



## Editorial On caring

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The renewed focus on Mental Health in Australia through the discussions at the Council of Australian Governments (COAG) is to be applauded. The promise of \$1.9 billion in new funds from the Australian Government, with the expectation of matched funding from the States and Territories, will go a long way to solve many of the resource issues which have plagued mental health services since the first Mental Health Strategy. With the explicit focus on PPEI - promotion of emotional wellbeing, prevention of mental illness and early intervention - this is also an opportune time for us to develop coherent strategies in prevention to stem the ever increasing burden of mental health problems.

My hope is that the funding will be used specifically to enhance clinical services, and not used to seek any more supposed alternative methods of addressing the problems – which have so often been based on flimsy evidence or the wishful thinking of transitory employees of health bureaucracies. In other words we need to focus firmly on enhancing existing services which have been so starved of funds, and not for ever look outward away from existing services in the vain hope we can find (or perhaps train up) some other group to meet the shortfalls in service delivery.

Let me give you an example of how the poor resources led to apparently sound decisions which in turn led to new problems demanding solution. As the funding contracted (against the ever burgeoning demand for clinical services), managers had to take decisions (rightly) to focus

resources on those with serious and complex needs. This is eminently defensible. With many services, what this meant was that to get in you either needed to be acutely ill, or you needed to have a clear cut diagnosis of a serious mental illness (for instance 5 out of 9 of the symptoms of clinical major depression). In turn, not only have we provided endless frustrations for consumers trying to get a service, but we have also had to repeatedly frustrate those trying to refer to mental health services. What do you say to someone who has four symptoms of major depression and therefore does not meet the entry requirements? “I’m sorry, please go and get another symptom and then we can treat you!” The frustrations have not just existed for those trying to get a service; they have also been immense for those in clinical services who could see that an ounce of prevention would have been worth a pound of cure, and that treating someone with four symptoms might stop them gaining five.

I have argued elsewhere that if you want the best of prevention in mental health then, as with prevention in other areas of medicine, you need to use (and further develop) the knowledge and expertise of the professionals who understand the trajectories of disorders, and have the passion to continue to work in mental health services even against the odds. Early intervention (primary prevention and early secondary prevention which may include some selective prevention and the majority of indicated prevention) is comparatively easy for those with clinical experience and expertise, as long as they

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have the time, energy and permission to take on the challenges. Rehabilitation (late secondary prevention and tertiary prevention) is also easy for experienced mental health professionals – again, as long as they have the time, energy and permission to take on the challenges. You do not need some new breed of preventive health professional; you need to make sure that those with a passion for mental health are not overwhelmed by the number, acuity, and severity of the cases they are obliged to see - day in, day out.

There may be an exception to this argument, and that is in the area of Mental Health Promotion. I have a firm belief that mental health promotion can be done in the consulting room with individual patients: “OK, it looks to me like we have got your symptoms and illness under control, now let’s take a look at all of those lifestyle factors that could have an impact on whether you get a recurrence in the future”. I also have a firm belief that mental health promotion is an activity for individuals. A father taking his 4 year old son down to the park for a game of footy can be promoting health. A mother stroking and patting her unborn child through her pregnant tummy is promoting the attachment relationship, the basis of all human mental health. A teacher helping a child in class is promoting skills and attitudes that build every day toward resilience, that ephemeral grail of mental health promotion. However, I can understand when Mental Health Promotion is also seen as a Universal preventive activity, and when arguments are made for it to be within the activities of Public Health or Population Health as a profession. It certainly makes good sense to think in terms of large-scale population-wide education programs to improve aspects of the mental wellbeing of the Australian population. My own view would be that the partnership between public health professionals and mental health professionals (the mix of large scale technologies with the passion to be drawn from having worked in the field) will provide the most sensible and effective solutions. We may ultimately see a new profession of population mental health emerge, but at this time we need to ensure that current mental health professionals have the conceptual frame and training to ensure they are able to consider developing mental health promotion in the context of their daily

clinical lives, and then provide them with time, energy and permission to allow them to take on the challenges.

