAMHS provides complementary support to the primary health care services for young people described in the first section of this chapter.

Community mental health teams

community mental health teams multidisciplinary teams of health professionals employed by the public health care system to provide services to consumers who live in the community

Community mental health teams (CMHTs) are part of the public health care system in Australia, and play an integral role in the delivery of mental health services to people with serious mental illness. The most common diagnosis for people accessing the services provided by CMHTs is schizophrenia, accounting for almost one-third of all contacts, followed by depressive episodes (11.7%), bipolar affective disorders (6.3%) and schizoaffective disorders (5.8%) (AIHW, 2012).

CMHTs comprise medical practitioners, nurses, psychologists, social workers and occupational therapists and are usually located in community health or mental health centres. The community-based location of CMHTs is central to their effectiveness. For example, when health professionals are located in the community rather than on a hospital campus, they are more likely to become an integral part of local service networks. This, in turn, fosters a primary health care approach, including promoting ideas of social inclusion and enabling access to other services such as housing, employment and recreation.

The responsibilities of a CMHT can include the delivery of ongoing care to people who are required by law to receive treatment in a community setting (see chapter 3). Most CMHTs also work with people who are willing to accept health interventions without the need of a psychiatric order.

The role of health professionals in CMHTs vary from service to service and location to location. For example, in rural and remote areas, community mental health professionals provide a number of different services from satellite locations, rather than offices in large regional centres. In general, CMHTs provide at least one of the following services:

A mental health nurse visiting an Indigenous community member.

- acute and continuing care, including clinical and medication management and Recovery planning
- acute assessment and treatment provided on a mobile basis at extended hours, 7 days a week (e.g. Mobile Intensive Treatment Teams)
- intensive or crisis treatment, sometimes called assertive outreach teams or crisis and assessment treatment teams, provided on an outreach basis and available on an extended hours basis, 7 days a week, for people with ongoing or recurrent serious mental ill-health and associated disabilities
- telephone triage, often utilising a 1800 telephone number — available 24 hours a day, 7 days a week — to triage consumers, to refer them to the most appropriate service
- consultation or shared care with local GPs, psychiatrists and other primary health care practitioners
- telehealth, comprising a two-way telecommunication linkup that enables specialist mental health professionals to provide advice, consultation, peer support, education and training services

- residential rehabilitation in community settings with round-the-clock on-site staff
- ongoing advice and **psychoeducation** to carers and significant others
- tertiary-level clinical care for specific groups such as forensic mental health clients (Mental Health Council of Australia, 2010).

CMHTs also work closely with relevant acute inpatient services. For example, a mental health professional who works for a CMHT will visit a consumer in hospital, if that consumer is usually case-managed in the community but is hospitalised for some reason. The mental health professional will work with health professionals located in the hospital to ensure the consumer is discharged in a timely manner. This collaboration promotes what is known as a 'seamless continuity of care' between inpatient and community services, an expression that describes the process whereby a person moves from community to inpatient and back to community care without disruption to their treatment, care or Recovery journey.

psychoeducation an approach that involves the provision of information to consumers and their carers or significant others regarding signs, symptoms, clinical management, Recovery planning and discharge related to mental health and illness.

Consumer and carer consultants

In many secondary sector public mental health services across Australia, consumer consultants and carer consultants are employed to assist with the delivery of a range of services. A **consumer consultant** is a person who has used a mental health service, is well along in their Recovery journey, and works within the mental health service to help other consumers. Mental health consumer consultants have the relevant qualifications or experience to enable them to support and assist people who are experiencing symptoms of mental illness. They may also provide training for health professionals to enable them to care more appropriately for consumers. A consumer consultant may work from a community health centre or a hospital.

consumer consultant consumer consultants are persons employed to represent the interests of consumers and advocate for their needs

A **carer consultant** is a person who has cared for a family member or significant other who used a mental health service, and is employed to provide resources and support to other carers. Like consumer consultants, many carer consultants have relevant qualifications and can work out of community health centres or hospitals.

carer consultant persons employed to represent the interests of carers and advocate for their needs

Health professionals need to work closely with consumer consultants and carer consultants to ensure that the consumer and carer perspective is considered in their decision making. Consumer and carer consultants also provide an important means of improving what is known as service responsiveness. This means that they are involved with the direct experience of mental health service delivery, and so they are often able to promote or advocate for change more quickly than may otherwise be possible if they were in an administrative position only. Generally, consumer consultants and carer consultants are involved in the following activities:

- ensuring consumer and carer perspectives are included in all aspects of the planning, delivery and evaluation of mental health services
- advocating for consumers and carers to the service and ensuring the particular needs of both of these groups are met
- communicating the broad views of consumers to mental health services and also other relevant services, such as housing or accommodation, Centrelink, employment and so on (Department of Health and Ageing, 2010).

Consumer and carer consultants will also provide training and professional development opportunities to health professionals and other workers.

Inpatient services

In Australia, there is a range of inpatient or bed-based services, including acute, subacute, older persons, forensic, perinatal, child and adolescent, young persons, rehabilitation and extended care services. These units may be voluntary or involuntary. Involuntary units are also known as 'gazetted' units, where people are provided with health care when they have been constrained under the mental health legislation of the state or territory in which they are located. Gazetted acute inpatient units can also accept voluntary admissions; in fact, only 30 per cent of all people discharged from a gazetted inpatient unit have been admitted involuntarily (AIHW, 2012). Involuntary or gazetted facilities are most often locked or have sections within them that are locked, which means that entry into and exit out of the unit or locked section is restricted. This practice is to ensure the safety of the consumer, the community and also the staff working in these units.

Mental health units operate in the same way as any other specialty hospital units or wards. As with conventional bed-based facilities, some mental health units are operated as part of the public health care system, while others are private facilities that provide mental health services to people who are able to pay through their private health insurance or personal resources.

Acute mental health inpatient units

Most hospitals in metropolitan or regional cities have one or more acute mental health units. The majority of these are for adults. The more specialised units — such as adolescent, perinatal or forensic inpatient facilities — are generally located in metropolitan areas and viewed as tertiary-level services.

Acute adult mental health inpatient units are hospital-based and staffed by a multidisciplinary team of consultant psychiatrists, psychiatry registrars, other medical officers, RNs and ENs, occupational therapists, psychologists, social workers, and welfare officers. This team provides the following services:

- clinical assessment and treatment of the acute symptoms of mental ill-health that are being experienced by the consumer
- care planning, including medication management and related psychoeducation
- psychological, social and occupational or functional interventions, individually or in groups
- support and psychoeducation for carers
- **care coordination**, with the team working closely with carers and families, community mental health teams and community organisations to ensure consumers receive the appropriate level of care and support once they are discharged into the community (Baumgartner & Herman, 2012; Treatment Protocol Project, 2003).

care coordination an activity undertaken by an advanced practice health professional who manages and coordinates the overall care process of the consumer

In light of the primary health care model that is central to service delivery across Australia, and also the principle of least restrictive care espoused by the National Standards for Mental Health Services, people are only admitted to a mental health unit when they cannot be treated safely or appropriately in the community. The average length of stay in acute inpatients units varies across states and territories, from 11.7 days in the Northern Territory to 18.5 days in Western Australia (AIHW, 2012, p. 15). Generally, the length of stay in a rehabilitation unit is much longer.

Rehabilitation and extended care facilities

Rehabilitation or long-stay inpatient mental health units are located across Australia. Some of these facilities are situated in buildings or on grounds that were previously a part of a psychiatric institution. Rehabilitation or long-stay mental health facilities generally house people who experience severe symptoms of mental illness and require far more time and a higher degree of psychosocial support than that which can be provided in acute mental health units or in the community setting. The most common length of stay for consumers in these facilities is 2 weeks or less (50.7%), with about 5 per cent of all consumer stays lasting more than 1 year (AIHW, 2012). Residents admitted involuntarily account for about 29 per cent of all episodes.

As with acute inpatient units, rehabilitation or long-stay inpatient mental health units are staffed by a multidisciplinary team of allied health, medical and nursing professionals. This team will provide one or more of the following services, depending on the policy of local health service management:

- life skills education, including cooking, paying bills and maintaining employment
- psychoeducation, including managing behaviours and the side effects of medications
- extended care, for those who are having issues with finding appropriate accommodation and support in the community
- respite care, to enable carers to have some short-term respite from the primary responsibility of caring for people who have high support needs
- care coordination, where the health professional coordinates the care and treatment provided to the consumer. This will include the health professional engaging directly with the consumer; managing the overall care process, including the development and communication of the treatment or care plan to all relevant stakeholders; and ensuring that all treatment and care is delivered to meet the quite particular needs of the consumer and their carer (Banfield et al., 2012; Nutt & Hungerford, 2010).

The focus of care in rehabilitation and extended care facilities is Recovery-focused and is aimed at providing the person with the skills to live a full and meaningful life in the community.

Mental health consultation liaison services

As had been noted throughout this text, 20 per cent of Australian adults experience mental illness in any one year (ABS, 2007). This statistic includes adults already being treated by health professionals for a physical condition in a hospital or a community setting. This means that one in five of the adults seen by any health professional are likely to have a coexisting or comorbid mental health issue. In addition, other people may develop mental health problems in the course of their stay in hospital or during their treatment in the community (van der Watt, 2010).

It is also concerning that 15–20 per cent of people with a chronic physical illness experience symptoms of depression, anxiety or other psychological distress, but 75 per cent of these people do not any receive mental health treatment or interventions for these conditions (Kelly & Turner, 2009). The reason for this high percentage is that the mental health issues were not recognised by the treating health professionals. Another reason is that some health professionals feel unequipped to provide appropriate treatment (see chapter 9). This situation is problematic as it means the person with the comorbid condition is not receiving the care they need.

