Mental Health in Nursing

Theory and Practice for Clinical Settings

6th Edition

Kim Foster
Peta Marks
Anthony O'Brien
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CONTENTS

Foreword, vi
About the authors, viii
Contributors, ix
Reviewers, xi
Introduction, xii

PART 1: Positioning Practice

1 **Why Mental Health Matters**, 3
Anthony J. O'Brien, Peta Marks, Kim Foster and John Hurley

2 **Nursing and Mental Health in Context**, 14
Kim Foster, Peta Marks, Anthony J. O'Brien and John Hurley

3 **The Mental Health and Illness Continuum**, 29
John Hurley, Peta Marks, Kim Foster and Anthony J. O'Brien

4 **Safety in Care, Safety at Work**, 39
Scott Brunero and Scott Lamont

5 **Working with Families in Mental Health**, 55
Sophie Isobel and Chantel Jurcevic

6 **Aboriginal and Torres Strait Islander Mental Health**, 71
Matthew Scott, Monica Guha and Luke Molloy

7 **Kua Takoto Te Manuka**, 85
Andrea E. Donaldson and Bryce Taiata Samuel

8 **Professional Self-Care**, 99
Julie Sharrock

PART 2: Knowledge for Practice

9 **Mental Health Assessment**, 117
Graham Holman and Michelle Cameron

10 **Legal and Ethical Issues**, 137
Anthony J. O'Brien

11 **Anxiety**, 156
Anna Elders

12 **Mood Disorders**, 173
Greg Clark and Sophie Temmhoff

13 **Substance Use and Co-occurring Mental Health Disorders**, 184
Megan McKechnie

14 **Psychosis and Schizophrenia**, 211
Catherine Daniel and Elizabeth Currie

15 **Eating Disorders**, 228
Peta Marks and Bridget Mulvey

16 **Personality Disorders**, 249
Katrina Campbell and Marika Van Ooyen

17 **Mental Health in Childhood and Adolescence**, 264
Lucie Ramjan and Greg Clark

18 **Mental Health in Older Age**, 281
Jim Xu and Kerry Capelin

19 **Autism Spectrum Disorder and Intellectual Disability**, 297
Andrew Cashin

20 **Physical Health in the Context of Mental Health**, 308
Andrew Watkins and Patrick Gould

21 **Psychopharmacology**, 323
Richard Lakeman and Irene Ngune

PART 3: Contexts of Practice

22 **Mental Health in Every Setting**, 347
Peta Marks

23 **Preparing for Mental Health Clinical Placement**, 352
Stephen Van Vorst and Nicole Graham

24 **Primary Care and Community**, 359
Elizabeth Halcomb, Elissa-Kate Jay and Taylor Yousiph

25 **Emergency Care**, 367
Justin Chia

26 **Generalist In-Patient Settings**, 373
Catherine Daniel and Cynthia Delgado

27 **Care of Older Adults**, 380
Sharon Rydon and Jane Ferreira

28 **Perinatal and Infant Mental Health**, 389
Julie Ferguson

29 **Forensic Mental Health Nursing**, 397
Tessa Maguire and Brian McKenna

Index, 406

FOREWORD

Mental Health Nursing: Theory and practice for clinical settings, 6th edition, is a text with welcome differences because it draws upon the narratives of people with lived experience of mental health issues who have been under the care and treatment of nurses. It also, bravely, brings into the open lived experience narratives of nurses who themselves have experienced trauma and mental health issues. Because of this, and because of the focus placed on recovery and the humane treatment of people who have experienced trauma and psychological distress, it is an honour to write the foreword for this text. In doing so, I hope to enthuse students and nurses to consider the important role they play in the lives of each person they treat, care for, support and work with. Whether the care is offered in primary, community, in-patient or other clinical settings, the impact of nurses with lived experience on people can have lasting positive (or detrimental) effects on their lives, their sense of self, recovery and subsequent outcomes.

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

My career in mental health has had wide dimensions. I have been a lived experience volunteer, peer worker, manager of peer workers and a director of a large public mental health service. I founded Vision in Mind, a national systemic advocacy, consultancy and training body. I was the inaugural Deputy Commissioner with the NSW Mental Health Commission and an executive member of a large specialist community-managed organisation. For years I have written policies, issues papers, strategic plans, guidelines and protocols, and have always undertaken these utilising co-design practices. I am also a person with lived experience of trauma and subsequent mental health issues. Through all these experiences I have had the personal and professional honour of working with great mental health nurses who work from a strong human rights base and use strengths-based language, and who practise empathy and holistic care with each person. Nurses working in this way regard people with mental health issues as individuals, not as a diagnosis or as a constellation of problematic behaviours. They do not pathologise the human experience. High-quality mental health services and nurses work in respectful, multidisciplinary teams, including all clinical staff and peer workers. The individual needs of each person in their care are central to everything good nurses do and they respect the lived experience mantra of "Nothing about me, without me". The power dynamic is recognised and smoothed out, providing a respectful, holistic and therapeutic alliance with the people they care for and, where appropriate, with their family.

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

I have had the great honour of speaking at conferences and workshops for the ANZ Nurses and Midwives Association over a number of years. The focus over the past 12 months has been on the mental health and wellbeing of nursing staff. One strategy I encourage nurses to embrace is to change the victimhood narratives they may have fallen into – where nurses feel like they are victims of underfunding, unrealistic expectations, understaffing, bullying and intimidation from colleagues (including other nurses, registrar, doctors and executive decision-makers), as well as experiencing trauma during "take downs" and incidents of seclusion and restraint.

As a person who has experienced a great deal of trauma and powerful feelings of victimhood, I know the value of changing your worldview and personal narrative away from being a victim, and into claiming your agency and leadership. Not focusing on what has happened and what you can't do, but rather focusing on your strengths and capabilities and what you can do; what you can impact; what you can change. I ask you to imagine yourself as a leader, each nurse engaging with the feeling of being a leader rather than a victim; to cultivate narratives that leaders use in self-talk, to own these narratives for yourself and to approach problem-solving from the perspective and demeanour of a leader to create the changes you know are needed for all stakeholders, especially the people you care for and colleagues. Don't leave this important work up to a handful of people; Everyone needs to claim their leadership and go forward in hope and strength and create the light at the end of the tunnel.

