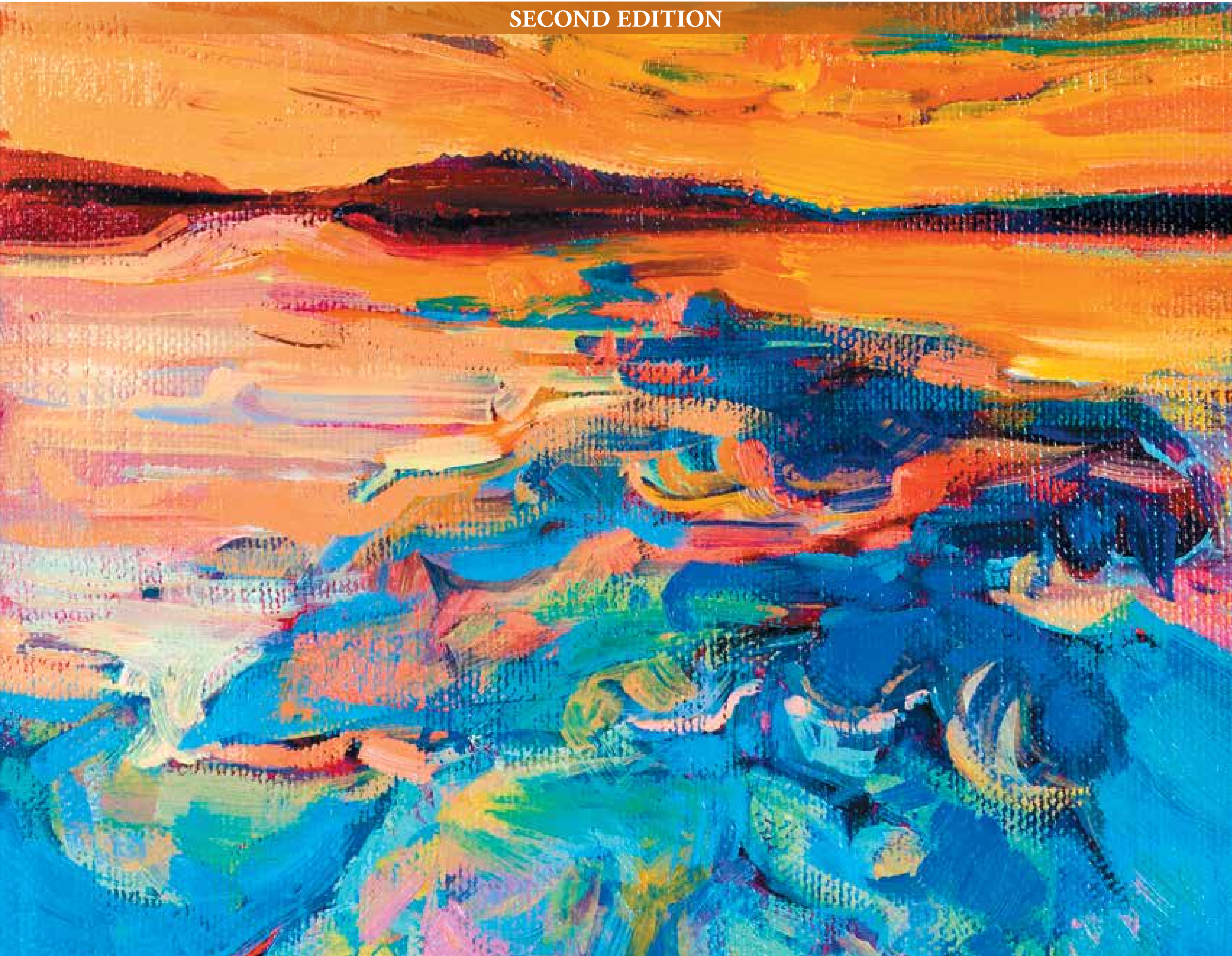
Mental Health Care

An Introduction for Health Professionals in Australia

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

SECOND EDITION



WILEY

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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.

Due acknowledgement must also be extended to the following publishing team at John Wiley & Sons for their assistance in the development of this textbook and its associated resources: Terry Burkitt (Publishing Editor), Kylie Challenor (Managing Content Editor), Emma Knight (Senior Publishing Assistant), Tara Seeto (Publishing Assistant), Beth Klan (Editorial Assistant), Christine Ko (Copyright and Image Researcher), Delia Sala (Graphic Designer) and Jo Hawthorne (External Composition Coordinator).

