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Introduction to mental health and mental illness: Human connectedness and the collaborative consumer narrative

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Learning objectives

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

- Describe the nature and scope of a narrative approach in mental health nursing.
- Identify and discuss the implications of social determinants of mental health such as social, cultural, biological, environmental, employment/work and societal determinants; determinants of inequity; and evidence and population datasets.
- Explain key concepts such as mental health and mental illness; recovery; consumer participation; human rights; vulnerability; promotion, prevention and early intervention in mental health; collaborative practice in mental health; and practical aspects of human connectedness as a means of engaging with people and communities at risk.
- Make real-world links to concepts such as incidence and prevalence; mortality and morbidity; life expectancy; quality adjusted life years; international classification of functioning, disability and health; and potential years of life lost due to mental illness.
- Discuss issues related to the everyday experiences of consumers and carers, including enablers and barriers to meaningful engagement between clinicians and consumers, carers and family members.

Introduction

This chapter reflects a coming together of key issues and themes embedded in everyday

consumer

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

carer

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

work with **consumers** and **carers**. Carers include immediate family and friends, and may also include extended family such as grandparents and cousins. In transcultural and other contexts it is important to use humanistic language in line with a recovery approach; for example, the terms ‘support person/people’ and ‘support networks’ may be preferable to the term ‘carer’ in mental health practice and mental health nursing. This approach provides a foundation for human connectedness, and sets the consumer narrative as central to mental health practice and mental health nursing, specifically.

Consumer narrative — Michael's story

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

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

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

A narrative approach to mental health

The story of Michael – and many others contained within this book – is central to both the narrative and person-centred approach taken in each chapter. A person-centred approach is concerned with human connectedness: the capacity for feelings to be received and understood, and lives to be revealed. A narrative approach illuminates the needs of the person with a mental health condition, her or his family, carers and clinician through an interactive process of dialogue and information exchange. At a deeper level, narrative is a means of storytelling.

Storytelling is a profoundly human capacity. Meaning is accomplished through an interaction between the teller and the listener. The listener enters into the world of narrator, constructs and helps in the telling of the story; thus, a narrative is jointly accomplished, according to shared knowledge and interaction (Michel & Valach, 2011). Such activity is central to the practice of mental health nursing. This is because the discourse itself involves stories that together become a joint action.

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

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

This task can be made more productive through the use of reflective questions and thinking about opportunities for translation to practice.

Defining mental health and mental illness

Mental health

Mental health is the ability to cope with and bounce back from adversity, to solve problems in everyday life, manage when things are difficult and cope with everyday stressors. Good mental health is made possible by a supportive social, friendship and family environment, work–life balance, physical health and, in many instances, reduced stress and trauma.

Mental illness

Mental illness is a clinically diagnosable condition that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2012) or the International Classification of Diseases (ICD; World Health Organization (WHO), 2013a). Mental illness affects men, women and children of all ages, nationalities and socio-economic backgrounds, and affects the lives of many people in our community, their families and friends. The experience of mental illness is common, with the most recent national data indicating that 45 per cent of adults (aged 16 years and older) in Australia and 40 per cent in New Zealand have experienced a mental illness at some point in their lives (Australian Bureau of Statistics (ABS), 2007; Oakley Browne, Well & Scott, 2006). Moreover, approximately one in five adults in Australia and New Zealand experience a mental illness each year (ABS, 2007; Oakley Browne et al., 2006). In both Australia and New Zealand, mental illness more commonly influences young people, with prevalence of mental illness typically being highest for those individuals aged between 16 and 24 years. This includes the experience of anxiety and depression, conditions associated with substance misuse and longer-term conditions such as anxiety, chronic and recurrent depression and schizophrenia. Comorbidity (the experience of more than one condition/disease by an individual) is quite high. For example, of those individuals in New Zealand who experience an illness over 12 months, 37 per cent experience more than one (Oakley Browne et al., 2006). The most likely co-occurrence is of anxiety and mood conditions (Oakley Browne et al., 2006). In both countries, women are more likely to experience mental illness than men, and this is largely accounted for by the higher incidence of anxiety conditions among women (ABS, 2007; Oakley Browne et al., 2006). Despite the relatively high prevalence of mental illness among Australian and New Zealand adults, approximately two-thirds of people with a 12-month or longer mental health condition do not receive treatment for their mental illness (ABS, 2007; Oakley Browne, et al., 2006).

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

Anxiety conditions

Anxiety conditions generally involve feelings of tension, distress or worry. This can include diagnoses of panic, agoraphobia, social phobia, specific phobia, generalised anxiety, obsessive-compulsive conditions and post-traumatic stress. Anxiety is the most common type of mental health condition in Australia and New Zealand, affecting 14 per cent and 15 per cent of people aged 16–85 years, respectively (ABS, 2007; Oakley Browne et al., 2006). In both countries, women are more likely to have experienced anxiety than men (18 per cent compared to 11 per cent in Australia, and 19 per cent compared to 11 per cent in New Zealand; ABS, 2007; Oakley Browne et al., 2006). These conditions are most commonly experienced by women aged 16–54 years in Australia (21 per cent; ABS, 2007) and women aged 16–24 years and 25–44 years in New Zealand (18 per cent each; Oakley Browne et al., 2006).