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

Until recently, the interconnection between mental and physical health was generally ignored. Doctors and nurses could often be dismissive of consumers' concerns about their physical health and attribute symptoms to "paranoia", "being all in their mind", "hypochondria" or "just attention seeking". Discrimination has led to the physical health needs of people with mental health conditions being seen as less important than their mental health, than other people's physical health, and the community's discomfort about "the behaviour" of the person. Also, the negative impact of mental distress and pharmaceutical treatment on a person's health was underestimated and downplayed. Clinicians often point to a person's life choices, such as diet, lack of exercise, drugs, cigarettes and alcohol use, as being the causes of their physical health issues. However, ethical clinical treatment is transparent about the unwanted effects of prescribed psychiatric medications on people's short- and long-term health. Ethical clinical treatment is also transparent about the risks that electroconvulsive therapy (ECT) may have on people's memory and physical health. To achieve holistic care, preserving memory and the physical health of people with mental health issues must also be seen as a priority in all services, including acute, stepped, community and primary healthcare settings. Ethical practices ensure that people know what their treatment involves and

the possible unwanted side effects of medication, which often includes obesity, metabolic syndrome and a major gap in life expectancy. Physical illness that is untreated, or inadequately treated, increases the burden of disease on the community and on individuals, and diminishes the speed and likelihood of recovery, and increases the gap in life expectancy. The relationship between personal and family trauma, social dynamics and environmental impacts on mental and physical health are being increasingly understood.

This text outlines a social and ecological approach that integrates the various influences on mental health from biological through to environmental and social. Valuable nurses recognise that the causes of mental health issues include external factors and rarely lie solely within the individual. Childhood and adult abuse, harsh environments, the impact of global warming (fire, floods, drought, earthquakes and destruction of nature), neglect and intergenerational trauma, including the destruction of family and communities through war, stolen lands, stolen children, sexual abuse and poverty, all contrive to undermine people's lives and wellbeing.

Epidemiological studies show that mental health and addiction issues affect up to 50% of people in their lifetime. It would seem obvious by this figure that mental health issues can no longer be seen as "crazy", disordered or abnormal, but rather on the spectrum of normal responses to trauma, abuse, neglect and harsh living conditions.

As this text points out, the World Health Organization recommends that mental health care be based in primary care. While this trend is increasing in Australia and New Zealand, a large percentage of clinical and acute treatment takes place in psychiatric wards. Throughout my career I have worked in and attended mental health settings across Australia, New Zealand and internationally, amid diverse cultures with varying degrees of wealth and poverty. Some services have been exciting, empathic environments exuding hope and healing, even when resources have been scarce and the facilities poor. Sadly, my excitement has often been overwhelmed by shame, anger and painful questioning as to why all clinical and community mental health services are not holistic, therapeutic, trauma-informed and person-centred/person-led environments.

I have consulted multiple stakeholders about the reasons for the variations in service quality and outcomes. While mental health certainly needs more funding and resources, contrary to popular narratives, I believe the variants do not relate to resources and finances; rather, they are based in individual nurse and clinician attitudes and the collective culture of the services. This can be evidenced by comparisons between services within the same states of Australia. State public services are working under the same funding models and the same policies and protocols, yet vary dramatically in culture and outcomes. Interactions between nurses, clinical staff and the people they care for are either empathic, hopeful and respectful cultures engaged in respectful multidisciplinary teams producing outcomes desired by the people accessing the service and staff, or that of a culture with inequitable power dynamics, in which nurses and clinicians primarily pathologise the human experience and see people as the diagnosis, disorder or "problem behaviour". The latter culture produces detrimental outcomes, including higher instances of seclusion, restraint and suicide, with people feeling further marginalised and traumatised by the so-called "trauma-informed treatment and care" they receive. Such detrimental cultures are also often characterised by workplace bullying, increased staff trauma and burnout.

This text speaks to the importance of respect, care and wellbeing for all stakeholders. As previously mentioned, *Mental Health Nursing: Theory and practice for clinical settings* takes the brave and wonderful step of including not only the voices of people accessing services with lived experience, but also nurses' stories of their own lived experience. This deserves to be applauded. While the practices of nursing and mental health peer work are very different, nurses with lived experience have a positive impact on service culture and outcomes. Nurses and clinical staff with lived experience are valued and celebrated in this text, as they should be in all workplaces. The stigma and discrimination shown against people with mental health issues has, in the past, driven nurses to hide their lived experience. This, coupled with workplace bullying and incidents of seclusion, restraint and enforced treatment, leads to trauma for both people being "treated" and staff, and burnout among good nurses. Cultures such as these intimidate good staff and breed fear in people who need to access mental health services. People often turn to alcohol and drugs to self-medicate and to self-harm or suicide rather than return to a service where they feel unsafe, traumatised and humiliated.

Australia and New Zealand are signatories to the United Nations' declarations and conventions on human and disability rights. Nurses who focus on human rights and the innate value and needs of each person build healing, trusting relationships and workplaces for all stakeholders. Coercion, bullying, seclusion and restraint are non-existent or rare in services that are focused on respectful interactions. Nurses working in this culture see incidents of seclusion and restraint as failures of the service, rather than the fault of the person in distress. While this text points out that current laws allow for seclusion and restraint in New Zealand and Australia, it also speaks to the need for these practices to be used as a last resort. However, lived experience advocates declare restrictive practices as abuses against human rights. I hope you will permit me to challenge all nurses to work as if seclusion and restraint were illegal and to consider alternative protocols to meet individual needs, such as the support of peer workers. Peer workers use mutual experiences to connect with people and provide a calming and hope-filled influence that can lead to a positive shift in the power dynamic between the multidisciplinary team and the people they care for.

The editors of this edition of *Mental Health Nursing: Theory and practice for clinical settings* have engaged chapter authors who focus on the particular aspects of ethical nursing practice. They have used vignettes written from different perspectives and consulted people with lived experience, peer workers, family/carers, clinicians and academics. The use of "Critical thinking challenges" engages nurses in reflective thinking, learning and practice. This text draws on lived experience, professional experience and tools to produce a learning experience based in ethical practices and the therapeutic alliances built between caring, respectful nurses and the people they treat and care for, their families and communities.

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

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

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Peta Marks is a credentialled mental health nurse and family therapist working in private practice, who specialises in working with people who have eating disorders and their families. Peta has extensive experience undertaking mental health project management at the national level and as a mental health writer and subject matter expert for online learning platforms. She is currently working as the National Programs Manager for InsideOut Institute and is the Chief Operating Officer for the Australian Eating Disorders Research and Translation Centre.

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

John Hurley is a credentialled mental health nurse, counsellor, gestalt psychotherapist, educator and researcher. Currently a professor of mental health at Southern Cross University, his research interests focus on the preparation and worth of the mental health nursing discipline, emotional intelligence and youth mental health. John has worked in the United Kingdom and Australia, and continues to clinically practise mental health nursing through a regular headspace clinic.

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INTRODUCTION

Welcome to the sixth edition of this popular text on mental health in nursing. This edition continues the direction followed by its predecessor, reflected in the title – *Mental Health in Nursing: Theory and practice for clinical settings*. Mental health is increasingly recognised as part of the holistic care provided by nurses in every clinical setting, as well as a diverse area of specialist practice. Nurses respond to mental health needs of consumers across the lifespan and across different practice settings, including emergency departments, aged care, acute medical and surgical services and primary care. Specialist settings include acute in-patient care, eating disorders, forensic mental health and addiction services. The text is intended to appeal to undergraduate nursing students and to nurses in their early years of clinical practice. It is also intended as a resource for nursing teachers charged with introducing students to mental health concepts.

