Handout 1: Mental Health Through the Ages

Throughout history, disorders of the mind have been called different names; madness, lunacy (from the belief that people became more obviously ill during a full moon), insanity, mental health problems. Beliefs about the causes of such disorders include; an imbalance of bodily fluids (the Greeks and Romans), possession by devils or heresy (medieval times in Europe), and witchcraft (17th century Europe and America). In England, the mentally ill were, until the 18th century, viewed as deviants, belonging with vagrants, the physically disabled and petty criminals, not as a separate category requiring special care and accommodation. However, the 18th century saw ‘insanity’ defined as a ‘disease of the brain’, and the development of huge institutions called asylums, usually located on the outskirts of cities or in the country, where ‘the insane’ could be treated (and be kept out of sight and out of public awareness). The treatments of the time were harsh; flogging, bleeding, cold water baths, etc. In Australia, the first asylum was established in 1811 (the Castle Hill Asylum). Psychological treatment methods did not evolved until the early 20th century, starting with the ideas of Sigmund Freud. Electro-convulsive therapy was developed in 1938 (although electric shocks were used as a form of both treatment and discipline in the previous century), and psychosurgery in 1936. Modern drugs to treat the major mental illnesses began to be developed from the 1950’s.

Modern approaches to mental health

There have been great changes in the care of people with a mental illness in the 2nd half of the 20th century. The advances in drug therapy, as well as a growing anti-psychiatry lobby that argued against the institutionalisation of people with a mental illness, meant the focus moved away from isolation and treatment in psychiatric institutions to an emphasis on treating and supporting people with a mental illness in their own communities through a range of community mental health services. The large psychiatric hospitals began to close in the 1960’s, with inpatients (many of whom had spent years living in the asylum) moving to a range of accommodation in the community. This process is called ‘deinstitutionalisation’. Community mental health teams and supported accommodation are among some of the workers and services that have been introduced to enable people with mental illnesses to live in the community. People with a mental illness, their relatives and friends have formed lobby groups to improve conditions for people with a mental illness and funding for research, and to combat the stigma associated with being diagnosed with a ‘mental illness’. Mental health policy is increasingly concerned with raising community awareness and understanding of mental illness, and with improving the rights of people with a mental illness.
Handout 2: Mental Illness/Mental Health Problems

It is estimated that mental illness and mental health problems will affect one in five of the adult population in their lifetime. Mental illness affects all age, social and cultural groups. Factors which increase the risk of developing mental health problems include low socio-economic status, unemployment, poor physical health and experiences of physical and sexual abuse. Equally, people with mental health problems and mental illness may face a higher risk of unemployment, poor physical health, and physical and sexual abuse.

Approximately 4% of people in Australia will experience severe mental disorders which significantly interfere with their mental well being and reduce their capacity to participate fully in community life; Many people who develop such a mental illness have only one episode, and if given appropriate care, are likely to recover completely. Of those who have more than episode of an illness, most are able to be treated adequately and can lead productive lives. However, some individuals may become chronically disabled as a result of their illness, requiring ongoing assistance from family and/or mental health and other community support services.

Handout 3: Types of Mental Illness/Mental Health Problems

Schizophrenia

It is estimated that one in a hundred people in Australia have this illness. This is a serious disorder that is believed to be caused by chemical imbalance in the brain. The disorder affects how a person thinks, feels and acts, and is characterised by a variety of symptoms including hallucinations, delusions, withdrawal from social activities, incoherent speech and impaired reasoning.

Mood disorder

Mood disorders include depression and bipolar disorder (also called manic depressive disorder). Symptoms include mood swings such as extreme sadness or elation, sleep and eating disorders, and changes in activity and energy levels. Suicide or risk taking behaviours may be a problem with these disorders.

