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Student Details:

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Location **	Australia - BUNDABERG - 4670

Assessment Type:

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Year/Term	2009 Term One
Assessment Nbr & Title	1 - Psychosocial assessment
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Lecturer/Tutor	Lisa Loots
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Assignment Word Count	2487 words

Student Remarks:
Please also see attached further info for consideration of extension request.

Extension Information:

Extension granted ☐ No ☒ Yes++

Revised due date 24.4.09

Extension approved by Lisa Loots

Approval date 6.4.09.

DECLARATION

I certify that this assignment is my own work, based on my own personal study and/or research, and that I have acknowledged all material and source used in the preparation of this assignment/report whether they be books, articles, reports, lecture notes, any other kind of document, electronic or personal communication.

I also certify that this assignment has not been previously submitted for assessment in any other course or at any other time in this course, unless by negotiation, and that I have not copied in part or whole or otherwise plagiarised the work of other students and/or persons. I have read the CQU policy on plagiarism and understand its implications.

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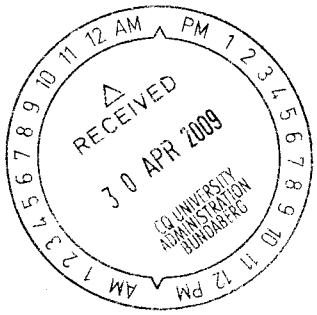

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Mark/Grade: HD

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Marker's Comments

Very well researched + knowledged integrated ~~to~~ + applied to the case of Mr. J.

Well done!

15 MAY 2009

Continue on back of page if required.

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SOWK 19021

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Social Work and Mental Health

Assessment One

Psychosocial Assessment

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Due Date: 17th April 2009

Extension Granted

Introduction

This essay evolves from an understanding of the case study presented on Mr J. Firstly, various perspectives with regards to mental health are examined. These perspectives include the medical model, the biopsychosocial perspective, the structural model and the recovery movement. Mr J resides in rural Australia, so risk factors associated with mental health issues in rural areas will follow the perspectives discussion. Further risk factors of marijuana and alcohol use, and previous suicide attempts were identified with Mr J, so these will also be discussed. Finally, the importance of the family will be outlined followed by an overview of social work and mental health. A psychosocial assessment will be provided as an appendix to this essay, which will highlight any gaps in the case study that require further investigation.

Perspectives

The medical model appears to dominate and be the most common form of treatment in the mental health field. 'The medical model asserts that mental illness is a pathology and in the same way that any physical disease can be assessed by signs and symptoms, so can mental illness' (Stickley & Timmons 2007, p. 156). Meadows, Singh and Grigg (2007) provides a description of the medical model. The assessment of the patient begins with questioning around the presenting complaint. This can lead into the observation of a symptom. Following this is the examination, where signs, or observations can be detected. These observations are then used to determine a diagnosis, with treatment being guided by the diagnosis that gets made (Meadows, Singh & Grigg 2007, p. 24). Beecher (2009) conceptualises the medical model in two ways. These are the biomedical model, where mental illness is seen as a brain disorder, or central nervous system disturbance which can be treated with pharmacological or physical treatments, and the practice oriented model, where a diagnosis is made then treatment is provided (Beecher 2009, p. 10). Whilst the medical

model has been widely used and appears to be the most commonly used model with regards to mental illness, it can also be seen to be too focused and simplistic, without taking in the holistic view of an individual (Beecher 2009).

In contrast to the medical perspective, the biopsychosocial perspective takes on a more holistic view. The use of the biopsychosocial perspective, allows practitioners to encourage the use of preventatives for health related issues (Zittel, Lawrence & Wodarski 2002). For example in the case study of Mr J, it outlines the history of suicide in his family, and also his father talking about an Aunt who was "very odd". Further information is required here, but this could indicate a predisposition to a mental illness and the undertaking of a biopsychosocial assessment can help identify this. Psychosocial assessments 'involves a specific focus on mental state, personal relationships and social situation' (Barr, Leitner & Thomas 2005, p. 131). From the information provided in the case study, a psychosocial history can be developed. This is a report on Mr J's current symptoms, problem, situation and life history, and can come from a number of sources including Mr J himself, his family or reports from other agencies (Sands 1991). If the written report includes medical findings obtained from the general practitioner (GP) along with psychological and social findings, it becomes a biopsychosocial assessment. The biopsychosocial assessment is used to 'denote a broad understanding of the client's situation, biological, psychological, and social functioning, and needs' (Sands 2001, p. 79). Items that will be found in the psychosocial assessment of Mr J includes his personal details, life circumstances, medical and psychiatric history, his presenting problem, employment history and relationships information (Sands 1991). The National Mental Health Policy (2008) provides a holistic approach to mental health, and acknowledges '[m]ental health problems and mental illness are influenced by a complex interplay of biological, psychological, social, environmental and economic factors'

(Commonwealth of Australia 2009, p. 10). An example of a psychosocial assessment for Mr J can be seen in appendix A.