For this edition, John Hurley of Southern Cross University has joined the editorial team of Kim Foster, Peta Marks and Anthony O'Brien. John is a Professor of Mental Health at Southern Cross University and is a credentialled mental health nurse with 30 years' experience. He maintains his clinical practice at headspace and is a Fellow of the Australian College of Mental Health Nurses. John is a widely published academic whose expertise covers education, clinical practice and professional issues. John has contributed to several chapters in this edition and has brought an extensive professional background to the editing role. We acknowledge the contribution of former editor Toby Raeburn to the fifth edition of the text. Toby maintains a presence in the sixth edition through the historical anecdotes that appear in Parts 1 and 2.

The editorial team is once again thankful to Jarrad Hickmott, who contributed to the text as a lived experience consultant. With an established reputation as a mental health advocate, Jarrad is a peer support worker at Prince of Wales Hospital in Sydney, and has served as a youth adviser to the national board of headspace, Australia's national youth mental health foundation. As with the fifth edition, Jarrad has reviewed numerous chapters and authored several lived experience commentaries throughout. Jarrad's story of recovery journey is available in both written and video materials associated with this publication. The text also contains contributions from many others with lived experience who have been involved as co-authors. Their contributions remind us that lived experience is central to mental health care and to the practice of nursing.

The fifth edition introduced the socio-ecological approach to mental health nursing practice, which remains in this current edition. The socio-ecological approach provides a model for integrating the many influences on mental health at the levels of individual, society and environment, expressed in the relationship between nurse and service user and in the skills of the practising nurse. The socio-ecological approach is used to frame all chapters of the text, reflecting our belief that this approach can assist nurses to understand mental health within a broad framework, and that it can support nurses in developing skills of holistic practice.

The change of direction introduced in the fifth edition, where we extended the range of clinical contexts to include many generalist settings, has remained for this sixth edition. This change was in recognition of the centrality of mental health to the health encounter, and to the practice of nursing. Part 3 provides seven chapters on nursing in a range of generalist and specialist health settings, with a focus on the mental health needs of health consumers in settings such as primary care, older adult care and emergency care. These chapters have been contributed by clinical experts in each area. We trust that the clinical scenarios in Part 3 provide students and nurses who work in generalist contexts with knowledge and confidence by providing information focused on the practical application of mental health nursing skills.

A new inclusion in the sixth edition are the two chapters on Indigenous mental health. The chapters on Aboriginal and Torres Strait Islander mental health and Māori mental health speak to the experience of the Indigenous populations of Australia and Aotearoa New Zealand, and the impacts of colonisation and dispossession on the mental health of Indigenous peoples. The chapters have been contributed by Indigenous nurses and reflect the dual clinical and cultural skills of the authors. In these chapters, readers will find a historical background to Indigenous mental health and advice for culturally safe nursing practice.

Another inclusion for this edition is the chapter on preparation for mental health clinical placement. *Mental Health in Nursing* is widely used in preparing undergraduate students for placement in mental health specialist settings and this chapter is intended to help students ready themselves for their clinical experience in mental health. We hope the chapter will provide the student with strategies for engaging with their mental health placement and developing the mental health skills that are fundamental to nursing.

The current concepts of mental health have deep roots, requiring nurses to have historical knowledge in order to be informed members of the profession and to formulate views and opinions grounded in understanding past practices and beliefs. The historical anecdotes of the fifth edition are once again included throughout Parts 1 and 2. Through these glimpses into our past we aim to promote awareness of how current practices and beliefs have parallels and precedents with previous historical periods. Historical understanding provides an important lens of critique and promotes different readings and interpretations of what is accepted as contemporary knowledge.

The language of mental health is a contested domain, and the different terminology used to describe the experience of mental distress and illness, and the people nurses care for, is reflected across the text. As students and as nurses, you will hear a wide range of terms used, reflecting the preferences and experience of consumers and professionals. We have not taken a position on what the "correct" language is, and we encourage students and nurses to follow this approach in their own professional practice. Nurses need to develop flexibility of thinking, rather than adopt a fixed approach to language. Many different terms can be used to describe a person with lived experience of mental illness, including consumer, patient, client, service user and person with (or experiencing) a mental illness. You will hear all these terms (and more) in clinical practice, depending on the setting and people's preferences, and you will read them all in this text too. The language we use needs to reflect the preferences of the people we care for, and at times, the requirements of services, health policies and legal frameworks. One practice we do promote is that health consumers are referred to in person-centred language rather than as diagnostic labels such as "schizophrenic" or "a psychotic". For example, we might describe someone as "a person with a lived experience of psychosis", reminding us that this is a person experiencing an illness or set of symptoms, rather than as "a schizophrenic", which is an objectifying label implying that the individual's identity is defined by the disorder. Person-centred

language also reflects the view that although someone may experience mental distress or illness, they might not identify as a consumer of mental health services. In every clinical context, mental health is part of nursing, but may not be the primary reason the person seeks health care.

Mental Health in Nursing is organised into three sections. Specialist mental health nursing knowledge and skills are a key focus, particularly in Parts 1 and 2, with Part 3 outlining mental health skills for practice in generalist settings.

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

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

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

Familiar features of the text have been retained, including lists of useful websites, nurses' and consumers' stories, key points, key terms and learning outcomes, critical thinking exercises and exercises for class engagement. Part 2 chapters, as in previous editions, include the language of diagnosis but not sets of diagnostic criteria, which are easily available elsewhere. Although diagnosis is a major concern of clinical services, it is also imprecise, contested, and can be unreliable. In addition, diagnosis does not capture individuals' subjective experiences. The focus of nurses is on people's experiences and their responses to adversity, stress and distress, rather than on diagnosis and symptoms. Our aim is to emphasise the nursing role in responding to the experience of individuals, rather than to a diagnostic label.

The new chapters of this text have been externally reviewed, and all previously included chapters have been revised to include references to contemporary research and scholarship while retaining core references that situate the text within the scholarly history of mental health and nursing.

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

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2

Nursing and Mental Health in Context

Kim Foster, Peta Marks, Anthony J. O'Brien and John Hurley

KEY POINTS

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

KEY TERMS

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

LEARNING OUTCOMES

The material in this chapter will assist you to:

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

INTRODUCTION

Mental health nursing is one of the most interesting and challenging areas of nursing practice. It requires a fusion of personal characteristics, professional knowledge and experience, and clinical and interpersonal skills. The challenge of mental health nursing is working with people who are experiencing mental and emotional distress and may doubt themselves, the environment and the people around them. The reward of this work is often the satisfaction of using knowledge and skills to provide a context of safety and care where trust in self and others can be re-established.

People with mental illnesses may have complex and long-term needs, engage in frequent and regular encounters with the healthcare system or have a one-off experience that brings them briefly into contact with mental health services or providers. The long-term and cyclic nature of some more complex mental illnesses means that the therapeutic relationship between mental health nurses and consumers can last for long periods. This relationship will also vary in intensity as consumers move along a continuum between periods of high dependence at one end (in acute phases when they are experiencing acute distress or illness) and independence at the other (when their symptoms are less troublesome or they are mentally healthy). This health–illness continuum is explored in depth in Chapter 3.