Mental health consultation liaison services, based upon the seminal work of Caplan (1970), provide one means by which the appropriate care and treatment can be provided to people with comorbid issues. **Mental health consultation liaison (CL)** is a generic term that applies to various mental health services delivered in a range of practice settings that involve mental health professionals consulting and liaising with generalist health professionals about a person with a comorbid mental health issue. In Australia, CL teams or workers can be found in both urban and rural settings; in general hospitals, including wards and emergency departments; or in community teams that provide support and advice to health professionals (e.g. GPs) in primary care settings, the emergency services or community service organisations. The CL team comprises a range of health disciplines, including psychiatrists and other medical practitioners, nurses, and psychologists and other allied health professionals who have specialised in the field of mental health. Health professionals who work in health settings that focus on physical conditions are encouraged to seek the help of the CL team for support or assistance when working with someone with a comorbid mental health issue.

mental health consultation liaison (CL) mental health services that are consultative in nature and delivered by specialist mental health professionals in a range of health settings

The role of the CL team

The role of the CL team is to undertake direct clinical work with people who exhibit symptoms of mental illness in a physical health setting and to engage in consultation or liaison activities with health professionals in these settings. Services provided by the CL team include:

- mental health assessment
- risk assessment and management
- brief psychological interventions and advice on medication management
- mental health promotion
- advice on mental health treatment and care
- clinical supervision
- education to health professionals, consumers or carers regarding mental health issues
- connection between the general hospital and mental health services.

The assistance provided by the CL team is collaborative, with members of the CL team working alongside other health professionals located in general settings to ensure that the mental health needs of the consumer are identified and addressed.

CL teams may work across a range of health settings, but the most common settings include those where acute stress or chronic illness is more frequent, such as emergency departments, renal units and cancer units. Reasons health professionals refer a person on to the CL team may include:

- self-harm or suicidal ideation
- mood disorders, including depression, anxiety or bipolar disorder
- acute stress reactions
- disturbed, aggressive or 'bizarre' behaviour
- problems associated with excessive alcohol and illicit drug use
- confused states and dementia.

This list is by no means exhaustive or exclusive. Health professionals who work in any context and are concerned about the mental health status of a person should not hesitate to contact their local CL service for advice. They can do this by accessing the website of their local health service.

Referral to the CL team

In some instances, it may be difficult to decide when or why a referral needs to be made to the CL team. Sometimes a referral may be generated for no other reason than that the health professional has a sense of uncertainty about what is needed to help the person. As already noted, a valuable and essential aspect of the CL team is the provision of advice, information and guidance before problems become severe or entrenched.

There may also be times when more formal referrals are required. In these instances, referrals should be considered in the same way as referrals to other specialist teams. Some conditions, such as delirium, acutely disturbed behaviour, agitation or uncooperative behaviour, can lead the health professional to assume the person is exhibiting symptoms of a mental illness, when in fact these types of behavioural symptoms are more frequently associated with an underlying physical cause. The most common physical symptoms that may be mistaken for a mental health problem are outlined in table 12.3. The most common side effects of medications that may be mistaken for a mental health issue are outlined in table 12.4 (overleaf). It is important that all possible underlying causes of unusual behaviour are excluded and treated before a formal referral is made to the CL team.

TABLE 12.3 Physical causes of issues commonly associated with mental ill-health

Symptom	Possible physical cause
Depression	Cancer Infections Electrolyte imbalance (e.g. low sodium level) Endocrine disorders (e.g. hypothyroidism) Neurological disorders (e.g. epilepsy, Parkinson's disease, dementia, stroke) Addison's disease Autoimmune disease (e.g. systemic lupus erythematosus, rheumatoid arthritis)
Anxiety	Endocrine disorders (e.g. hyperthyroidism) Substance withdrawal (e.g. sudden cessation of benzodiazepines, sudden cessation of alcohol) Hypoglycaemia Pheochromocytoma Neurological disorders
Fatigue	Anaemia Sleep disorders (e.g. sleep apnoea) Chronic infections Diabetes Endocrine disorders (e.g. hypothyroidism, Addison's disease, Cushing's syndrome) Cancer Radiotherapy

(continued)

TABLE 12.3 *(continued)*

Symptom	Possible physical cause
Weakness	Autoimmune disease (e.g. myasthenia, rheumatoid arthritis) Peripheral neuropathy Neurological disorders (e.g. Parkinson's disease)
Headache	Migraine Brain tumours Temporal arteritis

TABLE 12.4 Medications with side effects that may be mistaken for mental ill-health

Side effect	Medication
Acute confusion (i.e. delirium)	Central nervous system depressants (e.g. hypnotics, sedatives, antidepressants, antihistamines) Antimuscarinics (e.g. procyclidine) Beta-blockers Digoxin Cimetidine
Psychotic symptoms	Appetite suppressants Beta-blockers Corticosteroids Levodopa Indometacin
Depression	Antihypertensives Oral contraceptives Antipsychotics Anticonvulsants Corticosteroids Levodopa
Elated mood	Antidepressants Corticosteroids Antimuscarinics (e.g. benzhexol)
Behavioural disturbance	Anaesthetic agents Benzodiazepines Antipsychotics Lithium toxicity

The referral process for the CL team will vary from service to service and team to team. Health professionals are advised to identify their local CL operational policy, which should clearly identify the role and function of the CL team in their area.

However, before initiating referral, it is important to ensure that all members of the treating team have been consulted. Best-evidence practice in this area includes:

- discussing reasons for a mental health referral with the treating team
- being familiar with the role of the CL team, to answer any questions or concerns about the need for a referral
- discussing the need for a mental health review with the person being referred. Wherever possible, the views and consent of the person being referred should be obtained. If the person agrees, it is also advisable that the health professional discuss the matter with the person's significant others
- ensuring that the relevant history and background information is available and accessible before making the referral (e.g. contacting the person's GP, obtaining collateral information from significant others, community health teams or other community services)
- being clear of what is expected of the CL team (e.g. what you hope the outcome of the assessment will be). This may include obtaining specialist advice regarding treatment or care, participating in discharge planning by arranging mental health follow-up, or identifying ongoing risk
- being open-minded and receptive to the ideas or advice offered by the CL team (Watt, 2010).

By taking a consumer-centred approach to care, the skills of the mental health professionals can be utilised proactively to improve the person's experience. This stands in contrast to a 'tick-box' approach that views a mental health service as a task that needs to be completed but has little impact on the health outcomes of the person receiving the treatment.

CL services are now an important part of health services in Australia and have enabled the integration of physical and mental health treatment and care. By working together with the CL team, health professionals can ensure that the person receives comprehensive health care that addresses the full range of their biopsychosocial needs. Health professionals can also enable the person to achieve the best possible outcomes.

IN PRACTICE

Providing comprehensive health care

- Health professionals are called to attend to Troy, 79 years of age, in his home in the middle of the night. Troy is in a wheelchair and being cared for by Selina, his wife, who is also 79 years of age. Selina is crying. She says she can no longer manage to attend to her husband's physical needs as she is not strong enough. She also says that he seems down, is never happy and just stares at the floor all day long without saying a word, apart from when he wants something to eat or to go to the toilet. All her grown-up children live some distance away and she is at her wits' end. She tells the health professionals to please take him to hospital as she cannot cope a minute longer.

➜

- Health professionals are called to attend to a man in his mid-40s. He has chest pain and is very anxious. His wife tells the health professionals the man is overreacting and his only problem is that he is stressed. He 'always' gets chest pain when he is stressed.
- Health professionals are called to attend to a woman who has fallen over in the street and, it is reported, has broken her leg. When they arrive, the woman is ranting and raving in what sounds like 'gibberish'. Some of the bystanders say she must be drunk. Others say she is a well-known homeless person who is quite 'mad'.

Questions

1. What are the social needs of each of the people involved in these scenarios?
2. What are the physical needs of each of the people involved in these scenarios?
3. What are the mental health needs of each of the people involved in these scenarios?

Perinatal mental health services

With the development of the implementation of the Australian government and *beyondblue* clinical practice guidelines for depression and related disorders — anxiety, bipolar disorder and puerperal psychosis — in the perinatal period, perinatal mental health is gaining an increasing and very necessary profile across Australia (beyondblue, 2011; Bilszta, Erikson, Buist, & Milgrom, 2006). As noted in chapter 7, postnatal depression alone affects almost 16 per cent of new mothers in Australia. Puerperal or postnatal psychosis is less common; however, it presents a serious risk to the mother and baby, and health professionals are required to make prompt referral to specialists if this condition is suspected. The implications of postnatal depression and puerperal psychosis for the mother, baby, partner, family and community are discussed in more detail in chapter 7.

It is important that all health professionals are aware of the importance of identifying a perinatal mental health issue as early as possible. The symptoms for women with perinatal mental health issues include marked changes in mood; prolonged lack of interest or pleasure in routine activities; and persistent feelings of anxiety or inadequacy, failure, hopelessness, guilt and shame (see chapter 7). Treatment options include psychological intervention and medication (beyondblue, 2011). A mother, her partner, or other family members may not be aware that there is a problem, with perinatal mental health issues presenting themselves in ways that may at time be ambiguous. The arrival of a baby is always a time of great change. This, in turn, generates stress. Consequently, unusual behaviours may be rationalised as 'just a stage' the woman is going through. Early and effective assessment provides one means of identifying the problem and providing the most appropriate treatment.