With the opportunities, of course, come obligations. And this brings me to the title of this editorial, which may not be comfortable for some to think about. Increasingly I hear stories in health circles about the level of care, and the quality of caring, provided to our patients. Much seems to centre around whether an illness or problem is self-induced. So recently I heard several stories about fat people in hospital. One story was that nursing staff, without any discussion, unilaterally ordered a weight reducing diet from the hospital kitchen, and arranged to place the patient on Optifast, a complete weight reducing compound. This was not in the context of a carefully planned strategy to continue after discharge, just the whim of a prejudiced professional. When the patient complained, first the nurse ridiculed them, then attacked them for not doing better with their weight. Underlying the situation was the belief of the nurse that the patient was fat, lazy and stupid, and deserved to be fixed, that the obesity was self-inflicted. Whatever the truth of the situation, the attitude is based in stigma. A second story is about a group of elderly people in a hospital who got infective diarrhoea. The burden on staff was considerably increased, and tensions arose with relatives who were naturally worried about their kin. Placed on water to allow the infection to run its course, the elderly people felt they were being starved. Complaints led to ridicule, and an unwarranted extension of the fluids-only regime. The underlying attitude seemed to be based in a belief of some staff that the elderly people would be better put out of their misery, and that the gastroenteritis provided an opportunity to assist. Again there is stigma here, and considerable lack of care.

A third example is unfortunately all too common. A young woman was presented to an emergency department of a hospital with an overdose that she had believed would be fatal. The staff assessed the lethality and time since ingestion, put a drip into a vein, and left her on a barouche in a corner for several hours until she could be discharged. Regular observations were done, but no-one took the time to try to understand the issues, provide comfort or suggest solutions. There is a disdain for the

young woman's problems in the actions of the staff. They rated her as not serious about suicide, as wasting their time, and as not worthy of further exploration. I have heard worse stories around people who self-injure. Not only are they reviled and rejected as time wasters, not only do staff jump to the conclusions that they are 'borderline personality' disordered on little evidence, but they are often brutalised further by being stitched up without anaesthetic. Just what you need when your background history may have been of extensive physical abuse.

A final example will suffice. A colleague recently told me about a series of suicides which had occurred after hospitalisation – within the first 2-3 weeks; a time of great danger for those with serious mental illness on the way to recovery. Somehow, many of the patients had not been followed up by mental health professionals just to make sure everything was going well, somehow communications to the GPs and to other community health supports had just not got through, and somehow people in a fragile transition phase had been left to get on with their lives alone.

All of these examples are to do with caring, that quality of professional life which should be central to what we do. A very strong argument could be put forward that because our resources in health services across the country have been decimated, because we are all working harder than we have ever done before, because the quality of casework is harder and more complex than ever before, because we all have more paperwork to complete than ever before, we don't have time to care. I sympathise with those who put such arguments forward, but that does not make them right. I think there are other elements which also contribute to this style of working. 'Case management' to my mind has been a very dangerous way of trying to organise our professional lives under pressure. It seems to me that care has become fragmented, that there are lots of people involved in a program of care or a management plan, the case manager spends a lot of time running around coordinating everyone, but no one person is doing the therapy, the listening to the patient, the caring. Another element relates to the forms of therapy that have emerged as evidence based over the last few years. They are largely short term, often manualised, and sometimes mechanistic. They

are about the tasks to be completed, not about the human being struggling to complete the tasks, but also struggling to make some meaning of their lives.

Well, now is the time for us to consider a radical change in direction. If the whole process of COAG is not just smoke and mirrors, and if the new funding genuinely comes through to mental health services, we may have sufficient resources to train our personnel better, supervise them more often and with more time available, and support them in the very hard tasks they are expected to perform. They may have time left over from direct casework to consider what they are doing clinically, or what they have achieved. More than that they may have the time to consider developing skills in early intervention, prevention, or mental health promotion, and time to apply them during the working week. Through all of this we have to make sure that our staff recover their ability to care, and not just see the patients they work with as throughput toward some sort of output.

And so to this issue of AeJAMH, another extraordinary achievement.