This chapter outlines the social ecological framework for mental health nursing practice that frames the text. This is a holistic framework for practice and the various elements of the framework are described: therapeutic relationships and consumer–nurse partnership; personal and contextual factors influencing practice; identities, including gender and culture (nurse and consumer); and the context of practice (including social determinants of health and major approaches to mental health care – recovery-oriented care and trauma-informed care). The remainder of the chapter explores the interpersonal relationship as the essential foundation of effective mental health nursing practice and the knowledge, attitudes and skills needed to work with people in mental distress. Key concepts and issues that are fundamental to effective and safe mental health nursing practice are also introduced.

Holistic and skillful mental health nursing requires a sound knowledge of human physiology, health and illness, as well as a biopsychosocial understanding of mental illnesses and their treatments, including pharmacology. In addition, to practise effectively, nurses working in mental health need to be open-minded and reflective and to have

developed an understanding of concepts such as compassion, empathy, spirituality and hope. Personal qualities, such as responsiveness, self-awareness and insight, are essential for effective therapeutic relationships. Nurses in all settings care for the mental health and wellbeing of consumers, and mental health skills are required of all nurses and can be applied in all clinical settings.

SOCIAL ECOLOGICAL APPROACH TO MENTAL HEALTH NURSING PRACTICE

In this text we take a social ecological approach to mental health nursing practice. A social ecological perspective refers to the dynamic interactions between a person and their environment that influence their health and wellbeing. This person–environment interaction involves a number of factors and processes. Mental health can be understood as involving a person's physical, mental, emotional and spiritual characteristics, and the interactive processes that occur between them and their environment or ecology (including their social and family context). This includes being able to access available resources that help sustain their mental health (Ungar & Theron 2020) and support their recovery. These resources can be human, such as relationships and supports in the form of family and friends, and/or healthcare resources, including nursing and mental healthcare (hospital or community-based), and/or practical resources such as financial support and housing. A social ecological or holistic perspective is relevant to understanding mental health and mental health nursing practice because mental health problems can challenge people across every aspect of their life, including relationships, healthcare and finances. Equally, mental health problems can be worsened or mitigated by these factors. Similarly, nursing practice is shaped by our personal characteristics and skills, and the health service context we work in. This dynamic person–environment interaction involves personal and contextual factors that influence nurses' practice and their relationships with consumers.

Therefore, from an ecological perspective, nursing practice includes:

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

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

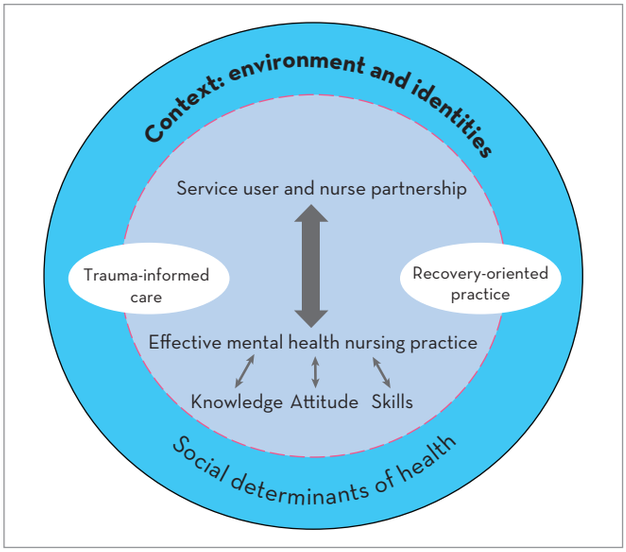

FIG 2.1 Social ecological approach to mental health nursing practice.

Social Determinants of Health

In relation to the context or environment of mental health, the social determinants of health are the social and economic circumstances within which we are "born, grow, work, live and age" (World Health Organization (WHO) 2022). These determinants are shaped by social norms, policies and systems relating to the distribution of power and resources in society and can lead to health inequities because they have a direct influence on the prevalence and severity of mental health conditions, which can extend across the life course (WHO 2022).

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

- early childhood development
- mental health stigma
- poverty (employment, education)
- violence
- forced migration
- insecure living conditions, including homelessness (WHO 2022).

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

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

An ecological approach to nursing therefore requires that nurses understand and respond to the social contexts within which people live. Nurses working clinically do not necessarily have the capacity to influence, prevent or intervene with all these factors, but it is vitally important when working with mental health consumers, and as relevant for the person, that these factors are considered and identified during history-taking and assessment. Indeed, the nurse needs to position and understand the consumer as a person within these social contexts, rather than being simply a person with symptoms. Then, as part of the work of the multidisciplinary team, wherever possible and relevant, various factors can be directly addressed to help decrease risk and increase protection against further ill health. This may be negotiating adequate housing for consumers (and ensuring people are not discharged if they have nowhere to go), helping to build social support for consumers who are isolated and/or providing psychological support for the psychological impacts of trauma and associated distress, such as a trauma-informed approach to care. An ecological approach to nursing also requires that nurses understand the environments within which they practise.

TABLE 2.1 Social and Cultural Determinants of Mental Disorders

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

Adapted from Lund et al 2018.

Contexts of Mental Health: Environment and Identities

It is important to understand that the models of care and the health service approach within which nurses work directly influence our practice. Equally, nursing practice can influence and shape the environments within which we work. Working with people who experience mental illness can pose unique ethical challenges to nurses; for example, where a person experiences episodes of mental ill health that necessitate compulsory admission under mental health legislation, removing part or all of their autonomy due to considerations of risk and safety. Involuntary admission often makes it difficult for nurses to apply recovery-oriented approaches that seek to provide people with choice and opportunity to develop strengths. Working in such challenging environments means that nurses need not only have an up-to-date working knowledge of health conditions and interventions, but also need to be able to empathise with the difficulties consumers face as they navigate their recovery from experiences of mental ill health within what are often disconnected and under-resourced healthcare systems (State of Victoria 2019).

Cultural, Sexual and Spiritual Identities

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

Cultural identity. Cultural identity refers to a person's sense of belonging to one or more cultural groups. For Aboriginal and Torres Strait Islanders and Māori, Indigenous culture may be the most important source of identity, but they may also identify, through ancestry or association, with non-Indigenous cultures. Most healthcare providers support consumers to declare their own cultural identity, and clinicians should respect this statement. Cultural identity is an important source of beliefs, values and practices that impact on mental health and assist individuals to develop their own frameworks for recovery. As nurses, it is important that we reflect on our own cultural identities and how these may influence our interactions with consumers (cultural awareness). We cannot be knowledgeable or skilled in all the cultures of a health service's consumers, but it is important that we ask about and respectfully acknowledge consumers' culture, seek to listen, learn and respond to their cultural preferences (cultural sensitivity), and work in a culturally safe way (Best 2021). See Chapters 6 and 7 for a discussion of Aboriginal and Torres Strait Islander and Māori mental health.