The structural model was developed by Freud, who, by dividing the mind conceived the id, ego and superego model (Farhall et al. 2007). Further study in this field has expanded on the theories originally coined by Freud, and this can all be grouped together as the psychoanalytic or psychodynamic approach (Farhall et al. 2007). The next section of this essay will further expand on Freuds structural model: id, ego and superego. The id is found in biological realms, and contains the most basics of human desires and impulses, and generally part of the unconsciousness. Ego is that part of the mind that curbs or represses the id. Finally, the superego is made up of the can'ts and disgusts, it is the moral compass (Jelliffe 1939).

> Recovery is a journey as much as a destination. It is different for everyone. For some people with mental illness, recovery is a road they travel on once or twice, to a destination that is relatively easy to find. For others, recovery is more like a maze with an elusive destination, a maze that takes a lifetime to navigate.
>
> O'Hagan 2001, p. 87

The final model to be discussed in this essay is the recovery model. The concept of recovery in the mental health field took momentum in the 1990's (Anthony 1993). It is important to note that the term recovery in this instance does not necessarily mean a cure, or the cessation of all symptoms, nor the moulding of a person into the way a health care workers wants them to be. 'Recovery is aimed at helping people be who they are' (Browne 2006, p. 153). The recovery model stems from a variety of mental health developments including social inclusion, person centred approaches, self management approaches and social role

valorisation (Davidson 2005). The National Mental Health Policy 2008 fits in well with the recovery model, discussing social inclusion, recovery, increasing an individual quality of life, and promoting community access (Commonwealth of Australia 2009). Within the medical model, as outlined previously, recovery would take on a different meaning, and would encapsulate such terms as being free from symptoms, undertaking full or part time work or education and independent living (Fox 2007). Mental health recovery however, as defined by Anthony (1993, p. 13) is:

> 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 one grows beyond the catastrophic effects of mental illness.

Risk factors: Rural Issues

According to Hodges, O'Brien and McGorry (2007), 27% of 18 to 25 year olds experience mental health problems each year, but only one in four of them receive professional help (Hodges, O'Brien & McGorry 2007, p. 77). It is imperative therefore, now that Mr J has been referred, effective support is provided for him. Living in a rural location provides further implications for his mental health well-being. For example, statistics show that Australia has one of the highest suicide rates in the world and the suicide rate in rural areas is nearly twice as high as in capital cities (Hodges, O'Brien & McGorry 2007, p. 77). Evidence suggests that there is less availability of mental health services in rural Australia, and that the GP is heavily relied upon for mental health care (Caldwell et al 2004). In fact, Lockhart (2006), confirms that of those people with a mental illness who seek help, 75-90% of cases are managed by a GP. The study by Lockhart discusses the referral and collaboration between GP's and mental health workers (MHW) in rural Australia. The results show that

whilst GP's were referring, they were unaware of services available, or what they offered. Furthermore, from the MHW perspective, they tended not to communicate directly with the GP as they felt the GP did not have an interest in either mental health issues, or the role of the community mental health team (Lockhart 2006).

The research by Bambling et al. (2007) outlines some of the challenges faced in providing mental health services in rural Queensland. Some of the findings of this research includes the perception of GP's that there is inadequate staffing to cater for all the referrals made to mental health services, and that on occasion, referrals for suicidal patients were unsuccesful. Response from community mental health workers indicated a rise comorbid drug use, resulting in aggressive patients, or extra challenges in diagnosis. This is something to be aware of with Mr J as the case study indicates his use of marijuana and alcohol consumption, and this will be discussed further later in this essay. Finally, the community sector respondents in this research outlined issues in follow up from mental health services once clients were considered stable (Bambling et al. 2007). Further issues for youth experiencing mental health issues in rural areas are outlined in a plethora of studies. One example includes a lack of anonimity for those in rural areas. As Mr J also resides in a rural area, this is something to be considered. As Boyd et al. (2007 p. 197) indicated "the difficulty of keeping aspects of their lives a secret". This study also indicated a rural culture of self reliance, where you have to deal with problems on your own, and seeking help is seen as a weakness of character (Boyd et al. 2007). Further, Aisbett et al. (2007) cite transport and travel issues, long wait lists, lack of after hours support and rural gossip as further barriers for those experiencing mental health issues in rural Australia.