Our guest editorial this issue comes from Denmark with Eva Jané-Llopis, from the World Health Organization mental health program, making several strong points. In reviewing the literature she suggests that the evidence of the effectiveness of mental health promotion is good; however there is an evidence-dissemination gap that must be resolved. Even then, training programs, and the political will to fund programs, will be needed to put the evidence into large scale practice.

Annette Beautrais, from the Canterbury Suicide Project in New Zealand is one of the foremost international researchers and authorities on suicide prevention. She reviews the idea of national strategies, noting that the unique profile of suicide in each country tends to shape its national suicide prevention strategy, despite a common international evidence base. She examines areas of action for which we have strong evidence of effectiveness, and in a challenging conclusion, somewhat against Rose's theorem and current community based approaches, argues strongly that we should continue to focus our efforts on those clinically at high risk.

In a welcome and really useful re-evaluation of psychotherapeutic approaches in psychosis, Richard Lakeman from Townsville, in an excellent overview of current approaches, argues that health professionals involved in the care of people with psychosis ought to interact in a psychotherapeutic manner and further develop psychotherapeutic skill. Taking an eminently rational approach but well grounded in the available literature he argues that, in utilizing psychotherapy, we must understand the client's current capacity, carefully match the interventions, and overall enhance coping skill.

The paper on building resilience in young people by Kylie Oliver and colleagues suggests that meaningful participation is a key to resilience because it can enhance a young person's sense of connectedness, belonging and valued participation, and thereby impact on mental health and well-being. The paper draws on 10 years of experience with the Reach Out! Program (auspiced by Inspire Foundation), particularly focusing on the Youth Ambassador program. In concluding, the authors argue that the program meets all elements of a resilience building program in developing interpersonal and communication skills, increasing young volunteers' confidence, self-esteem, and self-efficacy, encouraging connections to other young people and adults in the community, and fostering caring and compassion.

Karla Hayman-White and colleagues from The University of Melbourne remind us that the current proportion of health expenditure afforded to mental health is not comparable to the prevalence of mental illness or the related burden of disease, and this makes it almost impossible for us to match the quality of care available to people experiencing a mental illness to those suffering physical illness. Having explored the facts regarding costs in some detail, they argue cogently that this represents discrimination, and conclude that it may be the mental health nursing workforce who could act to redress the balance.

Tricia Nagel, a Northern Territory psychiatrist, argues for relapse prevention strategies in the context of remote indigenous mental health service delivery challenges of isolation, staff recruitment and retention, and cultural, language and literacy issues. From a telephone survey of service providers she explores training, ability

and confidence, and concludes that both policy-related strategies and community-level activities are needed to provide a template for best practice in relapse prevention.

In a literature review exploring the links between domestic violence and suicidal ideation in women, Marika Guggisberg from Perth notes that women who have been abused by their intimate partners are almost four times more likely to have suicidal ideation and are also more likely to develop mental illness compared to non-abused women, and that domestic violence is more damaging than street violence. In conclusion, it appears that historically rooted victim-blaming attitudes may still exist in society and in health professionals, and these established prejudicial attitudes may increase the risk of abused women becoming suicidal.

In a paper on the impact of the attitudes of professionals in a position of authority on the mental health in others, Rob Donovan and colleagues, from Curtin University in Perth, report on a fascinating piece of large scale telephone interview based research. They note that within the sample there may be different pairings of authority, but that 'providing stimulation' and 'positive reinforcement' were the top two behaviours for ensuring the mental health of those in their care. There are admitted limitations in this predominantly qualitative research, yet the authors are able to conclude that the data do identify areas where awareness and understanding need to be increased to facilitate an increase in behaviours that support good mental health and decrease behaviours that negatively impact on mental health.

In the final paper of this very rich edition of AeJAMH, Robert King and colleagues from the University of Queensland describe in detail the development and evaluation of a Clinician Suicide Risk Assessment Checklist, specifically aimed at assessing the effectiveness of risk assessment training programs, and a possible accreditation process. With only a small number of expert raters to test the questionnaire, there is still further work to be done to validate and test the reliability, but the authors conclude that preliminary results indicate that the questionnaire advances the evaluation of risk assessment competency and provides a basis for further development.