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Catherine Hungerford
Donna Hodgson
Michael Monisse-Redman
Richard Bostwick
July 2014

ABOUT THE AUTHORS

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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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TEXT

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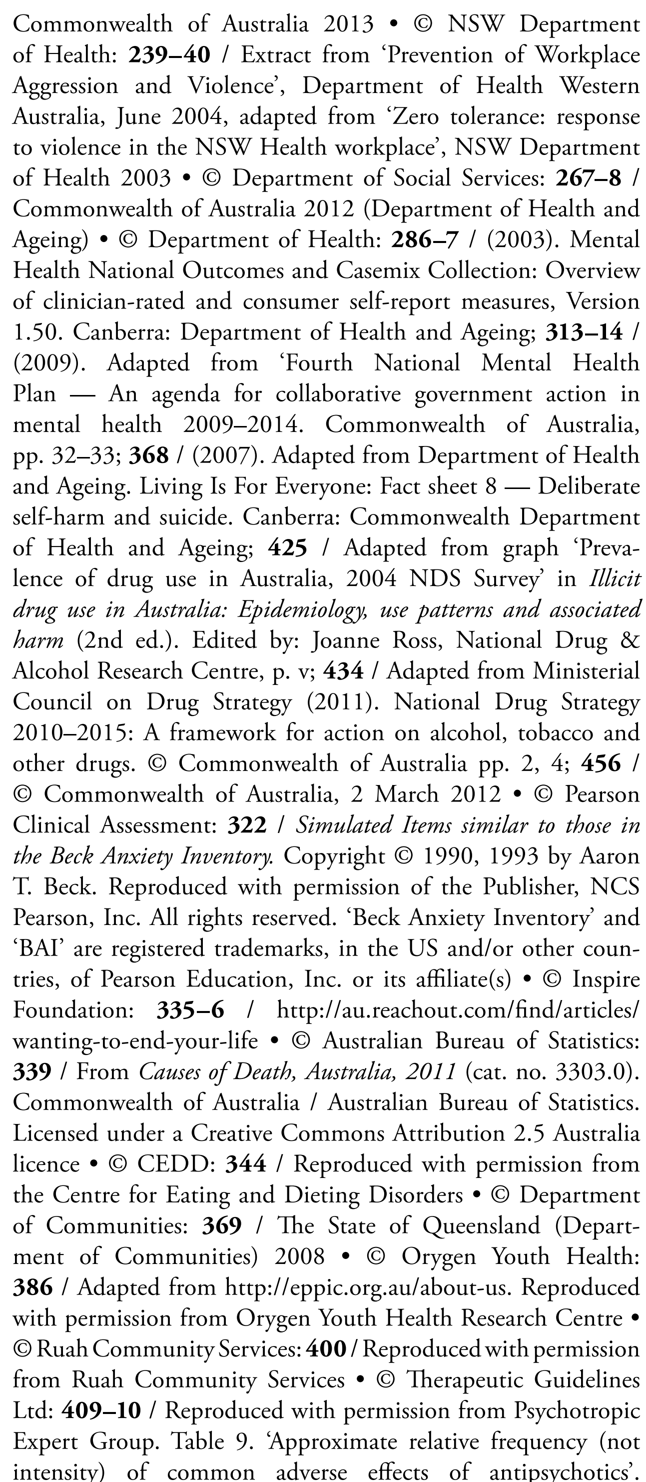

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Reproduced with permission from Orygen Youth Health Research Centre • © Ruah Community Services: **400** / Reproduced with permission from Ruah Community Services • © Therapeutic Guidelines Ltd: **409–10** / Reproduced with permission from Psychotropic Expert Group. Table 9. 'Approximate relative frequency (not intensity) of common adverse effects of antipsychotics'. In: *Therapeutic guidelines: psychotropic*. Version 7. Melbourne: Therapeutic Guidelines Limited, 2008, p.32 • © Drug and Alcohol Office WA: **433** / © 2006–14 Government of Western Australia / Drug and Alcohol Office • © Thomas Babor: **458** / 'Examples of substance screening tools', adapted from Babor et al., 2007, 'Screening, brief intervention and referral to treatment (SBIRT): toward a public health approach to the management of substance abuse', *Substance Abuse* • © Richard Clancy: **465** / Adapted from Clancy R, Terry M. 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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.

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.

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

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.

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.

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.

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

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

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

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

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.

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

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

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.