Perinatal mental health services are now a common feature of many mental health services (Harvey, Fisher, & Green, 2012). These services are collaborative and include midwives, maternity and child health nurses, GPs, mental health nurses, psychologists and psychiatrists. The structure of these services will vary from jurisdiction to jurisdiction. Most often, perinatal mental health services offer the assessment, diagnosis and treatment of women experiencing significant mental health issues in the preconception, antenatal and postnatal periods, rather than clinical management or counselling. Care coordination is also important, as multiple services may be required to meet the complex needs of the woman, baby, partner and family unit. Other services a health professional may recommend to the woman with perinatal mental health issues include the:

- *Post and Ante Natal Depression Association (PANDA)*, which provides support groups for both women and men experiencing depression and anxiety related to pregnancy, birth and early parenting (www.panda.org.au)
- *Australian Breastfeeding Association*, which provides information and education on perinatal mental health and ill-health (www.breastfeeding.asn.au).

If women at risk of postnatal depression or other issues are identified during pregnancy or as early as possible after birth, and effective psychological and social interventions are provided, then it is possible that the impact may be reduced in severity or prevented altogether.

Older persons mental health services

The most important aspects of providing a health service to older people with mental health issues are discussed in chapter 11. Mental health service delivery for people in this population group is highly specialised, because the older person often has a number of comorbid and chronic issues that add layers of complexity to their care (Heslop et al., 2012). Older persons community mental health teams, older persons mental health inpatient units and older persons mental health residential services all form part of the services provided to older people. Other, more specific initiatives or programs implemented by the states and territories are described in figure 12.4, and provide some insight into the breadth of services that are now provided in this important area.

FIGURE 12.4 Mental health initiatives for older people

Examples of mental health initiatives that have been developed for older people across Australia include the following.

- In NSW, the Department of Health has developed a plan to guide the development of appropriate Specialist Mental Health Services for Older People (SMHSOP) over ten years (Futeran & Draper, 2012; NSW Department of Health, 2008). It is argued that pressure on these specialist services will grow as the population ages and the number of older people with complex mental health problems increases. These services include the establishment of integrated Behavioural Assessment and Intervention Services (BASIS) to provide SMHSOP input to assessment and management of older people with severe, complex behavioural disturbance, in partnership with aged care services; and the establishment of a number of pilot Special Care Units within residential aged care facilities for older people with complex behavioural and psychological symptoms, to be operated by residential aged care providers in partnership with NSW Area Health Services (NSW Department of Health, 2008).

(continued)

FIGURE 12.4 *(continued)*

- In South Australia, the Aged Mental Health Care Services operates a number of different services, including a country liaison service that allows for direct clinical assessments of people in their usual place of residence, video-conferencing based assessments of people, assistance to service providers with formulating management plans, a remote consultation service for service providers, and education for service providers and the community as a whole on topics relating to the mental health issues of older people. This service also seeks to address the lower life expectancy of Aboriginal and Torres Strait Islander peoples, who may be referred from 45 years of age.
- In the NT, *beyondblue* has been working with Council on the Ageing NT to raise awareness of depression among older people in the Territory through the *beyond maturityblues* peer education program.

More generally:

- The Australian government provides a directory of services across Australia for older people. This can be found at www.agedcareaustralia.gov.au.
- Alzheimer's Australia offers a range of support and information services for people diagnosed with dementia, carers, family members and others affected by a diagnosis of dementia, whatever its cause. Alzheimer's Australia also provides information and education for health professionals (www.alzheimers.org.au).

In light of the ageing population in Australia, it is important that health professionals are aware of the variety of services available to assist them in working together to coordinate the delivery of the best possible mental health service to older people.

UPON REFLECTION

The changing face of mental health services

According to eminent psychiatrist Alan Rosen (2006), the effects of competition for limited resources between services that provide direct treatment, care and support, and services that take a more population-based public health approach to prevent mental illness and promote mental health, has meant that neither approach is doing particularly well in Australia. In addition, there has been a recent loss of momentum of mental health reform since the advent of deinstitutionalisation in the 1980s, due to the failure of governments to continue to drive and fund mental health services adequately.

Questions

1. Consider the range and type of services that were available in the 1980s, prior to deinstitutionalisation. Compare them to the range and type of services that are available today. What the main differences and similarities between the services of old and the services of today?
2. What are the benefits and challenges of the changing face of mental health services for consumers, carers, health professionals and health service organisations?

Tertiary health care services

As noted in chapter 1, tertiary sector services are characterised by high specialisation and are most often located in larger service centres. There are many different tertiary-level mental health services available. This section describes two of these:

1. forensic mental health services
2. dual disability services.

Dual diagnosis or comorbidity services are also important, but these have already been described in chapter 10.

Forensic mental health services

forensic mental health mental health services provided to people who are or have been involved with the criminal legal system

Forensic mental health refers to the mental health services provided to people who are, have been, or are at risk of being involved in the criminal legal system in some way and exhibit symptoms of mental ill-health. Forensic mental health is an important and fast-developing area of mental health service delivery in Australia. Reasons for this growth relate to the incidence of mental health issues in the forensic population.

A study undertaken by the AIHW (2010) shows that the forensic population has a higher rate of mental illness and substance abuse than the general population, with rates of the serious mental illnesses such as schizophrenia and depression, three to five times higher in the forensic population than in the general community. This situation has been attributed to a range of factors including a limited access to mental health services in the forensic system; the intolerance of many societies to difficult or disturbing behaviour, leading to high rates of incarceration; and the failure to promote treatment, care and rehabilitation for all populations groups (WHO, 2009).

The commitment by the federal and state/territory governments across Australia to provide systematic mental health assessment and appropriate treatment and ongoing support to the forensic population is timely. Not only will such services assist in enabling equitable health outcomes for this group of people; they may also assist in diverting people from the forensic system to be more appropriately supported by the mental health services (Lee, Crowther, Keating, & Kulkarni, 2012).

Forensic services

A person may be referred to forensic mental health services for assessment by any health professional, the police, courts or corrections personnel. A range and diversity of forensic mental health services currently exist across Australia — in the community, the hospital and the forensic system. These services include assessment of the person's capacity to make a plea in court; assessment of the person's state of mind at the time of the offence; and provision of ongoing treatment to the person. Treatment may be provided in the community, in prison or the person may require hospitalisation in a secure facility, as per the following examples.

- *Court assessment and liaison services*. In these programs, mental health professionals, including allied health workers and mental health nurses, assist the courts by conducting assessments, obtaining information about prior contact with mental health services and by connecting people with a mental illness who are coming before the courts with mental health service providers. There will also be times when written

reports are provided to the referrer and these can include an opinion on fitness to plead.
- *Remand services*. These include the assessment of all people, including adolescents, who have been taken into custody or sentenced.
- *Detainee or prison services*. These services provide tertiary mental health care to alleged offenders, remandees and sentenced prisoners, including mental health assessments of people entering the custodial environment. Health professionals may also provide mental health services to people with mental health issues who are located in the prison system, with mental health professionals working alongside the health services that operate in the prison itself. These services usually involve screening upon entry into the forensic system, ongoing assessment, crisis intervention, acute care or rehabilitation and planning for release.
- *Secure inpatient facilities*. The nature of these facilities is dependent upon the legislation of the state or territory in which they are located. There are stand-alone facilities, facilities co-located with prisons and facilities co-located with major hospitals. One of the major challenges for health professionals working in these facilities is the integration of security with therapeutic approaches (Griffith, Daffern, & Godber, 2013).
- *Community outreach services*. Given that relapses in mental illness can contribute to deterioration and ultimately re-offending, information about an offenders' mental health needs should be shared with parole authorities so that appropriate conditions may be attached to parole to help ensure that offenders receive mental health services when released from custody.
- *Youth services*. These services work with younger people and are similar to early intervention and treatment services described in the first section of this chapter. The earlier a young person at risk is identified and appropriate intervention provided, the greater the likelihood of positive health outcomes.

It is anticipated that the bedding down of these services will assist in lowering the incidence of mental health problems in the forensic system and increasing overall health outcomes.

Dual disability services

Many states and territories provide dual disability services. These services are made available to people who experience symptoms of mental illness and who also have an intellectual disability or developmental delay. **Intellectual disability** is a developmental disorder that is most often experienced by a person from an early age. People with an intellectual disability have great difficulty in learning new things, solving problems, understanding concepts, concentrating, and remembering. This means that they need additional support to learn and live full and contributing lives (Department for Communities and Social Inclusion, 2012; Taua, Hepworth, & Neville, 2012).

intellectual disability a developmental disorder that involves the person experiencing great difficulty in learning new things, solving problems, understanding concepts, concentrating and remembering

According to WHO (2001), there are three criteria for intellectual disability:
- significant limitations in intelligence — that is an intelligence quotient (IQ) of about 70 or less as measured on a standardised intellectual assessment. It should be noted, however, that such tests can be problematic, as people from diverse backgrounds, experiencing a wide range of issues can also have low IQ for reasons other than limitations in intelligence

- significant limitations in the skills needed to live and work in the community — including difficulties with communication, self-care, social skills, safety and self-direction
- limitations in intelligence and living skills that are evident before the person turns 18 years years of age.

All three criteria must be present for a person to be considered to have an intellectual disability (Schalock, 2011; Obi et al., 2011).

Causes of intellectual disability

Quite often, there are no clear reasons for a person's intellectual disability or developmental delay. However, some of the more common causes or reasons are:

- genetic conditions, such as Down syndrome or Rett syndrome
- problems during pregnancy, including infections or exposure to toxins
- problems during birth, such as lack of oxygen
- health problems, such as measles or meningitis
- environmental factors, such as inadequate medical care or exposure to poisons such as lead or mercury.