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

Gender identity. Gender is another source of identity where previous mental health practice has treated difference as pathology and sought to impose compulsory treatment on individuals whose gender identity and sexual preferences did not fit dominant social norms. From being perceived as a fixed function of biology (individuals assigned either male or female gender at birth with no anticipation of change), gender is now understood as a fluid, socially constructed concept, and gender identity as reflective of the person's own internal sense of being a man, woman or someone outside that gender binary. A range of terms reflects the changing perspectives on gender in contemporary society, seen in the term LGBTIQA+, which incorporates a range of sexual orientations and gender identities. Specific terms related to gender include transgender, non-binary, gender diverse and cis-gender. Gender should not be confused with sexual preference, which refers to an individual's gender preferences in intimate relationships in the acronym above – lesbian, gay, bisexual. Preferences are

not necessarily fixed and can change over the course of psychosocial development.

As a nurse you will meet people with gender identities and sexual preferences that are different from your own. It is important that you become comfortable with relating to gender diverse consumers, including using appropriate pronouns and terminology, as the stigma and prejudice commonly experienced in response to a person's gender and/or sexuality may be a source of distress.

Identity, stress and mental illness. While a strongly developed sense of who we are as a person is important to our mental health, identity can also be a source of stress for those whose identities are disvalued and subject to stigmatising views and prejudice. The term "minority stress" (Spittlehouse et al 2019) refers to the experience of stigma and discrimination encountered by people in relation to their identity. This can relate to social and cultural dimensions of gender, race, ethnicity, religious affiliation, sexuality and other aspects of identity (e.g. ability, age, socio-economic status) (Victorian Transcultural Mental Health [VTMH] 2021). Micro-aggressions, overt rejection and discrimination can create a hostile environment in which minority stress leads to cognitive and affective changes that increase susceptibility to symptoms of mental illness, including depression, anxiety, suicidal ideation and harmful substance use (Bailey 2019). People who are subject to one form of marginalisation are more likely to also experience other forms of marginalisation, a concept referred to as "intersectionality" (Grzanka & Brian 2019; VTMH 2021).

Nurses encounter many consumers who experience one or more forms or marginalisation and need to be aware of how these experiences shape the person's health experience and the responses of clinicians. Supporting consumers to negotiate what may be viewed as "contested" identities enhances their mental health and helps build resilience for living in an environment in which stigma and discrimination are regrettably common. From a service level, an intersectional response ensures that a multiplicity of identities and experiences are considered when designing services, gathering information or analysing data.

HISTORICAL ANECDOTE 2.1

Stigma and Mental Illness

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

Read More About It

Goffman, E. 1963. Stigma: Notes on the Management of Spoiled Identity. Prentice-Hall, Englewood Cliffs.

Mental health nurse identity. Finally, mental health nursing also has a distinct identity. The identity of the mental health nurse can be understood as possessing both technical skills, such as delivering psychological interventions and undertaking complex assessments, and interpersonal or non-technical skills, such as those supporting interpersonal relationship building, communication and emotional intelligence. Mental health nursing identity includes a considerable component of interpersonal therapeutic work and the use of a personal and professional self, all directed at enhancing the wellbeing of consumers. This identity is at odds with how the discipline is sometimes understood by those outside of it, who can construe that the identity of mental health nursing is limited to simply dispensing medications (Hurley et al 2022). However, the social ecological approach and consumer identity factors previously outlined should alert you that mental health nursing work has significant complexities necessitating a wider identity role than pharmacology alone.

Concepts of Recovery

Clinical Recovery

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

As people with lived experience of mental illness gained political influence over the past few decades, they challenged the concept of clinical recovery and models of care that focus on medical treatment alone (Cleary et al 2018). This led to a review of how recovery from mental illness is understood, including the concept of personal recovery. Recent research suggests that clinical and personal recovery are overlapping constructs and that recovery from one perspective is associated with recovery from the other (Dubreucq et al 2022). While there are distinct differences between conceptualisations of clinical and personal recovery, they can be considered complementary (van Weeghel et al 2019). For many people, symptom change is important, but it's not the only indicator of recovery, or the most important one.

Personal Recovery

The concept of "personal recovery" emerged from the consumer movement that developed in the second half of the 20th century to advocate for the rights of people living with mental illness. People with lived experience have emphasised that recovery is a transformational, deeply personal journey of reclaiming the right to a meaningful life, even if symptoms of mental illness persist. It is a subjective, multidimensional, continuous process that is defined by the person (who is considered the "expert"). It is unique and means different things to different people (Slade & Wallace 2017).

There is no single definition of mental health recovery; however, one of the most commonly used explanations was written by Bill Anthony in 1993 (p. 15), who described it as:

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

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

CASE STUDY 2.1: Mary O'Hagan

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

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

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

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

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

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

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

CRITICAL THINKING EXERCISE 2.1

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

In 2012, Glover presented the stories of two women and their personal experiences of mental distress managed in Australia by involuntary inpatient admissions. The women's perceptions of their care included that they were not helped to make sense of their experiences, felt stripped of their power and were not responded to as people but as "diagnostic categories". Their experiences were described using the language and meaning of the professional knowledge base; their own meaning and language for their experiences were not encouraged or valued. What makes Glover's work so powerful is that while both women had very similar experiences, one story took place in 1985 and the other in 2010. The latter occurred at a time when services were promoting their model of care as "recovery-informed", leading Glover to ask, what has actually changed in the previous 25 years?

The next section of this chapter overviews recovery-oriented and trauma-informed care approaches that have been developed to support people with mental illness in their personal recovery. These approaches are increasingly used in mental health care and can be used by nurses in all settings to better support people who are experiencing mental distress or illness.

Recovery-Oriented Care

In 2011 Leamy and colleagues undertook a systematic literature review to identify experiences commonly associated with personal recovery. After screening more than 5000 papers, the authors identified five processes that are common in personal recovery, known by the acronym CHIME: Connectedness; Hope and optimism; Identity; Meaning in life; and Empowerment (Leamy et al 2011). Not only have experiences associated with personal recovery been well explored, but the concept is increasingly incorporated into government mental health policies, including Australia's national mental health service policy and framework for recovery approaches to service provision (Commonwealth of Australia 2013) and the *Fifth National Mental Health and Suicide Prevention Plan* (Department of Health 2017; see also Progress Report 4 – Australian Government National Mental Health Commission 2021). Concepts of recovery have also influenced mental health policy in New Zealand (Ministry of Health 2021).