Anxiety disorders

Anxiety disorders are the most common mental illnesses. The three main types are: phobias, panic disorders and obsessive-compulsive disorders. People who suffer from phobias experience extreme fear or dread when exposed to a particular object (e.g., snakes) or situation (e.g., being in a closed space). Panic disorders involve sudden, intense feelings of terror for no apparent reason and physical symptoms which are similar to those of a heart attack. People who have obsessive-compulsive disorder try to cope with anxiety by engaging in repetitive, ritualistic behaviour (such as constant hand washing) or by repeating words or phrases.
Eating disorders
Two major forms of these disorders are anorexia nervosa and bulimia: these are serious, potentially life-threatening illnesses. People with these disorders have a preoccupation with food and an irrational fear of being fat. People with anorexia severely restrict their food intake: people with bulimia have cycles of bingeing (consuming large quantities of food) and purging (self induced vomiting or abusing laxatives). Behaviour may also include excessive exercise.

Personality disorders
This category refers to people who have maladaptive and inflexible patterns of behaviour which impair their functioning in relationships, in their work, and in their social lives. They cope poorly with the ups and downs of everyday living, and can much distress to family and friends through their behaviour. Types of personality disorders can range from individuals who are odd and eccentric to those who are dramatic and self-centered: others may be very dependent on others.

Note: Your TAFE Library will have books and videos on the various types of mental illness if you wish to read further in this area.

Handout 4: Issues Facing People With a Mental Illness/Disability

Unlike people with a physical illness, people with a mental illness usually do not evoke community concern and sympathy. As well, the community has not always recognised the needs of people with a mental illness/disability, or their right to lead independent lives.

Key issues that people with a mental illness/disability have to face include:

Stigma
This means a label of disgrace or shame which affects not only society’s view of an individual, but that individual’s self-esteem and confidence, relationships and social life. Stigma is a major barrier to the full and equal participation in society, both economically and socially. People with a mental illness and their carers experience substantial stigma, which results in stereotyping, prejudice, discrimination, marginalisation and restriction or denial of their rights.

Discrimination
People with a mental illness also experience discrimination in many areas of living. This includes denial of access to institutions (such as education), and inferior treatment by service providers across a range of facilities. Discrimination is also reflected in the lower provision of services for people with a mental illness when compared to those for people with a physical illness.
Housing

People with a mental illness find it extremely difficult to access adequate accommodation. Sometimes this is because they are unable to work because of their illness and are consequently on a low income such as some form of benefit: mostly it is due to community prejudice and discrimination. Private accommodation providers are often reluctant to let accommodation to people with a mental illness because of mostly unfounded fears they will ‘cause a disturbance’ or they won’t pay the rent. Some people with a mental illness end up homeless, particularly ageing, chronically mentally ill people.

Unemployment

Employment in the open labour market benefits people with a mental illness/psychiatric disability in a number of ways: economic independence, self-esteem, and opportunities for social interaction. However, people with a mental illness face a number of barriers when looking for work: attitudes of potential employers and colleagues, the impact of the particular mental illness and treatment on capacity to work, and limited access to employment training programs. Lack of suitable employment opportunities for people with a mental illness increases their risk of poverty and homelessness.

Handout 5: The Key Rights for People With a Mental Illness/Disorder Are:

- equity – all people, regardless of age, gender, culture, sexual orientation, socio-economic status, religious beliefs and physical or other disability experience fairness, justice and equal opportunity in all aspects of a service
- access – a mental health service is accessible to all members of all communities across all geographical locations
- choice - access to a range of treatment options and information to assist consumers to select the most appropriate options for themselves (empowerment)
- Quality – a mental health system which provides a high level of service in a range of treatment and related areas to consumers and carers.
Handout 6: Key Principles and Philosophies in Delivering Mental Health Services

Key principles and philosophies in delivering mental health services are:

- **least restrictive care** – for example, a person being subject to a Community Treatment Order (see the Glossary) rather than be involuntarily admitted to a hospital when refusing to take medication.
- **normalisation** – integration of the mental health sector into mainstream services.
- **consumer focused whole-of-lifespan approach** – focusing on the individual and his/her needs in all areas of psychosocial development throughout the whole lifespan.
- **community consultation** – service providers actively seek the views and opinions of consumers and their carers, interest groups, community based organisations as a means of determining community needs and appropriate service directions.
- **participation** - consumers, carers, community based community organizations and interest groups work in partnership with the service provider in planning and implementing services acceptance of difference – the interventions provided by the service take account of and cater for differences including: cultural, physical, religious, economic and social.