Affective conditions

Affective or mood conditions involve a disturbance in mood or a change in affect, and diagnoses include major depressive condition, dysthymia and bipolar affective illness. Depression involves signs such as a depressed mood, low self-esteem and reduced energy or activity over a period of at least two weeks. Bipolar illness involves episodes of mania, either alone or with depressive episodes. Manic episodes may be characterised by reduced need for sleep, increased activity or restlessness and disinhibited behaviour. Affective illnesses are experienced by 6.2 per cent of Australians aged 16–85 years, with a slightly higher prevalence in women (7.1 per cent) than men (5.3 per cent; ABS, 2007). Similarly, these conditions are more common among females (9.5 per cent) than males (6.3 per cent) in New Zealand, and are most prevalent in the 16–24-year age bracket (12.7 per cent; Oakley Browne et al., 2006).

Substance misuse

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

Similarly, in New Zealand, these conditions account for 2 per cent of the female and 5 per cent of the male population, and are most common in the 16–24-year age bracket (9.6 per cent; Oakley Browne et al., 2006).

Contemporary approaches

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

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

Mental illness and social determinants

The social determinants of health are the circumstances in which people are born, grow up, live and work, and the systems that are in place to deal with illness (Commission on Social Determinants of Health, 2008). These circumstances are all shaped by wider societal factors, and by the social and economic conditions in which people live. Mental health promotion is therefore not only the responsibility of the health care sector, but also of many other sectors such as housing, education and employment (Keleher & Armstrong, 2005).

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

Individual: These include an ability to manage feelings, thoughts and life in general, emotional resilience and an ability to deal with stress.

Community: These include social supports, and having a good sense of belonging and an opportunity to actively participate in your community. For some people with strong cultural affiliations, understanding and responding to a mental health condition are

largely guided and derived from self-identity through community affiliation and cultural belonging.

Organisations: These include factors such as safe housing, employment options and educational opportunities, access to good transport and a political system that enhances mental health.

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

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

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

Mental illness and life expectancy

Life expectancy from birth of people with serious mental illnesses is between eight and 14.7 years less in men and between 9.8 and 17.5 years less among women than in the general population. In both groups, schizophrenia has been associated with the greatest reduction in life expectancy (Parish, 2011). A recent Australian survey of people living with psychotic illness ($n = 1825$) (of whom just under 50 per cent had a diagnosis of schizophrenia) found that in the previous month 33 per cent did not have breakfast on any day of the week (Morgan et al., 2011). In the same survey, 41.5 per cent ate only one serving or less of vegetables a day, and 7.1 per cent did not eat any vegetables at all (Morgan et al., 2011).

Since nutrition is inextricably linked to physical health, it is not surprising that the major cause of death for people with a diagnosed serious mental illness is not suicide, as many believe, but cardiovascular diseases. While mental health clinicians are well practised at assessing the risk of self-harm, they are less familiar with assessing the risk of cardiovascular disease. Given that people with a serious mental illness are more likely to be inactive, obese and smoke, compared to the general population, it can be seen that incidents of metabolic syndrome are more common in this population group (Parish, 2011). It must be noted that, collectively, the effects of second-generation anti-psychotic medications, inactivity, overweight and obesity are also the results of psychotropic medication. In this circumstance, poor physical health is associated with the combined elements of the mental health condition as well treatment by psychotropic medication (Saha, Chant & McGrath, 2007).

The largest proportion of non-communicable disease deaths for people diagnosed with a mental illness is caused by cardiovascular diseases (48 per cent), followed by cancers, chronic respiratory diseases and diabetes, which alone are directly responsible for 3.5 per cent of deaths. Behavioural risk factors, including tobacco use, harmful use of alcohol, physical inactivity and an unhealthy diet, are estimated to be responsible for about 80 per cent of coronary heart disease and cerebrovascular disease. Behavioural risk factors are associated with four key metabolic changes: hypertension, obesity, hyperglycaemia and hyperlipidaemia (WHO, 2012). The prevalence of metabolic syndrome in people with a diagnosis of schizophrenia is approximately three times higher than in the general population (De Hert et al., 2009).

The combined and cumulative nature of diet, lifestyle and treatment factors have substantial effects on both quality of life and life expectancy. A recent systematic review covering studies from 25 countries concluded that people with schizophrenia have a standardised mortality ratio for all-cause mortality of 2.58 (Saha et al., 2007). Also important is the knowledge that the physical health care needs of people with a mental illness are often neglected by health care workers, due to stigma. Often, physical complaints are disregarded by clinicians who label the consumer as anxious or somatically focused. Given the vast amount of evidence that people with a mental illness are more likely to suffer poor cardio-metabolic health, clinicians need to listen carefully to the needs of consumers and act to reduce the incidence of cardiovascular disease.