Good insight Jennie.

Risk factors: Marijuana and Alcohol Use

There is a growing amount of evidence linking marijuana use to mental health disorders. Aside from the high monetary costs and the illegality of marijuana, further risks associated with marijuana use include depression (Chen, Wagner & Anthony 2002), suicide (Kung, Pearson & Liu 2003), conduct disorder, ADHD and anxiety (Diamond et al. 2006) and schizophrenia (Cannon & Clarke 2005). The case study indicates that Mr J is using marijuana on a daily basis. This needs to be considered when developing the recommendations/treatment plan in the psychosocial assessment.

✓ well done.

It is further indicated in the case study that Mr J partakes of alcohol, to the point of binge drinking every weekend. Following the National Survey of Mental Health and Wellbeing (NSMHWB) in 1997, Teesson et al. (2000) outline the findings. The survey found that one in fifteen, or 6.5% of respondents had an alcohol-use disorder. Alcohol-use disorder is higher amongst males (9.4%) than females (3.7%), and the age group with the highest rate of alcohol-use disorder are the 18 – 34 year group (10.6%). Further, alcohol-use disorder was higher amongst those who are unemployed, than their employed counterparts, higher amongst those who had never been married than those who are married, separated or divorced and finally, higher for those born in Australia compared with those born in non English speaking countries (Teesson et al. 2000 p. 208). The important factor to note here is that Mr J meets every single one of the above mentioned; he is male, aged 21, unemployed, never been married and born in Australia. In addition, one third of males with alcohol-use disorder suffered from at least one other mental health issue such as anxiety, drug-use or affective disorder (Teesson et al. 2000). As already discussed, Mr J is a regular marijuana user. His alcohol use is an essential factor to consider when developing an intervention plan.

Risk factor: Suicide

Research shows that suicide rates amongst males are higher in rural areas than within urban areas (Taylor et al. 2005; Judd et al. 2005; & Phillips 2009). Taylor et al. (2005) shows that suicide rates amongst males in rural areas are higher than amongst their urban counterparts, they also report that the utilisation of mental health services and GP visits in rural areas by males are lower than in urban areas. This is something that has already been discussed, and is now further emphasised due to Mr J's previous suicide attempts. Now that he has been identified and referred for support, it is essential that effective treatment be offered in order to avoid another suicide attempt. Judd et al. (2005) examine suicide and discuss some of the factors contributing to the risk of suicide, including alcohol and drug abuse, stressful or difficult life events or interpersonal and family factors. Alcohol and marijuana use has been associated with Mr J and discussed earlier. The case study indicates that Mr J has attempted suicide on previous occassions. There is evidence to suggest that those with previous suicide attempts are at high risk of hospitalisation again for more suicide attempts, or of death from suicide (Gibb, Beautrais & Fergusson 2005; & Wong et al. 2008). Effective assessment, treatment and follow up with Mr J can hopefully reduce the risk of another suicide attempt. While distance, lack of mental health services or Mr J not being willing to engage in treatment may pose barriers, it is important that procedures are put in place to attempt to move these barriers.

Mr J and Family

If an individual has strong family ties and support and a strong social network, the better the life outcomes of that individual will be (Furlong 2003). The case study indicates that Mr J lives at home with his parents and two younger sisters. He has indicated his parents are supportive and that he did have a good relationship with his sisters, but his aggression has put

a strain on this relationship. When developing a treatment plan, it is important that the family be involved. This will not only help the family to understand Mr J, but also provide an opportunity for Mr J to voice his needs to the family, and vice versa. Bland (1994) examines the family based interventions in use at a Brisbane hospital for patients with schizophrenia. Whilst the case study does not indicate schizophrenia for Mr J, there is evidence of a possible mental health issue, hence the relevance. Suggestions by Bland (1994) include exploration of the experiences of the family of the individual experiencing mental illness, understanding mental illness, engagement and involvement of families, coping strategies, developing independence and acknowledging the stress the illness causes on the individual and family. These are all considerations when working with Mr J.

Usher, Jackson and O'Brien (2005) highlight the effects of drug use on families. Violence, criminal activity, threatening behaviour and high stress levels are all cited as experiences of families of drug users and it is suggested that families facing alcohol and other drug issues will react either by meeting the problem head on, tolerating the problem, or withdrawing from the abusing family member (Usher, Jackson & O'Brien 2005). The latter options are not the optimum, so effective engagement with the family of Mr J is neccessitated. As Mr J has shown signs of violence, and this has resulted in strained relationships with his siblings, efforts to rebuild the family ties should be made. Working with, and drawing on the strengths of both Mr J and the family are a starting point in this situation.