Identification of a cause or reasons for the disability can be useful, because it helps health professionals to work with the person and their families to more effectively identify the best intervention or way to manage the disability (Department for Communities and Social Inclusion, 2012; Taua, Hepworth, & Neville, 2012).

Intellectual disability or mental illness?

Some people will argue that the difference between mental illness and intellectual disability is quite clear — for example, mental illness is a medical condition with a biological basis, while intellectual disability is a result of problems with the structure or working of the brain. Mental illness can be treated and the symptoms reduced, while intellectual disability is characteristically static and needs to be managed. Recent advances in science at the cellular and genetic level, however, suggest a biological basis for both mental illness and intellectual disability, suggesting the two conditions have more in common than may previously have been thought (Madden et al., 2012).

This commonality reflects some overlap in the challenges for health professionals who work with people with a mental illness and people with intellectual disability. Such challenges include stigma, unemployment, homelessness, reduced capacity to maintain relationships or manage money, and inappropriate behaviours on occasion. There are also commonalities in the broad approaches to addressing these problems, including the provision of psychosocial support, together with educational, vocational and recreational assistance (Taua, Hepworth, & Neville, 2012).

Challenges for service delivery

Perhaps the most significant challenge in relation to service delivery for people with an intellectual disability who also have a mental illness, is determining which issue — for example, challenging behaviour — is a consequence of the person's intellectual disability and which issue is the result of the person's mental illness. Once this determination has been made, the next challenge is to identify the most appropriate referral service.

The different ways in which intellectual disability and mental illness have been viewed in the past have also led to differences in the approaches taken by services providers. For example, one of the principles guiding the development of disability services is 'normalisation'. People with an intellectual disability are encouraged and supported to lead a 'normal' life, with the same choices and opportunities as the larger population. As a consequence, a case manager who works for disability services will assist consumers to access services through the regular channels rather than directly provide these services. Certainly, there are some exceptions to this — for example, accommodation services and behaviour interventions for people with an intellectual disability. Most often, however, the approach taken by those who work for disability services stands in stark contrast to the approach taken by health professionals, who provide direct treatment or therapeutic interventions to people. However, many health professionals presume disability services are the same as health services, when in fact a disability worker is more a broker, enabling the person with a disability to access the services they need.

Impact of dual disability

One of the consequences of these different philosophical underpinnings is that a person with an intellectual disability can sometimes be excluded by health professionals from receiving a mental health service (Department for Communities and Social Inclusion, 2012). Specialist health professionals may have the skills to assess and work with people with a mental illness but not people with an intellectual disability, and vice versa. This can result in mental health professionals sometimes saying, 'This is not our responsibility, the person has an intellectual disability!', while the disability workers will respond with 'But the person has a mental illness; they need help!' This becomes a lose–lose situation for the person with an intellectual disability.

Another unforeseen outcome of the philosophy of normalisation is the assumption of that 'normal' or mainstream health services are able to provide adequate treatment to people with an intellectual disability, when in reality they often require specialist health services. People with a dual disability can present with complex issues; and these issues are often beyond the experience or expertise of the GP or other generalist health professional (Madden et al., 2012). In addition, the divide between health services and disability services means that many health professionals and disability workers have a limited understanding of the other's work. The wise health professional will make it their business to bridge this gap at the individual level, and also encourage managers to develop links and protocols at the organisational level. It is important that people with a dual disability are supported by all to access the most appropriate specialist health services. A collaborative and consultative approach is required between all those involved — including health professionals, disability workers, carers, families and other agencies (Madden et al., 2012).

DisabilityCare Australia

DisabilityCare Australia is the national disability insurance scheme established in 2013 to provide long term, high quality support for the approximately 410 000 Australians who have a permanent disability that significantly affects their communication, mobility, self-care or self-management. The scheme focuses on early intervention; and includes a comprehensive information and referral service, to help people with a disability who need access to mainstream, disability and community supports. DisabilityCare Australia looks beyond immediate need to what is required across a person's lifetime, with particular emphasis placed on giving people choice and control, and encouraging social and economic participation, as well as early intervention.

People with a dual disability are eligible to apply for assistance through the DisabilityCare Australia. This is a significant step forward for this consumer group, who can seek support to develop an individual plan, obtain an individually funded package; and access information about the different supports and services available in the community and from government programs that relate to health, employment and education. Information about DisabilityCare Australia is available on the DisabilityCare Australia website: www.disabilitycareaustralia.gov.au.

UPON REFLECTION

A vicious cycle?

There is a higher incidence of people with mental health issues in the Australian criminal justice system than in the general population.

Questions

1. How could the deinstitutionalisation of people with a mental illness in the 1980s have contributed to this situation?
2. How could this situation have been affected by the limited capacity of community-based mental health services to address the needs of offenders with a mental health problem?
3. How could a lack of mental health services in the forensic system have exacerbated this problem?

SUMMARY

This chapter described the major approaches to mental health service delivery in Australia, as well as the way in which these services are structured. Consideration was given to the differences between primary, secondary and tertiary health services and the different approaches taken by each. A particular focus was the importance of health professionals providing mental health promotion, illness prevention and early intervention strategies in their day-to-day work. It was argued that the primary health care approach to service delivery is one that makes a difference for individuals, families, communities and population groups across Australia. This difference is achieved by raising awareness of how optimal levels of mental health and social and emotional wellbeing can be achieved and sustained.

An understanding of the information provided throughout the text is an important means by which health professionals can work more effectively with mental health consumers, carers, families and friends, communities and particular population groups. Mental illness is one of the most prevalent health issues in Australia today, and it significantly affects the social and emotional wellbeing of the community. To address the effects of mental illness throughout the community, it is important that health professionals work together to support the health reforms that continue to be rolled out in Australia. It is also important that health professionals work closely and collaboratively with all stakeholders to improve access, enable the implementation of early interventions when required, ensure an integrated service delivery, and support pathways to Recovery.

Indeed, the importance of and need to promote Recovery to those who are experiencing symptoms of mental illness is perhaps this text's most important 'take-home message'. Rickwood (2005) identifies the 4As of the promotion of Recovery as:

1. *Awareness* of the mental health status and factors that affect mental health and mental illness, including potential vulnerability to further episodes of illness
2. *Anticipation* or planning for future mental health needs, including self-management, continuity of care, crisis planning and Recovery
3. *Alternatives* such as different services or ways of addressing risk and protective factors for mental illness
4. *Access,* including early, easy and equitable access to services that meet all the changing care needs of people who have been affected by mental illness, including their carers or families.

The information provided in this text supports health professionals to develop awareness; assist with planning for the future; find alternative pathways or interventions when required; and enable access to services for people affected by the symptoms of mental illness. The tools provided in the text will also support health professionals to inspire hope in those with whom they work — hope being the cornerstone of Recovery. Indeed, it is hope that enables a person to act, and continue to act. Hope is the means by which people can grow and develop.

The Recovery journey in mental health is one of healing and transformation. It enables an individual to live a meaningful life in the community and strive to achieve their full potential as a person. It also enables partners, carers or family members to grow and develop as people with strengths, skills and abilities. Health professionals are privileged to share this journey with the consumer — to support and witness their healing and transformation. Health professionals are also privileged to work in collaboration with partners or carers towards a common goal. This text will go some way to supporting the journey — and, in so doing, support the achievement of better health outcomes for all.

Review questions

1. What is the difference between primary care and primary health care?
2. Why do 'early intervention' approaches achieve better outcomes for people with a mental illness?
3. How can 'mental health literacy' be achieved in marginalised population groups, such as Indigenous communities, refugee groups, and people who are unemployed?
4. What are the five risk factors and five protective factors that affect the likelihood of developing a mental health issue?
5. List and describe five early warning signs for mental health conditions.

6. What do you understand by the term 'mental health consultation liaison service'?
7. Describe the range of perinatal mental health services available to women and their families.
8. How can consumers and carers be supported to participate in the planning, implementation and evaluation of mental health services?
9. Name six different types of services that are available to people in the forensic health system.
10. What is the difference between a mental illness and an intellectual disability? How important is this difference?

Discussion and debate

1. Consider the following proverbs in the mental health context.
    - 'A stitch in time saves nine.'
    - 'Better to be safe than sorry.'
    - 'Prevention is better than cure.'

    What does the emphasis upon illness and disease in our current health system say about our commitment to health prevention and promotion? How can we as individuals change this commitment?
2. As a health professional, what can you do to participate in the ongoing education of people from all levels of society and all sectors of health in relation to mental health? What can you do to ensure a continuous flow of information between service providers and community organisations in relation to mental health?
3. There are many different primary health care services available to support those affected by symptoms of mental illness. Discuss the strategies you would use to help a consumer or carer to identify which services would be most helpful for their particular circumstances?
4. The work of any community mental health service is important and complex. Likewise, the work undertaken by community mental health workers is a mix of prevention, promotion, support and maintenance, and highly specialised and ongoing assessment and treatment.
    - (a) Does a community mental health team fall into the primary, secondary or tertiary health category? Upon what evidence do you base your answer?
    - (b) Do you think it matters which category community mental health teams fall into? Why?
5. What is the difference between mental health literacy and psychoeducation? What are some practical tasks you could undertake as a health professional working in any context to provide psychoeducation?
6. Discuss the role of the care coordinator. Why is 'continuity of care' so important?
7. There will be times when a person with a dual disability is admitted to hospital for the treatment of a physical condition. Discuss the management strategies that could be used to support this person should they exhibit behavioural disturbances.