Handout 7: Workers in the Mental Health Sector

A number of professional groups work in the mental health sector. These are:

- **psychiatrists** – these are specialist doctors who are trained to **diagnose (identification of an illness, based on a particular pattern of symptoms)** and treat (including prescribing **medication**) mental illness and mental disorder.
- **community mental health nurses** – these nurses work out in the community to assess, support and provide education to people with a mental illness.
- **clinical psychologists** – psychologists who are trained in the assessment and treatment of emotional or behavioural problems. They can work with individuals, couples, families or groups.
- **social workers** – trained to understand and assess problems and issues facing people. They provide counselling, support, information and practical assistance to people with a mental illness and their families: they also liaise with other agencies.
- **occupational therapist** – assess vocational and living skills, and are involved in rehabilitation programs for people who have a mental illness.
Handout 8: Types of Intervention in the Mental Health Sector

- Primary health care services such as doctors in general practice – their role is to identify, manage and where appropriate refer to specialist mental health services.

- Psychiatric hospitals/units. Up until 30 years ago, people with mental health problems, particularly psychotic illness, often spent long periods of time in psychiatric hospitals, where they became institutionalised. Now, admission to a psychiatric hospital or unit is seen as a temporary measure when a person cannot cope at home because his/her symptoms have become worse, and the person can no longer look after themselves. Such hospitals/units are based on a clinical model of intervention.

- Community Mental health Teams – these teams provide assessment, case management, supervision and support for people with a mental illness living in the community. They also can provide support and information to the families of people with a mental illness.

- Residential units/group homes – these provide community located supported accommodation for people with a mental illness/psychiatric disability.

- Crisis care/emergency teams - these teams provide 24 hour emergency help for people with a mental illness who are in crisis. These teams are mobile and can assess people in their homes or on the street.

- Psycho-social rehabilitation programs – these can include work-oriented and vocational training, supported employment, and social and living skills training. One model of vocational rehabilitation services is the Clubhouse model, where people with a mental illness become members of a ‘club’ which runs employment and living skills programs from the clubhouse.

- Consumer- run models such as self-help groups; e.g., GROW, Schizophrenia Fellowship, Association of Relatives and Friends of the Emotionally and Mentally Ill – these groups provide support and information to people with a mental illness and/or their relatives and friends. They frequently also advocate on behalf of people with a mental illness and their families and lobby governments for funding and services.

- Mental health promotion services – these services are focused on the promotion of emotional and social wellbeing in communities and thereby in individuals, by improving the social, physical and economic environments that affect mental health.

- Mental health prevention services – these programs are aimed at decreasing the incidence of mental health problems.
Handout 9: Service Providers in the Mental Health Sector

Services can be provided by the Commonwealth or State governments, by private companies, or by non-government organizations. Current thinking in the mental health field stresses the importance of co-operation between the public, private and voluntary sectors.

- Commonwealth government. The role of the Commonwealth government is primarily that of providing funding. This includes funding of strategies contained in the National Mental Health Policy and Plan (1992) (you can find the web address for this site in the library), and a number of mental health related services that are part of the Disability Services Program, Home and Community Care (HACC) and the Supported Accommodation Assistance Program. These programs provide interventions such as accommodation support, respite care, living skills training and support and home help, among other services.

- State governments are the primary providers of services such as crisis/extended hours services, community mental health teams, mental health inpatient facilities (psychiatric hospitals, general hospital services, community-based treatment beds) and group homes.

Limitations include: insufficient funding to the mental health sector to meet the needs of consumers and carers, shortage of psychiatrists in the public sector, imbalances in resourcing, (such as between urban and rural areas) shortage of specialist services for particularly vulnerable groups such as children and adolescents, Aboriginal and Torres Strait Islanders, the elderly, refugees and the homeless, over-closing of long term inpatient facilities.

- Private. These include psychiatrist in private practice, and private psychiatric inpatient/outpatient services. As well, doctors in general practice are frequently the first point of contact with the medical sector for people who are affected by a mental illness and/or their carers.