TABLE 2.2 Key Differences Between Recovery-Informed and Traditional Practice

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

In respect to mental health recovery, there are five key domains that health professionals and mental health services are expected to practise within:

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

To better understand the sort of practices promoted in government guidelines, Le Boutillier and colleagues (2011) undertook a qualitative analysis of 30 recovery policy documents from governments in England, Scotland, Ireland, Denmark, New Zealand and the United States. They found that the policies promoted four common practice domains, including organisational commitment, supporting personally defined recovery, working relationship and promoting citizenship. Despite these findings, the authors concluded that a key challenge for mental health services is the continued lack of clarity about what constitutes service-level recovery-oriented practice (Raeburn et al 2017). This lack of clarity has remained an ongoing knowledge gap, with researchers observing that while government policy may promote the concept of personal recovery, most mental health interventions still aim to reduce symptoms and improve a person's functioning rather than promote personal recovery (Leendertse et al 2021); and that evidence is lacking regarding how recovery practices are implemented and whether (and how) this is achieved in practice within individual services (Slade et al 2015).

Greater collaboration and co-design of services, service planning, policy and research by people with a lived experience of mental illness is required for better recovery-oriented care (Gordon & O'Brien 2018). This requires a purposeful shift away from paternalistic and authoritative ways of treating people towards more mutually respectful person-centred care (Reid et al 2018). Consumers and carers understand the inadequacies and opportunities that exist within the health and mental health system (Banfield et al 2018) – after all, they are the ones who are attempting to navigate it! Transforming the health and mental health system to be fully recovery-oriented requires genuine integration of lived experience perspectives, addressing discrimination and factors that inhibit consumer participation at all points in the healthcare continuum. Transformation of the mental health system means focusing more on enhancing hope, empowerment and life meaning in mental health interventions, to support personal recovery (Leendertse et al 2021).

Trauma-Informed Care

An essential component of a recovery-oriented approach is to practise within a framework that recognises many people experiencing mental health challenges have a background that includes trauma experience(s). A trauma or traumatic event can be described as a distressing event – for example, a severe physical injury or a specific experience that triggers mental and emotional distress. Trauma is often linked with loss and grief, which are a universal part of life. Loss can be described as an event where something that belongs to you, is either precious or has meaning for you, has been taken away or destroyed. This encompasses a range of losses, from a "minor" loss, such as losing your wallet, to a "devastating loss", such as losing your home and all your belongings in a bushfire. Bereavement generally refers to being deprived of an object

or a person – usually used in the context of losing someone you love through death. Grief has been defined as "the response to the loss in all of its totality – including its physical, emotional, cognitive, behavioural and spiritual manifestations – and as a natural and normal reaction to loss" (Hall 2014, p. 182).

Research demonstrates clear links between trauma and the onset of a range of mental health problems (Green et al 2018). This makes it imperative for nurses to be sensitive to the vulnerabilities and potential triggers that may give rise to re-traumatisation and to be aware that this could impede recovery. While a single-incident traumatic event, such as a severe car accident, an unexpected death of a close family member or natural disaster, may result in an acute crisis, where the person's ability to cope is overwhelmed for a time, it does not necessarily result in mental illness. Research indicates that most people exposed to a traumatic event recover after an initial period of destabilisation, followed by adjustment and recovery. In fact, some people describe positive changes, such as a renewed appreciation for life and loved ones, personal growth and enhanced coping strategies (van Weeghel et al 2019). See Chapter 3 for more information about the mental health and illness continuum.

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

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

You will recall from your nursing education that the brain consists of three parts that develop from the bottom up. These parts "talk" to one another via trillions of neural pathways. The "reptilian brain" (brain stem) is responsible for the automatic functions, such as breathing, heart rate and survival. The "mammalian brain" (limbic system) is responsible for emotions and memory; it is about survival and safety. The "primate brain" (cerebral cortex) is responsible for higher order tasks, such as thinking, learning, decision-making, reasoning, organising, planning, meaning-making, gaining control over emotions and language. When people experience trauma and/or severe emotional stress, it can be much harder to engage the cerebral cortex. Instead, they "loop" in the limbic cortex and this builds stronger neural pathways, making it more likely they will experience distressing emotions in the future when challenges arise.

Consider how this information might be relevant when someone comes into a mental health inpatient unit. Personal safety is an important basis for effective nursing care; the key here is the absolute necessity for people to feel safe so they can effectively engage with others in their ongoing care. Often, people will be frightened of the inpatient environment, including acute mental health units, particularly if it is their first experience of admission to a mental healthcare setting. It is important to take time to find out how the person feels and what they need to feel safe and secure. This may be listening to them or helping them consider strategies they could use to increase feelings of safety – for example, calling for help if someone enters their room. Do not assume that the person experiencing mental distress will feel safe in the healthcare setting just because you feel comfortable in the environment as a nurse.

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

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

In summary, trauma-informed services are informed by key principles to guide practice (Wilson et al 2021):

- People need to feel connected, valued, informed and hopeful about their recovery from mental illness.

- Staff understand the connection between childhood trauma and adult mental health issues.
- Staff practise in empowering ways with consumers and their family and friends and other services to promote consumers' autonomy.

While these principles focus on the needs of consumers and their family and friends, a trauma-informed approach to care can also provide support for managing workplace stress (Isobel & Edwards 2017). Trauma-informed practice does not replace recovery-oriented practice, but is complementary and provides another perspective from which people (staff and consumers) may view recovery and therapeutic engagement. See Perspectives in practice: Nurse's story 2.1.

PERSPECTIVES IN PRACTICE

Nurse's Story 2.1: Katrina

Why I Chose Mental Health Nursing

I did not start my nursing education with a plan to work in mental health nursing. Like many of my fellow students I thought about paediatric nursing, or maybe cardiac nursing. I enjoyed all my clinical placements and my greatest pleasure was talking to consumers in whatever setting they were in. I found the most interesting theoretical study was of understanding people from a psychological, sociological and cultural perspective: how people came to be like they were; how they responded to health and illness and stress. My understanding about mental illness had been coloured by common community attitudes, by media depictions of psychiatric hospitals, and by the experience of an aunt being forcibly admitted for treatment. It was not really talked about in the family and I am not sure if anyone visited her while she was in hospital.

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

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

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

HISTORICAL ANECDOTE 2.2

We Were Convicts

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

Read More About It

Raeburn, T., Liston, C., Hickmott, J., Cleary, M. 2018. Life of Martha Entwistle: Australia's first convict mental health nurse. Int J Ment Health Nurs 27(1), 455–463.

EFFECTIVE MENTAL HEALTH NURSING PRACTICE

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

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

- preventive and early intervention strategies for mental health and mental illness
- biological processes that may underpin mental illness
- the impacts of social determinants of health on the development and course of mental illness
- the importance of social connections and relationships for mental health and illness
- psychological processes associated with mental health and illness
- cultural practices and beliefs and their relationship to mental health
- spiritual beliefs and faith and their relationship to mental health
- communication and interpersonal relationship knowledge and skills
- the physical health care of people with mental illness
- psychotherapeutic approaches and strategies for mitigating mental distress and mental illness
- the physiological effects and side effects of psychotropic medications and physical treatments for mental illness.