Project activity

As already noted in this chapter, MoodGYM is a primary health care initiative that aims to support the mental health of people in the community. MoodGYM aims to help people to identify and overcome emotions that are a problem for them; and show people how to develop good coping skills for the future so that they can enjoy good mental health.

MoodGYM was developed by psychologists at the Australian National University (ANU) and can be accessed at: https://moodgym.anu.edu.au/welcome. For this project activity, you will need to:

- register for MoodGYM,
- complete ALL MoodGYM modules.

Answer the following questions.

1. How does the MoodGYM program, and other similar online programs, fit with National Standards for Mental Health Services (2010)? Support your answer with evidence from the research literature and relevant government documents.
2. In light of the research literature, what are the benefits and challenges of the MoodGYM program for consumers, carers, families, communities and people from culturally and linguistically diverse cultures? How could these benefits be promoted and the challenges overcome?
3. With reference to your own experience of completing MoodGYM, what are the benefits and challenges of this program? How do you think could these benefits be developed or promoted, and the challenges overcome?
4. In light of the research literature and also your experience of the MoodGYM Program, how could you use online primary health care programs as a tool to support your future practice as a health professional?

Websites

ACSO is a community support organisation which assists some of the most highly disadvantaged members of our community, in particular those with complex presenting issues or offending history: www.acso.org.au

The Children of Parents with a Mental Illness website provides information for family members where a parent has a mental illness and for people who care for and work with them. The organisation also works with the media, researchers, educators, service organisations, consumers, carers and others: www.copmi.net.au

The Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs provides funding and oversees organisations and programs that support people to live in the community: www.fahcsia.gov.au

The Kids Helpline website provides information, games and interactive activities for children, teenagers and parents on mental health issues: www.kidshelp.com.au

Mental Health First Aid (MHFA) provides training and information to people in the community about mental health, mental health issues and ways of supporting family, friends or people in the community with mental health problems: www.mhfa.com.au

The Richmond Fellowship is a not-for-profit organisation that provides support programs, accommodation and hope for people with mental illnesses across Australia. In New South Wales, the Richmond Fellowship advocates community-based assistance and is a leader in providing mental health services. The Richmond Fellowship provides services to support people with chronic mental illness to live independently in the community: www.rfnsw.org.au

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GLOSSARY

A

abscond when a person leaves a health service setting without informing health professionals and against a medical officer’s advice (p. 365)

acopia a label often used to describe someone who has a low level of coping skills or finds it difficult to cope with life’s experiences; usually negative connotation (p. 487)

acute intoxication the altered mental state following intake of a psychoactive substance (p. 439)

acute stress reaction a transient anxiety condition that develops physiologically in response to a traumatic event; usually begins within minutes of the event and disappears after hours or days. (pp. 197, 320)

Addenbrooke’s cognitive examination (ACE) a self-reporting tool for assessing dementia, including the different types of dementia; the tool takes five minutes to complete and test memory (p. 493)

affective disorder a mental health problem that is characterised by a consistent alteration in a person’s mood that impacts on their thoughts, emotions and behaviours (p. 278)

agranulocytosis medically serious condition relating to low levels of white blood cells (p. 407)

ambivalence uncertainty or indecisiveness about an issue or course of action; it can also be described as being in two minds about doing something (p. 463)

analgesic medication or drug that acts to relieve a person’s pain (p. 453)

antenatal the period prior to the birth of a child (p. 301)

anticholinergic an action that inhibits the effects of the neurohormone acetylcholine or inhibits its cholinergic neuroeffects (p. 408)

anxiolytic a treatment or approach that reduces anxiety (p. 282)

assessment a comprehensive evaluation of the health needs and preferences of a person (p. 52)

ataxia difficulty with coordination, leading to people becoming unsteady on their feet (p. 411)

attempted suicide an action that involves a person endeavouring to intentionally cause his or her own death, but death does not result (p. 337)

atypical antipsychotic medications the newer generation of antipsychotic medications that treat psychosis (p. 384)

B

baby blues a transient mood change that occurs about four days after the birth of a baby, and which affects most women (p. 300)

benzodiazepines a class of drugs that has a hypnotic and sedative action; they are used mainly as tranquilisers to control symptoms of anxiety; they are also addictive (p. 319)

biomedical approach the Western, scientific approach to the treatment of illness or disease. The causes of illness are viewed as biological. The health professional’s role is to make a diagnosis, prescribe treatment interventions and achieve measurable outcomes. (p. 5)

biopsychosocial approach an approach to health care provision that addresses the full range of a person’s health needs and preferences (p. 53)

biopsychosocial person-centred approach an approach that understands the person as a biological, social and psychological being, with the person defined in terms of their relationships and interrelationships at the centre of the matrix of care (p. 489)

biopsychosocial understanding an approach that considers the biological, psychological and social dimensions of a person’s experience (p. 485)

boundary the limits of acceptability or appropriateness in a human interaction (p. 263)

burden of disease the overall impact of disease or injury on a society, including that which is beyond the immediate cost of treatment. Burden of disease incorporates individual, societal and economic costs. (pp. 2, 143)

C

cannabinoids chemicals which resemble delta-9-tetrahydrocannabinol (p. 448)

capacity a legal term that is used as a basis to determine that a person has understood the information provided to them, and that the person has made a decision based on their ability to process this information, including the benefits and risks involved (p. 115)

cardiomyopathy deterioration of the myocardium or heart muscle (p. 407)

care coordination an activity undertaken by an advanced practice health professional who manages and coordinates the overall care process of the consumer (p. 544)

carer a person who is affected by symptoms of mental illness by virtue of a close relationship or a caring role with a consumer (p. 534)

carer consultant persons employed to represent the interests of carers and advocate for their needs (p. 543)

cause in health, an agent or event that results in an illness or disorder; the illness or disorder is a direct consequence of the cause (p. 525)

central nervous system the part of the nervous system that consists of the brain and spinal cord. It is one of two major divisions of the nervous system, with the peripheral nervous system lying outside of the brain and spinal cord. (p. 436)

challenging behaviour behaviour of such intensity, frequency or duration that it places the physical, emotional or social safety of one or more of those involved at risk (p. 241)

clinical risk assessment the formal process by which health professionals gauge or estimate risk for a person in relation to factors such as self-harm, self-neglect, violence or aggression, vulnerability, poor adherence to treatment and homelessness (pp. 71, 355)

clinical supervision a formal and ongoing process of giving and receiving professional support through reflective practice (pp. 228, 249)

closed questions questions that require a single-word response, and are useful for eliciting or confirming factual information (p. 289)

cog wheeling muscular tension in limbs that gives way in small jerks when the limb is extended or flexed (p. 409)

cognitive decline deterioration or decline in abilities such as memory, reasoning, judgement, planning, decision making, language and other aspects of mental or intellectual functioning (p. 487)

collectivism a set of beliefs that upholds the group or collective/community as more important than the individual; this includes giving priority to the goals or 'greater good' and identity of the group over those of the individual (p. 171)

common law principles based on the decisions made by judges in individual cases (p. 103)

community managed organisations (CMOs) organisations that provide services to the community and are administered or operated by the community (p. 536)

community mental health teams multidisciplinary teams of health professionals employed by the public health care system to provide services to consumers who live in the community (p. 542)

comorbid relating to a disease, disorder or condition that occurs at the same time as another unrelated disease, disorder or condition (p. 33)

comorbidity the simultaneous presence of two or more health conditions, illnesses or disorders (pp. 431, 498)

competence when a person can speak, understand and comprehend the language used to communicate information to members of a community; satisfactory processing of this information allows a person to perform tasks and duties to an expected level within the community (p. 115)

competency a capability or standard or level of practice comprising knowledge, skills and attitudes that are measured by a set of valid and reliable items (p. 17)

consumer a person who is currently using or has previously used a mental health service (p. 534)

consumer consultant persons employed to represent the interests of consumers and advocate for their needs (p. 543)

consumer-centred care a model of care in which the health professional 'works with' the consumer rather than 'acts upon' the patient; this includes advocating for the consumer and enabling them to become active participants in their treatment and care (p. 25)

contagion suicides the effect whereby one suicide death seems to stimulate other people to likewise suicide; often linked to a series of events or media reports that apparently transmit the message (p. 368)

contract the written or verbal agreement between the consumer and health professional or health service provider that involves both the consumer and health professional or health service provider agreeing to conform to mutually agreed-upon behaviours (p. 264)

cultural awareness the state of awareness reached by a person who examines or reflects upon their own personal value-base and socio-politico-cultural beliefs in relation to the beliefs of different cultures (p. 176)

cultural competence a level of practice that is achieved when health professionals integrate awareness, knowledge and sensitivity (p. 176)

cultural discourse a coherent body of statements or a distinct framework that represents, maintains or develops 'reality' as understood by a particular culture (p. 171)

cultural knowledge understanding of the details of a particular culture, including the structures and accepted practices of that culture (p. 176)

cultural proficiency a stage of practice that follows on from cultural competence. It is achieved by health professionals when they become advanced practitioners as well as life-long learners in the area of culturally appropriate health care. (p. 175)

cultural safety a state of being, practice or environment that is safe for people from all cultures; it is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening (p. 175)

cultural sensitivity being receptive and responsive to cultural differences as a means of developing appropriate interpersonal or therapeutic relationships with people (p. 176)

culturally and linguistically diverse (CALD) a broad concept that refers to the wide range of cultural groups that make up a population or community, and differ according to ethnicity, language, race, religion, social traditions and other factors (p. 167)

culturally appropriate care the care that is provided to a person by a health professional that is consistent with the cultural values of the person who is unwell (p. 156)

culture the accepted patterns of knowledge, beliefs, attitudes and behaviours by which a group of people live (p. 138)