Mental health clinicians work at the intersection of mental and physical health, and have a vital role to play in lifting standards of physical care. Mental health clinicians have an important role in monitoring how medications affect consumers, and their physical health needs. Psychotropic and other forms of medication can cause or at least contribute towards – adverse physical health effects, including premature disability and death. There is tremendous scope to improve the quality of physical care for people with a severe mental illness by having a more direct role, such as assessing physical symptoms, liaising with medical practitioners and specialists, and providing physical health advice on important issues such as diet, exercise and sleep.

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

Mental illness and substance misuse

In situations in which mental illness is a factor, there is an emerging picture worldwide suggesting that illicit substance involvement is on the rise (WHO, 2013b). The breakdown of traditional, community based structures such as clubs and

societies – which promote a sense of belonging, peer support and valued community involvement – is thought to be linked to boredom among young people and increased exposure to substances such as cannabis, amphetamines and methamphetamine. The co-occurrence of a mental health condition and a substance misuse condition, commonly referred to as ‘comorbidity’ or ‘dual diagnosis’, is widespread and complex. It is well established that drug and alcohol misuse is commonly experienced by people with a mental health condition. According to the Australian National Mental Health and Wellbeing Survey (ABS, 2007) 63 per cent of Australians who reported that they misused drugs nearly every day within the previous 12 months had also experienced a mental health condition in the previous 12 months.

Comorbid mental health and alcohol and other drug conditions are more likely to be experienced by young people of refugee background when compared to their Australian-born peers. While it has been established that significant barriers to service engagement and service provision exist for young people of refugee background with one condition, the risk may be higher for those experiencing comorbidity, as they not only face cultural and linguistic barriers, disrupted or fragmented cultural affiliations, but are also often required to navigate two different service sectors (Posselt et al., 2013).

Mental illness and homelessness

Also significant is the prevalence of mental illness among homeless people – thought to be four to five times higher than within the Australian general population. These background factors are often closely associated with a lack of supportive accommodation options available for people with mental health conditions, the transfer of people with unstable mental health conditions to community settings, the episodic nature of mental illness and uncontrolled use of, and access to, illicit stimulants (Schizophrenia Fellowship of NSW Inc., 2008).

Mental illness and violence/aggression

A recent review of the literature examining crime and violence in people with schizophrenia, with and without comorbid substance-use conditions, concluded that increased risk of violent offending in schizophrenia cannot be solely attributed to the effects of comorbid substance misuse, although comorbidity certainly heightens the likelihood of criminality (Short et al., 2013). In addition to offending, people with schizophrenia are more likely than community controls to come to the attention of police through their involvement in family violence incidents. Having a diagnosis of schizophrenia is claimed to be a particularly strong risk factor for violence in females, yet this finding is not conclusive. This situation is made more difficult when we take into account two intersecting and interrelated issues. First, the notion that people with severe mental illness experience significantly more problems in interpersonal relationships, and that family members may often be the targets of violent behaviour (Short et al., 2013). Second, the considerable and continuing stigma and prejudice associated with mental illness in the wider community (Pescosolido, 2013).

Mental illness and risk

Some people are more vulnerable and at higher risk of developing a mental illness than others. The factors that may contribute to a person's risk include trauma and abuse, social isolation, homelessness, socio-economic disadvantage, physical or intellectual disability and genetic predisposition. Harmful use of alcohol and other drugs can significantly increase the occurrence of mental illness. We also know that Aboriginal, Torres Strait Islander and Māori people are more vulnerable to developing a mental illness secondary to intergenerational trauma suffered during European settlement and colonisation (Council of Australian Governments (COAG), 2012; Stewart-Harawira, 2005). Some people with mental illness experience disadvantage such as lowered educational achievement, lack of social connectedness, poverty, poor physical health and reduced life expectancy. These disadvantages may influence whether someone with a mental health condition is able to access the help needed. It is up to clinicians to be aware of these risk factors and how they affect the lives of people with mental illness.

The first signs of mental illness may emerge in childhood, adolescence or early adulthood. Young people at risk of developing a mental illness may be those who have been bullied at school, children of parents with a mental illness, children linked with the criminal justice system, refugees and children brought up in a traumatic environment. These children or young people at risk may already be linked to services offering counselling, or may be part of a youth group. It is therefore important for the wider community, across cultures and across the lifespan, to be able to identify and respond to people in mental distress in order to offer support early and reduce the risk of the person's situation becoming worse and more distressing (COAG, 2012).

Reflective questions

Imagine you are working with a woman who is concerned about her 15-year-old son who is experiencing sadness, irritability, loneliness and withdrawal from others around him. She is seeking information and guidance. Consider the following questions:

- What issues related to this young man's situation would you want to learn more about, and how would you approach this scenario with the young person?
- Why might it be important to focus on his distress and his experience of feeling the way he does?

Mental illness and stigma

Stigma and discrimination are factors that can affect a person's ability to seek help for mental illness. In general, the public – including some health professionals – perceives people who experience mental illness as difficult, dangerous and unpredictable, and those with chronic mental health conditions such as schizophrenia are the most feared (Mental Health Council of Australia, 2011). This perception can result in perpetual discrimination and stigma (Reavley & Jorm, 2011). Stigma can be defined as a spoiled identity that