Therapeutic Relationship – Consumer and Nurse Partnership

As nurses, we bring our knowledge and attitudes to mental health/illness, our identities (e.g. cultural and gender) and our values,

knowledge, experience and skills in nursing. This shapes how we develop a therapeutic relationship with consumers. The therapeutic relationship is the foundation of effective mental health nursing practice (Peplau 1997). We consider this relationship to be one of equal partnership. Partnership involves working with the person and their family/carers to provide support in a way that makes sense to them, including sharing information and working in a positive way to help them reach their goals (Commonwealth of Australia 2010). The therapeutic relationship is underpinned by the nurse's use of self. Key knowledge and skills for an effective therapeutic relationship include developing a therapeutic alliance, self-awareness and empathy.

LIVED EXPERIENCE COMMENT BY JARRAD HICKMOTT

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

Therapeutic Use of Self

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

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

Studies of the experiences of both mental health nurses and service users of mental health services overwhelmingly attest to the importance of therapeutic relationships. Consumers have identified the need to feel compassionately cared for, to have meaningful contact with nurses, to be listened to, and for nurses to know them as people and understand their predicament (Hurley et al 2023; Lakeman et al 2022). Similarly, studies of nurses' experiences identify that they see therapeutic engagement as the hallmark of good practice in mental health settings (Hurley et al 2022; Lakeman & Hurley 2021).

Empathy and Therapeutic Use of Self

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

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

The Therapeutic Alliance

The value of a therapeutic alliance, developed through therapeutic use of self, has been clearly identified from the perspective of nurses and service users in international studies (Zugai et al 2015). A therapeutic alliance is characterised by the development of mutual partnerships between consumers and nurses, and has been linked with greater consumer satisfaction with care (Zugai et al 2015). Several studies have indicated that a therapeutic alliance can have a significant impact on consumer outcomes and that it is possibly one of the most important factors contributing to the effectiveness of a mental health service (Stewart et al 2015). People who have a positive relationship with the clinician have better outcomes (Pilgrim et al 2009). However, a therapeutic relationship alone may not be sufficient to sustain health improvements, and so a combination of both a therapeutic relationship and the technical skill of specific therapeutic approaches may provide the best outcomes (e.g. see Hurley et al 2022).

HISTORICAL ANECDOTE 2.3

Mental Health Nurse of the Century!

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

Read More About It

Peplau, H. 1997. Peplau's theory of interpersonal relations. Nurs Sci Quarterly, 10(4), 162–167.

Self-Awareness

The process of working together and understanding others begins with understanding oneself. "Self" is a concept that describes the core of our personality. We use the concept of self when we want to convey our uniqueness as a human being. The self has consistent attributes that pervade the way we live in and experience the world. It is awareness of these attributes of self that can enhance the way we relate to others. A strong sense of self allows us to develop resilience in dealing with the difficulties and complexities of human communication and experience. Self-awareness is about knowing how you might respond in specific situations, about your values, attitudes and biases towards people and situations, and about knowing how your human needs might manifest in your work. The purpose of being self-aware is to identify those things in our background and in our way of relating that might affect how we relate to others. The way we view people is always subjective. The lens through which we look at the world is always our own. Although there can be no true objectivity, knowledge of the experiences that influence our subjective view of the world allows us to identify how they influence our thinking. Nurses need to be aware of the belief systems and values that arise from their cultural, social and family backgrounds. Everyone develops biases that affect the way they view other people's behaviour. Behaviour that is understandable to one nurse might not be understandable to another. However, the self is not static, but constantly evolving and sensitive to experience. We bring values, biases and beliefs to nursing and to our relationships with consumers, and in turn those relationships offer the opportunity for self-development. It is through the process of self-reflection and the examination of particular experiences that nurses can learn and flourish (Fowler 2019).

Working in the mental health field requires the ability to listen to, respond to and empathise with people from a range of backgrounds and with multiple identities. Unexamined belief systems can become obstacles to developing a therapeutic alliance. Lack of self-awareness can cause nurses to respond to a person's distress and behaviour in ways that may not be helpful. For example, it might cause nurses to use power coercively in the belief that what they are doing is best for the service user. Lack of self-awareness can also lead to nurses being overly concerned, refusing to allow consumers choice or overwhelming them with advice, in an attempt to protect them. Alternatively, nurses may avoid contact with particular service users or fail to respond to distress. This growing self-awareness needs to take place against a background of self-compassion, and to develop the ability to empathise with others requires "the ability to be sensitive, non-judgemental and respectful to oneself" (Gustin & Wagner 2013, p. 182). See Personal perspectives: Consumer's Story 2.1.

PERSONAL PERSPECTIVES

Consumer's Story 2.1: Therese

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

Therese then tells her own story:

I am 28 years old and have had lots of presentations to emergency departments. I used to cut myself often or take overdoses. However, in the past 3 years I have hardly had any presentations and no admissions to hospital. I have two children aged 4 and 2 and I am trying to get my act together for them. I do not want to lose my children. My childhood was chaotic with lots of foster care. I spent time in refuges and took drugs for a while. I do not take drugs or drink alcohol now. I have had a community mental health nurse who has been seeing me regularly for more than 3 years. Tonight I took an overdose of antidepressants that I had been prescribed. I feel ashamed because it was impulsive and stupid. I can see the staff talking about me and saying all the old things. They do not think I deserve care because I inflicted this on myself and everyone else here is physically ill or has had an accident. I just got to the end of my tether. I had a boyfriend who moved in and I didn't like how he treated the kids, so he has gone now. My community nurse is on leave. I couldn't contact anyone; I just felt so alone, empty and lost. I thought the kids would be better off without me.

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

CRITICAL THINKING EXERCISE 2.2

Consider Consumer's Story 2.1: Therese.

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

Emotional Intelligence

Skills such as self-awareness, communicating empathy and therapeutically engaging with others can be collectively understood as enacting emotional intelligence. Although there are several different models of emotional intelligence, they all share core features. *Emotional intelligence* is the ability to be aware of and correctly identify our emotions, and then integrate those emotions with our cognitive knowledge to best meet our needs, or desired outcomes (Dugué et al 2021). Other

core skills of emotional intelligence include identifying and regulating the emotions of self and others, displaying authentic behaviours, such as honest emotional communication, and positively influencing others through support, effective helping and problem-solving. The applications of emotional intelligence to mental health nursing, and nursing more broadly, are quickly evident. The capacity for self-awareness is intrinsic to emotional intelligence and supports an understanding of complex emotional and physiological responses to challenging work environments, trauma and distress. This skill of coping with our own emotions, as well as those of others, enables clinicians to manage stress more effectively, which subsequently supports their own health, as well as the individuals for whom they are providing care (Soto-Rubio et al 2020). This is especially relevant in relation to the high level of emotional work or burden of caring for consumers with high levels of suffering, pain, trauma and emotional distress. The concept of emotional intelligence also includes the ability to recognise the emotional states of others (Dugué et al 2021).