Limitations include: psychiatrists in private practice are less likely to deal with people with severe mental illnesses, private inpatient care is generally only affordable for those with private health insurance, access to private psychiatric services concentrated in Australian capital cities). General practitioners may not have the training to identify and appropriately treat people with a mental illness.

- Non-government sector (not-for-profit, community based services) provide a wide range of important non-medical services to people with a mental illness and their carers; accommodation, advocacy, rehabilitation and support programs. These services are often more immediately responsive and flexible to consumer needs than government services, and community managed non-government services place a large emphasis on consumer participation and community control.

Limitations: funding restrictions can limit number of staff and range of programs, policy of deinstitutionalisation means they are being asked to provide expanded services with extremely limited, and sometimes dwindling, resources, even though governments are relying increasingly on their services. Training of staff in NGOS in relation to the area of mental illness may be inadequate.
Handout 10: Mental Health Legislation

The State Acts do vary as to the criteria for compulsory admission or treatment. Compulsory admission may be short-term (2-7 days) or extended (2-6 weeks). Many mental health Acts also allow for long-term committals which allow for compulsory treatment and supervision of people within the community. At the same time, Mental Health tribunals (sometimes called mental health review boards) automatically review all committals, and patients have the right to appeal to the tribunal for reassessment. You might want to find out what the Mental Health Act in your State says about compulsory treatment, and the rights of consumers and carers.

Handout 11: Current Service Issues in Mental Health

The nature of work in the mental health sector has been influenced by changing views about the nature of mental health and also debate about the most effective way to manage a mental illness/disability.

One current service issues is deinstitutionalisation. This refers to the movement of patients, particularly long-term patients, from hospital to the community. Advocates of this policy argue that it is better for the mentally ill person and the community because people no longer spend long periods confined to hospitals. This normalises mental illness allowing the person with a mental illness to participate in the life of their community while receiving treatment in a familiar environment.

While in theory it is a great idea, in practice there have been lots of undesirable consequences for people with a mental illness including:

- insufficient services such as appropriate accommodation and support services for people with a mental illness living in the community
- increased burden on carers
- failure by governments to redirect the financial gains from closing hospital beds to community mental health services
- not enough long-term psychiatric hospital beds for those people with a mental illness who cannot live in the community, community rejection and discrimination.

Another issue is the policy of ‘mainstreaming’; incorporating public psychiatric services into mainstream health services rather than being physically and organisationally separate. For example, acute psychiatric inpatient care should be located within general hospital settings. This has the following advantages:

- it could be a means of removing the stigma still associated with mental illness
- it could significantly improve medical care for people who have a mental illness
- it may encourage people with a mental illness to seek help earlier
- it could mean that mental health services would be located closer to people’s family, community and cultural networks.
On the other hand, there are some disadvantages:

- mental health budgets may be eroded by the demands of the larger and more expensive health services in general hospitals
- psychiatric services may become more ‘medicalised’ at the expense of psychosocial approaches to treatment
- mental health services may be marginalised within the mainstream health service.

Other service issues currently of importance in the mental health sector are:

- **Accommodation.** There is a scarcity of adequate and affordable accommodation in the community for people with a mental illness, who often end up homeless or in crowded, run-down boarding houses. People discharged from psychiatric hospitals may not have families to look after them, and may be referred to homeless refuges or hostels, which are not equipped to appropriately care for them (e.g., supervise medication). Support from government mental health services for people with a mental illness living in refuges/hostels is frequently minimal due to under-resourcing of the services lack of culturally appropriate services. Mental health services, diagnostic tools and treatments in Australia are what is called ‘ethno-centric’: that is, they are based on Western ideas of mental illness and treatment which may not be appropriate for people from backgrounds with different ideas about ‘mental health’ and ‘mental illness’.

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**Handout 12: Documents Which Set Out the Rights of People With a Mental Illness**

Everyone has certain basic human rights and responsibilities. It is essential that people who have a mental illness/mental health problem are able to exercise those rights and responsibilities, and the diagnosis of ‘mental illness’ is not an excuse for inappropriately limiting their rights and responsibilities.

Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care were adopted by the United Nations General Assembly and endorsed by the Commonwealth government in 1991. These principles include:

- every person with a mental illness has the same basic rights as every other person
- discrimination on the basis of mental illness is not permitted
- every person with a mental illness has the right to live and work, as far as possible, in the community
- people who have, or have had, a mental illness have the right to protection from exploitation, abuse and degrading treatment
- all persons with a mental illness have a right to the best available health care
- individuals with a mental illness should be treated and cared for, as far as possible, in the community and in way suitable to the individual’s cultural background.

In 1993, the Report of the National Inquiry into the Human Rights of People with Mental Illness was released in Australia (you can find the website address for this
The inquiry found that people with a mental illness and psychiatric disability:

- experience widespread systemic discrimination and are consistently denied the rights and services to which they are entitled
- are still subject to ignorance and discrimination by the community.

The Inquiry also found that individuals with special needs (children, Aboriginal and Torres Strait Islanders, people from non-English speaking backgrounds, people in rural and isolated areas, prisoners) experience seriously inadequate specialist services.

In 1995, the Commonwealth government released a “Mental Health Statement of Rights and Responsibilities”, covering consumers, carers and advocates, service providers and the community. The document deals with the areas of prevention of mental health problems, assessment, treatment and rehabilitation and the expected standards of mental health care. The website for accessing this Statement is available in the Library.

Mental health rights are also contained in the various State government Mental Health Acts. For example, under the NSW Mental Health Act (1990), the Mental Health Review Tribunal has the role of ensuring that the rights of people in psychiatric hospitals or subject to Community Treatment or Counselling Orders are respected. State Anti-Discrimination legislation also protects the rights of people with a mental illness.

### Handout 13: The Mental Health Issues for People from Culturally and Linguistically Diverse Backgrounds

1. People from NES backgrounds
   
   The 1997 Survey of Mental Health and Wellbeing found that overall, migrants from non-English speaking countries had a lower rate of common mental disorders than both migrants from English speaking countries and the Australian born population. However, we need to remember that while most new arrivals to Australia settle successfully in the long term, the process of migration, settlement and integration into a new culture can be very stressful, and could trigger an existing vulnerability to mental illness.

   Factors that make adjustment stressful include:
   - limited proficiency in English (which can lead to social isolation, and difficult accessing mental health and other services)
   - grief associated with loss of the country, culture, family and friends left behind (even if migration is voluntary)
   - limited social networks and support in Australia
   - conflicting cultural values
   - housing and employment difficulties
   - racial discrimination.

   Refugees in particular face a high risk of developing a mental disorder. Many have suffered severe physical and emotional trauma, both in their country of origin and in refugee camps. Consequently, they may suffer from clinical depression or other
symptoms of other mental ill health, but find it difficult to seek help because of loss of trust. They may present to general medical services with physical complaints such as headaches and insomnia, which actually mask mental distress.

Young people usually adjust quicker to a new language and culture, but may find themselves in conflict with their parents where the attitudes, behaviours and values of the Australian community clash with those of their parents and older family members.

2. Aboriginal people (will write a summary here)
A good video to watch here is “Last Night I heard a Voice” which you may be able to access via your TAFE library.

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**Handout 14: Issues in Service Provision to People With a Culturally and Linguistically Diverse Background**

1. Different beliefs

People from different cultures may have very different systems of beliefs, ways of viewing the world, and different values regarding certain forms of behaviour and social relationships. The way different cultures view and explain ‘mental illness’ may be similar or very different to that of the dominant culture in which they live. For example, traditional Aboriginal culture sees the wellbeing of an individual as intimately associated with the wellbeing of the community, and both involve harmony in social and spiritual relationships and the fundamental relationship with the land. Diagnosis of ‘an individual illness’ is meaningless. In some cultures mental illness may be seen as a spiritual rather than a medical or psychological one. Also, the symptoms of a particular mental illness, and the specific ways in which an individual may experience it, can vary markedly from one culture to another.