D

D2 antagonist the D2 receptor is a specific type of dopamine receptor in the brain; an antagonist binds to a receptor without activating it (p. 406)

de-escalation the process by which a person's strong feelings or reactions are reduced in intensity (p. 201)

deep breathing exercises a relatively quick relaxation technique in which attention is focused on deep inhalation, holding the breath for a few seconds, exhaling, then repeating the process (p. 316)

defence mechanisms normally unconscious mental processes that can help to reduce potentially negative feelings such as anxiety, shame or fear (p. 245)

deinstitutionalisation the process of dismantling the asylum or mental institution network and rethinking the social position of people with a mental illness (p. 19)

deliberate self-harm (DSH) the intentional injuring of body tissue without suicidal intent (p. 332)

delirium tremens the 'DTs' is a complication of alcohol withdrawal involving perceptual disturbances, confusion, agitation and tremor; not to be mistaken for 'the shakes', which is a milder symptom of withdrawal (p. 443)

dementia a chronic, irreversible, neurological disorder that sees a progressive deterioration in a person's cognitive, mental and physical abilities (p. 494)

depersonalisation a feeling of being able to observe oneself, while not having control over what is happening (p. 317)

depot medication that is given by intramuscular injection and absorbed over a period of weeks (please note zuclopenthixol acetate is a shorter acting depot with its effect peaking at 48–72hrs) (p. 406)

derealisation perceptual disturbance in which the world seems unreal (p. 317)

determinant a factor that operates at the social, community or systems level to affect the likelihood that people will develop a particular health condition (p. 525)

dialectical behavioural therapy a type of cognitive and behavioural therapy used with positive outcomes for people with a borderline personality disorder and self-harming behaviours (p. 367)

differential diagnosis being able to identify which diagnosis, from a number of possible competing diagnoses, is correct (p. 509)

disaster a sudden event, such as an accident or a natural catastrophe, that causes great damage or loss of life (p. 212)

disaster health an interdisciplinary approach to the prevention of, preparedness for, response to, and recovery from the various health issues that arise from a disaster (p. 212)

discrimination the unfair treatment of a person or group of people based on categories such as gender, age, class, relationship, ethnicity, culture, religion, health issue or disability (pp. 12, 149)

distraction techniques a strategy used by a person to temporarily take their attention away from a strong emotion, compulsion or desire; it may involve an activity or refocusing of thoughts onto something else (p. 464)

distress where a person's wellbeing is compromised due to an ability to adapt to acute, severe or prolonged stressors, or multiple and cumulative stressful events (p. 195)

doctrine of necessity allows health professionals to provide non-consenting care to a person in order to save the person's life, to prevent serious deterioration of the person's health, and to minimise ongoing significant pain or distress (p. 115)

dopamine hypothesis a theory that attributes the cause of schizophrenia or psychosis symptoms to excess dopamine transmission in the brain (p. 381)

double stigma the stigma experienced by those who have two or more 'labels' that are viewed negatively by a society; for example, a mental illness and racial minority, or a mental illness and unemployed status (p. 150)

drug and alcohol consultation liaison drug and alcohol health services that are consultative in nature and delivered by specialist drug and alcohol health professionals in a range of generalist practice settings (p. 459)

DSM-5 the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, published by the American Psychiatric Association; its focus is psychiatry or abnormal psychology (p. 80)

duplication similar or identical health services that are provided to or imposed on people with no added benefit for the consumer and reduced efficiency for the health organisation (p. 70)

dysphoria generalised feeling of emotional discomfort (p. 444)

dysthymia mild to moderate depression that occurs for most of the day, more days than not, for at least two years (p. 278)

dystonia symptoms that include prolonged and unintentional muscular contractions of the voluntary or involuntary muscles (p. 392)

E

early intervention strategies that target individuals who are displaying the early signs and symptoms of a health issue (pp. 82, 527)

electrocardiograph (ECG) a graphical representation of readings of electrical activity in the heart (p. 408)

empathy a human quality demonstrated by a person that shows they are able to identify with the thought, feelings or experiences of another person (pp. 63, 261)

empirical data data gathered from observation or experiment, most often related to values that form part of the scientific method (p. 14)

empowerment the process through which people become more able to influence the people and organisations that affect their lives (pp. 13, 153)

epidemiological relating to the study of patterns of disease and treatments in defined populations (p. 280)

ethical decision making a decision based on personal moral, ethical and legal positions that needs to be made between two or more often unfavourable alternatives, in any given circumstance (p. 114)

ethical egoism an ethical theory proposing that people are entitled to make choices and decisions based on their own self-interest, over and above the interest of others (p. 113)

evidence-based practice relates to the health interventions or practices for which systematic research has provided evidence of effectiveness; also known as 'empirically supported treatment' (p. 14)

extra pyramidal side effects (EPSEs) physical symptoms sometimes associated with antipsychotic medications, including tremor, dystonia, slurred speech and akathasia (p. 407)

F

florid positive symptoms positive symptoms of schizophrenia that are pronounced or in their fully developed form (p. 394)

forensic mental health mental health services provided to people who are or have been involved with the criminal legal system (p. 553)

G

gap in health service provision the descriptor often used by health professionals and health services to refer to the absence or lack of services in a particular location or area of health (p. 163)

generic caring learned as part of a person's ongoing growth and development — by way of upbringing, family background and life experiences (p. 15)

Geriatric Depression Scale (GDS) a series of 30 questions requiring a yes/no response that gives a rating of the presence or absence of depression (p. 502)

geriatrician a medical specialist in the physical care of the elderly (p. 493)

globalisation the process by which the world's nations, economies and cultures are becoming increasingly interdependent — a result of technological advancement and improved telecommunications infrastructures, transportation and business networks (p. 138)

grandiosity overvalued sense of self — often related to elevated mood state in bipolar disorder (p. 389)

H

haematological relating to the blood (p. 408)

half-life the time it takes for the body to break down or reduce the plasma concentration of a drug by half (p. 447)

harm minimisation a pragmatic approach taken by health services and health professionals to reduce harm to the individual and the community (p. 435)

harm principle the principle that a person has the right to complete freedom of choices and actions, regardless of what the greater community believes, on the proviso that their actions do not directly harm, infringe or violate the same freedom of choice of others (p. 112)

health care a systematic and comprehensive service that is delivered in the health context; is person-centred, collaborative, supportive; and aims to improve health outcomes (p. 17)

health locus of control the extent to which a person believes that their health is controlled by internal, external or fatalistic factors (p. 215)

health professional a person who delivers competent, appropriate and effective health care in a systematic way (p. 2)

health promotion the process of enabling people to increase control over their health, to improve their health (p. 522)

high changeability a state of being that is demonstrated by a person who is quite ambivalent about suicide or self-harm (p. 360)

homeostasis the tendency in systems, including the human body systems, to maintain the balance, stability or wellbeing of those systems (p. 194)

homogeneous group a group with the same or similar characteristics, preferences, needs and lifestyle (p. 485)

homophobia an individual's or society's misunderstanding, fear, ignorance of, or prejudice against gay, lesbian and/or bisexual people (p. 355)

hypomania a period of elevated mood which has less impact on functioning than mania (pp. 283, 390)

hyponatraemia a blood electrolyte imbalance where levels of nitrogen are low (p. 450)

I

iatrogenic unintended adverse effects of treatment (p. 322)

ICD-10 the *International Statistical Classification of Diseases and Related Health Problems* manual, tenth edition, was developed by the World Health Organization. The ICD-10 encompasses all diseases and related health problems and is not specific to psychiatry or mental illness. (p. 80)

illicit substances substances that have been outlawed by governments but continue to be used illegally by people to achieve certain effects (p. 428)

illness prevention the measures taken to prevent the occurrence of disease, such as risk factor reduction, arresting the progress of disease or reducing the consequences of the diseases once established (p. 522)

impaired cognition a reduced capacity to think and analyse information (p. 439)

incapacity the inability of a person to look after their health, safety or welfare or to manage their affairs due to a cognitive deficit that impairs their decision-making abilities (p. 117)

individualism a set of beliefs or an ideology where the 'self' is the most important consideration; this includes giving priority to one's own goals and one's own self-definition or actualisation over that of the group (p. 171)

informed consent when a person agrees to a recommended course of treatment, a medical or surgical procedure, or participation in a clinical trial, following thorough explanation of the proposed treatment, including actual and potential risks involved, which the person has been able to understand (p. 111)

integrated community services services located in the community that have established links and work in partnership or a coordinated way to improve outcomes for consumers (p. 19)

integrated treatment the synthesis of mental health and substance use treatment interventions for the consumer (p. 432)

intellectual disability a developmental disorder that involves the person experiencing great difficulty in learning new things, solving problems, understanding concepts, concentrating and remembering (p. 554)

internalising a technique used by the health professional to assist the client to see the personal benefits of their changed behaviour; it replaces externalising the reasons for change (p. 472)

interpersonal style mannerisms or approaches used by a person when interacting with others, often stemming from personality and mood (p. 469)

interpersonal therapy (ITP) a time-limited therapeutic approach that aims to improve social adjustment by focusing on interactions that occur in current relationships, and the way a person perceives themselves in those relationships (p. 205)

K

key performance indicators (KPIs) a set of quantifiable measures used by health services to gauge or compare performance in meeting strategic and operational goals (p. 14)