Emotional intelligence is integral to nursing, in the context of addressing risks to mental health, as well as the genesis of core nursing skills, including effective communication, sensitivity and creativity, self-discipline, assertiveness and awareness of self (Soto-Rubio et al 2020). Effective therapeutic relationships are founded on emotional intelligence, as the ability to understand the emotions of others, as well as knowledge and regulation of our own emotional response is the foundation of acknowledging the experience of others, thus supporting empathy (Hofmeyer et al 2020). Significantly, emotional intelligence is something that you can increase with practice, unlike your IQ. Being more self-reflective, seeking feedback about yourself from trusted others and developing your understanding of the emotions of others, are a few simple ways towards achieving this end.

Hope and Spirituality

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

In a study of qualitative literature related to hope in older people with chronic illnesses, Carretta and colleagues (2014, p. 1211) identified characteristics of hope as including "transcending possibilities" and "positive reappraisal". Transcending possibilities involves finding meaning through searching and connecting with others. The positive role of health professionals in maintaining hope is described as supporting hope and the search for meaning. Positive reappraisal depends on the ability to seek and find meaning in the illness experience, and health professionals also have a role in supporting service users in this search. Hope has particular relevance to mental health nursing practice, and there is growing recognition of the concept of hope and its relationship to health, wellbeing and recovery from illness or traumatic life events. Closely linked with hope, Hemingway and colleagues (2014) describe therapeutic optimism in mental health nurses as a belief that they can make a difference and that the people they work with can recover.

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

Compassion and Caring

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

Caring is considered to be central to nursing theory and practice (Schofield et al 2013). Although the word "caring" is simple, its use in complex healthcare situations has rendered it problematic. Following a meta-synthesis of research, Finfgeld-Connett (2008) conceptualised caring as a "context-specific interpersonal process that is characterised by expert nursing practice, interpersonal sensitivity and intimate relationships" (p. 196). Finfgeld-Connett further elaborated on the concept to make explicit factors related to the roles of the consumer and the nurse, and to the working environment, discussing the "recipient's need for and openness to caring, and the nurse's professional maturity and moral foundations ... [as well as] a working environment that is conducive to caring" (p. 196). However, providing nursing care in mental health settings can be even more complex as people with mental illnesses may not acknowledge the need for care, or be open to

caring interventions, especially in acute phases of illness. Nurse scholars have invested much time and energy in trying to explain what it is that makes nurse caring special or different from informal caring, and from the caring provided by medical practitioners. There have also been many attempts to find a "fit" between caring as a construct and the biomedically dominated and economically driven healthcare sectors within which nursing is situated. From a mental health perspective, there are even more issues to consider in relation to caring. For example, there are special issues associated with caring for consumers who are compelled to accept professional care under mental health legislation.

Historically, mental health nursing was associated with custodial care and control. Godin (2000) captured the dilemma of mental health nurses when he raised questions about the *dis*-ease between the caring and coercive roles that mental health nurses assume. Godin positioned caring as "clean" and constructed the coercive control elements of mental health nursing (a term he used for forced treatment, community orders and so on) as "dirty" (Godin 2000, p. 1396). While Godin's argument focused on service users and nurses in the community, many of the issues he raised (related to forced administration of medication, seclusion and detention) are still relevant to nurses in inpatient and community settings. From the perspective of people who have been involuntarily detained for treatment, Wyder and colleagues (2015) found that having staff willing to listen empathically was important and that the person's involuntary legal status should not be an impediment to nurses providing compassionate care and forming therapeutic relationships. The absolute vulnerability of service users who can be detained against their will and subjected to various treatments that they may vigorously and robustly resist means that elements of the caring role, such as consumer advocacy, are critical to skillful and compassionate mental health nursing practice.

Professional Boundaries

In nursing, professional boundaries are invisible yet powerful lines that mark the territory of the nurse. They define a role and allow the nurse to say: "This is what I do. This is the purpose of my presence here." Professional boundaries are important in all areas of healthcare, but in mental health nursing they have an increased importance due to the highly personal nature of the work of mental health nurses and the vulnerability of consumers. Clear boundaries provide consumers and nurses with a safe interpersonal context in which therapeutic work can take place. Over time, there has been a decrease in formal divisions between staff and service users in mental health settings, with the encouragement of friendliness and collaborative partnerships. However, a power imbalance is always present in clinician–consumer encounters, and there are a number of ways that boundary violations can occur. Boundary violations can involve exerting power through coercion, use of force, over-treatment or under-treatment, or inappropriate intimate relationships. Maintaining professional boundaries while being involved in therapeutic relationships is a skill that cannot be underestimated in importance.

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

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

Self-Disclosure

Mental health nurses use self-disclosure as a way of developing therapeutic relationships with service users. Many of the relationships that nurses have with service users are long term, either by repeated admissions to hospital or by continued contact in community or primary care/private practice settings, so nurses and service users may come to know each other well. In a study of nurses in mental health, nurses often used self-disclosure. The most common reason they shared personal information was to impact the nurse–consumer relationship, and try to make it more open and honest, reciprocal and equal (Unhjem et al 2018).

However, self-disclosure should be used consciously and carefully. The boundary issue is not about whether disclosure of information occurs or does not occur. The issue is the nature of the disclosure and whether the nurse burdens the service user with their own personal problems. The decision about what to disclose to service users about your life needs to be made in advance. Self-disclosure does not include unburdening your personal problems. The focus always needs to be on the needs of the consumer and building the relationship with them.

CHAPTER SUMMARY

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

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

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REVIEW QUESTIONS

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

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

USEFUL WEBSITES

Emotional Intelligence

Genos International: www.genosinternational.com/emotional-intelligence/

Professional Boundaries

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

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

Recovery

A National Framework for Recovery-Oriented Mental Health Services – Guide for Practitioners And Providers: www.health.gov.au/sites/default/files/documents/2021/04/a-national-framework-for-recovery-oriented-mental-health-services-guide-for-practitioners-and-providers.pdf

National Standards for Mental Health Services – Principles of recovery oriented mental health practice: apmha.com.au/wp-content/uploads/practice-priniciples.pdf

Trauma

Adult Survivors of Child Abuse: www.ascasupport.org/

Adverse Childhood Experiences (ACE) study: acestudy.org/

Australian Government National Indigenous Australians Agency: Closing the Gap implementation plan: www.niaa.gov.au/2023-commonwealth-closing-gap-implementation-plan#:~:text=The%20Minister%20for%20Indigenous%20Australians,next%2012%20to%2018%20months

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

Mental Health Coordinating Council (MHCC) – Trauma-informed care and practice (including Trauma-informed Care and Practice Organisational Toolkit, Trauma-Informed Leadership for Organisational Change Framework and Trauma-informed Events Checklist and Policy and Protocol) search: www.mhcc.org.au/our-work/resources/

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

Phoenix Australia, Centre for Posttraumatic Health: www.phoenixaustralia.org/

Transcultural Mental Health Centre: www.dhi.health.nsw.gov.au/transcultural-mental-health-centre

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