2. Barriers to accessing services

People from culturally and linguistically different backgrounds might be reluctant to use mental health services in their community because of:
- cultural differences in approaches to mental health care
- mental illness is stigmatised in their culture
- fear of government services based on experience in country of origin
- fear that mental health services staff won’t understand their cultural/religious beliefs and practices
- lack of knowledge of the law in relation to mental illness
- fear of hospitalisation and removal from their families/communities.
People from CALD backgrounds may want to access mental health services, but have difficulty doing so because of:

- language barriers which can hinder access to information and services
- lack of knowledge of the range and structure of mental health services in Australia and how to access them
- lack of knowledge of their rights and responsibilities
- the culture, attitudes, values and beliefs of the service conflict with those of the CALD background person
- staff of mainstream services don’t understand the specific needs of CALD background consumers and their carers
- overt and covert racism
- direct and indirect discrimination
- lack of culturally appropriate services
- lack of bilingual staff/interpreters.

3. Cultural sensitivity and awareness  (not finished)

It is important that workers in the mental health sector develop greater awareness of some of the differences they can face when providing services to people from different backgrounds to their own. Equally important is greater sensitivity to the causes of problems that may arise in the course of service delivery.

Key points:

- Develop knowledge of the culture, beliefs and values of people from CALD backgrounds. This can be done by consulting community leaders, talking to workers from CALD backgrounds, asking consumers for service feedback, cross cultural awareness training.
- Gender is a major issue in cross cultural health care. In some cultures, a woman is always seen by a female professional and a man by a male professional. People from some cultures where women are subordinate may not accept a female psychiatrist or mental health worker as having any credibility. We need to develop awareness of our own current ethnocentric beliefs, practices, expectations and cultural practices and how these impact on the way we work with people from CALD backgrounds. For example, mental health services in Australia are mainly based on the biomedical model: other cultures may have very different beliefs about the causes and treatment of mental illness.
- Similarly, any mental health service is based on the predominant culture as well as the predominant medical model: this also influences practice and interactions with consumers.
- It is important that members of particular CALD groups are not seen as all being the same (i.e., not stereotyped). Within such groups people vary as to educational and literacy levels, rural/urban background, employment status, English language proficiency, etc.
- Similarly, do not assume all people from a region are the same: e.g., the ‘Middle East’ covers a wide range of racial, cultural and religious backgrounds. Be aware that people from people from particular countries are more likely to have experienced war and/or political persecution and torture. This may profoundly affect their ability to trust others, particularly people in positions of authority.
Also, be aware that some situations in the workplace, for example waiting in a small treatment room with no windows and door shut, may trigger a traumatic response because of some association with a past incident of torture.

- Be aware that in some cultures, the members of a family see themselves as a single client group with whom a worker must interact, not a collection of individuals. This may mean that the family unit needs to be involved in discussions and treatment (however, it is **not** advisable to use family members as interpreters). Also, “family” means different things in different cultures.
- The same body language may express different messages in different cultures.

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**Handout 15: Factors Increasing the Risk of Mental Ill-health for Aboriginal People**

These may need to be explained. For example, issues of violence and drug use may be misunderstood in this community unless the true/false issue is expanded. We need to expand this with HOW they effect the people in terms of mental health.

What are the historical and current factors which increase the risk of mental ill-health for Aboriginal people?

- Impact of colonisation
- Removal from their land
- Government policies of 'protection', segregation and assimilation
- Removal of Aboriginal children from their families
- Economic, educational and employment disadvantage
- Welfare dependency/poverty
- Drug abuse
- Violence in some Aboriginal communities
- Racism.
Handout 16: Skills for Working With People from a CALD Background

- Do not make assumptions about English proficiency, either verbal or written – check understanding
- Use of plain English – avoid jargon and slang
- Talk slowly and clearly (not loudly), and without being patronising
- Check that the person has understood the message you are sending
- Take time to explore issues
- Exercise sensitivity when using interpreters – some people may be reluctant to discuss sensitive topics in front of another member of their community. Check with the consumer which family/community members they wish to involve in discussions and treatment
- Do not make negative comments about religious beliefs and practices.