M

mainstreaming the integration of mental health services with general health services (p. 19)

major depressive episode a group of symptoms used to identify depression as a serious clinical mental illness involving profoundly debilitating symptoms, which may include a potential for self-harm or suicide (p. 500)

mania an episode of highly elevated mood which interferes significantly in day-to-day life (pp. 283, 389)

marijuana the least potent form of cannabis; contains the dried flowers and leaves of the cannabis plant; generally smoked by the user (p. 448)

melatonergic agonists pharmaceutical agents which bind to melatonin receptors in the brain, activating them; rarely used in treatment of depression (p. 294)

mental health the capacity of individuals and groups to interact with one another and their environment in ways that promote subjective wellbeing, optimal personal development, and use of their abilities to achieve individual and collective goals (p. 5)

mental health assessment a comprehensive assessment of a person's social, emotional, relational, behavioural, cognitive and functional wellbeing (p. 52)

mental health consultation liaison (CL) mental health services that are consultative in nature and delivered by specialist mental health professionals in a range of health settings (p. 546)

mental health literacy the knowledge and understanding about mental health and illness that assists people to recognise, manage or prevent mental health issues (pp. 222, 532)

mental health problem a mental health issue that is less severe than a mental illness or disorder which, if not dealt with, can develop into a mental illness or disorder (p. 5)

mental health promotion process or actions aimed at maximising mental health and promoting social and emotional wellbeing across entire populations, for groups and individuals (p. 522)

mental illness or disorder the term most commonly used in health care to describe the spectrum of cognitive, emotional and behavioural conditions that interfere with social and emotional wellbeing and the lives and productivity of people (p. 5)

mental illness prevention activities that occur before the initial onset of a mental health issue, aimed at preventing the development of that mental health issue (p. 522)

mental state examination (MSE) a systematic and structured way of observing and describing a person's current levels of mental health (p. 71)

metabolic side effects a collection of symptoms associated with antipsychotic medications that includes weight gain, hyperglycaemia, lipid abnormalities, metabolic syndrome and potentially type 2 diabetes mellitus (p. 407)

metabolic syndrome related to a set of risk factors associated with heart disease and diabetes; symptoms include central obesity, insulin resistance, high blood pressure and high lipids (p. 393)

methadone a synthetic opiate used as a substitute for people who are dependent on or withdrawing from an opiate (p. 452)

microskills in counselling terms, techniques that are used in the counselling situation (e.g. maintaining eye contact and using open-ended questions) (p. 471)

migrant a person who moves from one place, region, or country to another at their own volition (p. 168)

mindfulness a meditation method based on Buddhist principles; the focus is achieving a state of compassionate, non-judgemental awareness in the 'here and now' (p. 297)

mini mental state exam (MMSE) a brief psychological test that enables a health professional to assess a person for and/or differentiate between a dementia, delirium psychosis and affective disorders (p. 493)

monoamine oxidase inhibitors also known as MAOIs; type of antidepressant medications with strict dietary restrictions (p. 294)

moral imperative originally defined by the philosopher Kant, who described a principle of conscience and reason that compels a person to act (p. 15)

morbidity the incidence of ill health or disease (pp. 2, 390)

mortality the incidence of death in a population (pp. 2, 390)

multidisciplinary team a group of health professionals from a variety of disciplines, with different skills or areas of expertise, who work together to provide systematic and comprehensive care and treatment to those in need (p. 3)

multifactorial the term used to describe a state that involves, depends or is controlled by a number of elements or factors (p. 72)

N

National Mental Health Strategy the national long-term approach guiding the development, planning, implementation and delivery of mental health services in Australia, produced and articulated by the Australian government in collaboration with key stakeholders (p. 519)

National Standards for Mental Health Services an Australian government document that describes ten standards for mental health services that must be met by all organisations who provide these services in Australia (p. 520)

National Suicide Prevention Strategy provides the platform for Australia's national policy on suicide prevention with an emphasis on promotion, prevention and early intervention for mental health (p. 335)

negative symptoms psychotic symptoms that seem to be a deficit of ordinary thinking processes — where there is an absence or lack in the person's experience (p. 382)

neuroplasticity the neural pathways and synapses that develop in response to changes in behaviour, environment, physical injury and neural processes (p. 312)

neutropenia low levels of neutrophils — a subtype of white blood cells (p. 407)

nihilistic thoughts negative thoughts that the world or a person's body, mind or self is utterly worthless or does not exist (p. 501)

non-government organisations (NGOs) organisations that provide services to the communities and population groups that are administered or operated by non-government bodies (p. 536)

noradrenaline and specific serotonin antidepressants newer antidepressant medications which increase serotonin and noradrenergic transmission in the synapse (p. 294)

noradrenaline reuptake inhibitors (NaRIs) antidepressants with an action of blocking reuptake of noradrenaline at the synapse (p. 294)

normalising the process of reframing a person's feelings or perceptions of an event or situation so that these feelings or perceptions become more acceptable to that person (p. 197)

norms the beliefs and values held by a social or cultural group about the way in which members of that group should behave (p. 141)

not-for-profit organisations (NPOs) voluntary sector organisations that seek to promote and/or represent the interests of members and also the community (p. 535)

nurse a health professional with a holistic and comprehensive or 'whole of person' approach to health care (p. 4)

nurse practitioner a registered nurse with relevant postgraduate qualifications and extensive experience in a specialty field, who practises autonomously in an advanced and extended role (p. 539)

O

occupational therapist a health professional who supports and enables people to accomplish everyday tasks to achieve a maximum level of independence and safety (p. 3)

one-size-fits-all or universalist approach an approach or intervention that does not take into consideration diversity or difference; rather it demands that the needs of all people are met by a standardised approach or intervention (pp. 16, 162)

open questions questions that require a long explanation as a response (p. 289)

opiate a natural alkaloid found in the resin of the opium poppy (p. 450)

opioid a chemical that works by binding to opioid receptors, which are found principally in the central nervous system, peripheral nervous system and the gastrointestinal tract (p. 450)

oral traditions use of storytelling, song, dance or giving instructions as a means of passing on specific cultural practices and values and beliefs (p. 155)

P

parkinsonian slow rhythmic movements and tremor (p. 411)

paternalism attitudes or actions by people in positions of power (e.g. government, health professional) that subordinates should be controlled for their own good (p. 499)

pathologise the tendency for health professionals to place the ordinary human reactions, responses, thoughts, feelings and behaviours of various stages of life into a biomedical frame, label what is happening as a 'condition', and prescribe treatment (p. 485)

perinatal period generally considered to cover the time from conception to 12 months following childbirth (p. 300)

perpetuating factors the factors that prolong or support the continuation of a behaviour (p. 340)

person-centred care an approach to health care that involves the health professionals being responsive to the individual differences, needs and preferences of the person who is receiving the care (p. 59)

personhood the state or condition of being a person; defined by one's individuality and aspects such as family background, culture, ethnicity, systems of beliefs, sexuality, occupational and recreational activities (p. 53)

pharmacodynamic the physiological action of a drug on the body (p. 405)

pharmacokinetic the absorption, metabolism, distribution and elimination of a drug (p. 405)

physically dependent when signs and symptoms with a physiological basis are experienced or manifested when a person is no longer able to use a substance (p. 436)

polypharmacy the concurrent use of multiple medications by a person; these medications often interact in a way that is problematic for the person (pp. 405, 452)

positive symptoms psychotic symptoms that seem to be excesses or distortions of ordinary thinking processes — where phenomena are added to the person's experience (p. 382)

post-traumatic stress disorder (PTSD) a diagnosed mental health condition characterised by the development of a long-lasting anxiety reaction following a traumatic or catastrophic event (pp. 168, 197, 320)

postnatal the period after the birth of a child (p. 301)

postpartum occurring immediately after birth (p. 301)

postvention activities and strategies undertaken after a suicide death to reduce associated trauma (p. 368)

practice nurse a registered or enrolled nurse (RN or EN) who is employed by a general practitioner (GP) to provide nursing services to people who attend the general practice (p. 540)

precipitating influences the influences or triggers that elicit or provoke a behaviour in the present or 'here and now' (p. 340)

predisposing causes factors that render the person liable or more prone to the behaviour (p. 340)

primary care a subset of primary health care; it is accessible, affordable, and enables people or groups of people to participate individually and/or collectively in the planning and implementation of their health care (p. 23)

primary health care health care that focuses on the multiple determinants of health and the need for community control over health services (p. 22)

prime emotion an emotion in its simplest form. It cannot be divided into more than one particular feeling. (p. 198)

prodrome a symptom, or group of symptoms, that appears shortly before the development of an illness; most often indicates the period before the appearance of the first symptoms of schizophrenia (p. 379)

professional caring caring that is conscious, comprehensive, competent, context specific, and encompasses the physical, psychological, social and spiritual aspects of a person (p. 15)

projection the process in which one person assigns (or projects) their uncomfortable thoughts or feelings onto another person (p. 245)

protective factors factors that decrease the likelihood that an individual or group of people will develop a condition or illness; they are measured in terms of consequence and likelihood (pp. 85, 526)

psychiatrist a medical practitioner who has specialised in the field of psychiatry. Psychiatrists focus largely on the biological causes of illness and prescribing medication. (p. 4)

psychiatry the branch of medicine that specialises in the treatment of mental illness (p. 6)

psychoactive substances substances that act on the brain to alter the way a person feels or thinks or acts (p. 436)

psychoeducation an approach that involves the provision of information to consumers and their carers or significant others regarding signs, symptoms, clinical management, Recovery planning and discharge related to mental health and illness (pp. 292, 543)

psychogeriatrician a medical specialist in mental illness of old age (p. 493)

psychological dependence a strong urge or desire or attachment in relation to a substance based on the feelings aroused by the substance or the social and emotional needs it meets (p. 436)

psychologist a health professional whose focus is the cognitive and behavioural aspects of a person and their health. A clinical psychologist has a higher level of education and expertise in this area of health delivery than a psychologist. (p. 4)

psychometric assessment an assessment that focuses on the educational and psychological measurement of knowledge, abilities, attitudes and personality traits (p. 72)

psychosis a state of being in which a person loses touch with reality and experiences hallucinations, delusions or disorganised thinking (p. 379)

psychotic episode a temporary event in which a person experiences symptoms of psychosis (p. 379)

psychotic symptoms symptoms related to significant alterations to thought and perceptions, including delusions, hallucinations, loss of contact with reality and a deterioration in social functioning (p. 279)

psychotropic medications medication that is prescribed to alter the mental state of a person and to treat mental illness (p. 303)

public health care system universal health care funded and administered by the Commonwealth and state/territory governments in Australia. This system is subsidised by these governments through Medicare and state and territory departments of health, and can be accessed by all Australian citizens or permanent residents. (p. 22)

public health framework the overarching approach to health service delivery in Australia that focuses upon population trends, prevention of illness and promotion of health (p. 22)

R

reaction the immediate or instantaneous feeling, action, movement or tendency within a person that is caused by a stimulus of some kind (p. 194)

Recovery model a consumer-centred model of health care that focuses on hopes and goals for the future, optimism, and living life to the full (p. 26)

refugee a person who leaves the country of their nationality due to a well-founded fear that they will be persecuted for reasons of race, religion, nationality or membership of a particular social or political group (p. 168)

relaxation therapy a range of techniques that induce the relaxation response, such as deep breathing, music and meditation; used for the reduction of stress (p. 316)

repression an unconscious long-term process where feelings are minimised or ignored (p. 200)

resilience the psychological and emotional strengths, assets, stamina and endurance of a person to adapt to changed circumstances (pp. 216, 526)

reversible monoamine oxidase inhibitors a form of MAOI antidepressant without the dietary restrictions usually associated with MAOIs (p. 295)

reward pathway a system of dopamine neurons that reinforce behaviours such as sex, eating and drinking; also implicated in substance dependence (p. 438)

risk factors factors that increase the likelihood that an individual or group of people will develop a condition or illness; they are measured in terms of consequence and likelihood (pp. 85, 526)

rural–urban continuum a measurement of the way particular communities conform to levels of ruralism and urbanism (p. 157)

S

schizoaffective disorder a diagnosis that includes symptoms resembling a mood disorder, together with symptoms of schizophrenia, particularly psychosis and social withdrawal (p. 379)

screening instruments brief measures to help the health professional to identify if a person may require a more thorough assessment (p. 457)

secondary health care health care that is generally accessed after referral by a health professional. Secondary health care is typically delivered through hospitals or other related services funded by state or territory public health services. (p. 24)

selective serotonin reuptake inhibitors also known as SSRIs; non-sedating antidepressant medications which block the reuptake of serotonin at the synapse (p. 294)

self-efficacy a person's belief about their ability or capacity to accomplish a task or achieve a goal (p. 463)

self-soothing the processes or internal resources used by an individual to lower their personal stress and distress level (p. 367)

self-stigma when people with mental health issues view themselves in a negative light, giving rise to low self-worth, feelings of shame and a negative self-image (p. 391)

senile a state where the person may exhibit memory loss or unclear cognitive or mental impairment that is sometimes associated with ageing (p. 486)

sequelae the consequences of a set of circumstances, particular condition or therapeutic intervention (p. 320)

serotonin noradrenaline reuptake inhibitors also knowns as SNRIs; antidepressant medications which increase synaptic levels of serotonin and noradrenaline by blocking reuptake (p. 294)

serotonin transmission serotonin is a neurotransmitter associated with mood, sleep cycle, learning, memory, appetite and muscle contraction; antidepressant medications are the best known medications that modulate serotonin transmission at the synapse (p. 407)

social admission a label often used to describe a patient who has been admitted to hospital to address social needs, rather than a biomedical condition; usually negative in connotation (p. 487)

social determinants of health the social factors that determine the health status of all people. They include early childhood development, disability, education, employment, gender, health services, housing, income, nutrition, social exclusion, social safety networks and race. (p. 145)

social functioning the ability of a person to interact in a group or as part of society (p. 378)

social worker a health professional who intervenes to support those who are socially disadvantaged by providing psychological counselling, guidance and assistance with social services (p. 3)

society a large group of people who are connected by way of proximity, politics, the economy, social status, social networks or some other shared interest (p. 139)

somatic relating to apparent physical symptoms (p. 322)

somatisation the experience of a person who feels, reports, or is preoccupied with physical symptoms that have no biological cause and/or are disproportionate to any actual physical disturbance (p. 32)

somatoform disorder a group of mental health disorders in which people report physical symptoms for which no medical cause is present (p. 315)

splitting where an individual is unable to see that people are complex beings with both positive and negative attributes who may behave differently according to context. Instead, the individual reduces people and behaviours into simplistic and often polarised categories. (p. 246)

staff splitting a defence mechanism that occurs when a consumer idealises a health professional and manipulates them to meet their own needs; this behaviour challenges consistency of care and creates tension in the multidisciplinary team (p. 246)

statute law a law made by parliament (Commonwealth, state or territory); the relevance and enactment of this law is openly debated in the parliament prior to becoming law (p. 103)

stigma an attribute, behaviour or reputation that is perceived, constructed and/or represented by a group of people, society or culture in a negative way (pp. 8, 149)

strategies the actions taken by a particular person after due consideration has been given to the possible and/or actual affects and outcomes of a stimulus (p. 210)

stress the physical, emotional, psychological, social or spiritual reaction that is stimulated in a person in response to a situation, event or condition (p. 194)

stressor any event or circumstance that precipitates a stress reaction in a person (p. 194)

subculture the culture of smaller discrete groups of people, located within larger cultural groups, who share a subset of common attitudes, values, goals and practices (p. 139)

substance material such as alcohol, caffeine, nicotine or other drugs that are used by people to achieve certain effects (p. 424)

substance misuse the use of any substance that does lead to detrimental health effects for example physical ill health or mental health problems; usually occurs in the context of physical and psychological dependence (p. 424)

substance use the use of any substance that does not lead to detrimental health effects (p. 424)

suicidal ideation the thought, ideas or plans of a person about causing his or her own death (p. 332)

suicide the act of a person intentionally causing their own death (p. 332)

suicide clusters a number of suicides that are proximal but not usually simultaneous and grouped by association in a community (p. 368)

suicide risk assessment the formal process by which a health professional gauges or estimates a person's short-term, medium-term and long-term risk for suicide (pp. 71, 355)

suicide survivor someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person (p. 353)

suppression the process by which the person consciously puts feelings aside so he or she can cope with an event (p. 200)

T

tardive dyskinesia symptoms that include repetitive, involuntary, purposeless movements, such as grimacing, tongue protrusion, lip smacking, puckering and pursing of the lips and rapid eye blinking (p. 392)

tertiary health care health care that is delivered by highly specialised health professionals and services, often located in larger service centres (p. 24)

tetracyclic antidepressants less commonly used sedating antidepressant medications (p. 294)

therapeutic alliance the mutual and active collaboration established between a health professional and consumer to bring about change and healing (p. 62)

therapeutic communication the communication techniques utilised by a health professional to engage with a person, build and maintain a relationship, and enable the person to achieve personal change (p. 66)

therapeutic relationship the relationship between the health professional and person that enables change in or for the person (p. 61)

thiamine a vitamin, also called vitamin B1, that is found in yeast, cereal grains, beans, nuts and meat (p. 445)

third-person intervention the practice of using a third person during formal and informal conflict resolution to de-escalate perceived or actual conflict (p. 262)

tolerance when the body adapts to a substance so that increasingly larger doses are required to produce the same effect obtained earlier with smaller doses (p. 436)

transcultural a combining of the elements of, or extending through, more than one culture (p. 167)

transphobia an individual's or society's misunderstanding, fear, ignorance of, or prejudice against transgender people (p. 355)

Transtheoretical Model of Change the clinical name and theory behind the 'Cycle of Change' model, which describes the six stages a person will move through when making change in their life (p. 462)

tricyclic antidepressants also known as TCAs; sedating antidepressant medications that are highly toxic in overdose (p. 293)

trigger a word, comment, event or other experience that produces an immediate or instantaneous feeling or reaction within a person; a trigger is most often linked to a past event or experience (p. 200)

U

unconditional positive regard the positive and accepting attitude that is demonstrated by the health professional towards the person they are helping, regardless of who that person is or what they say or do (p. 61)

universal phenomenon a factor, feature, event, situation or dynamic that is not confined to any particular category, group, culture or population (p. 15)

W

Wernicke's encephalopathy a form of acute brain disorder resulting from a lack of thiamine most commonly occurring in people with chronic alcohol dependence (p. 445)

whole-of-life view of health an understanding of health as a state of wellbeing that is achieved through the balancing of mind, body, emotions, spirit, culture and the environment. It is similar to the 'holistic' approach to health. (p. 145)

withdrawal the objective and subjective symptoms following abrupt cessation or dose reduction of a psychoactive substance after a period of continued use (p. 439)

World Health Organization (WHO) an agency of the United Nations that is an overarching authority on international public health and coordinates international public health initiatives. Its headquarters is in Geneva, Switzerland (pp. 21, 145)

Z

zero tolerance an occupational health and safety principle that proscribes workplace violence. This includes physical and non-physical violence that may result in physical harm or psychological harm. (p. 238)

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