Mental Health and Social Work

The Australian Association of Social Workers (AASW) Code of Ethics (AASW 1999 p. 5) states '[t]he social work profession is committed to the pursuite and maintenance of human well-being'. This is achieved by working with clients, helping them achieve personal and

social well-being. Social workers work with those who are disadvantaged, neglected, vulnerable and have exceptional needs (AASW 1999). Mr J, as a client, comes to the social work profession with a myriad of needs and risk factors, some of which have been discussed above. It is important that work with Mr J is non-judgemental, empowering and client focussed.

Conclusion

Using the information provided in the case study of Mr J, the above has been an essay looking at the various aspects of mental health. A brief overview of some models and perspectives relating to mental health was first provided. Following this, the risk factors of rurality, marijuana and alcohol use and suicide were examined. The essay was concluded with a discussion of the role and inclusion of the family in Mr J's treatment and an overview of the social work profession in mental health. A psychosocial assessment of Mr J is included as an appendix to the above work.

Jennie,

This a well applied, researched and integrated work. A pleasure to read!

Regards
Lisa.

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Appendix A

Psychosocial Assessment (Using format recommended in Sands 2001, pp. 94-95).

Any gaps that have been identified are highlighted in yellow below. These are areas that require further information, either through direct discussion with Mr J and his family, or from medical reports and other agency reports.

1) Identifying Information

Name:	Mr J
Age:	21
Sex:	Male
Ethnic Group:	Not stated in case study
Employment:	Unemployed
Marital Status:	Single
Referral Source:	Local medical officer at Agnes Water
Referral Reason:	Presentation at Agnes Water hospital for suicide attempt
Data Sources:	Mr J case study, further data sources could be referral letter, interviews with other persons, examinations and other medical reports etc

2) Presenting Problem

Following his suicide attempt, Mr J has stated that he 'really doesn't want to end his life', but is going through some difficult times at present.

This part of the report should be written from what the client says. It includes details about the problem, symptoms, others involved in the problem, how they are involved and their view of the problem and contributions to the problem. Past experiences of the client and any similar situations, including how the client handled them. Identification of any life stressors

over the past year and how they were managed. Direct consultation with Mr J could further add to this section as information provided in the case study is very limited.

3) Current situation

Household: Mr J currently lives at home with his parents and two younger sisters. Mr J states his parents are supportive, but tend to 'annoy him'. He also states good relationships with his 2 younger sisters until recently when his violent outbursts resulted in one sister requiring hospitalisation. With Mr J in the house, the family is becoming increasingly stressed, and the mood less than happy.

Social Network: Mention of friends in the case study, but further information required

Economic Situation: Mr J currently receives Newstart Allowance from Centrelink and borrows money from his parents

Physical Environment:The case study does not indicate much about the details of Mr J's housing, (ie – house, apartment etc, neighbourhood details, crowded conditions etc).

Significant Issues: Alcohol use to the point of binge drinking every weekend and marijuana use on a daily basis, police involvement on previous occasions, following violent outbursts at home and a previous suicide attempt, previous suicide attempts

4) Previous Mental Health Problems and Treatment

The case study indicates that Mr J has attempted suicide on two previous occasions, but does not indicate any previous hospitalisation, treatment or outcome of treatment. One of the suicide attempts is stated as taking some anti-depressants that had been prescribed for him, so this could indicate some form of prior treatment for depression. Mr J, while admitting things could be better, does not believe there is anything much wrong with him and questions what seeing a mental health worker could achieve. This section of the psychosocial assessment is

something that could be explored further as it would be helpful to know further details about his previous suicide attempts, if he was hospitalised etc.

5) Background Information

Family Background: Further information is required here as we do not know anything other than he lives with his parents and 2 younger sisters. Further details could include extended family

Relationship History: The case study indicates Mr J has no girlfriend, but no details as to any past relationships

Education: The case study indicates his parents considered him intelligent and popular at school, but does not indicate if he completed high school or has participated in any further study

Employment History: Mr J is currently unemployed. The case study indicates he has not had a long term job since high school, but has had employment. Further information could be obtained here as to the type of work he has had, along with dates etc.

Drug use: Mr J binge drinks every weekend and smokes marijuana on a daily basis, the case study also indicated attempted suicide using prescribed anti-depressants, so further details could be added here. The case study also does not indicate any information regarding friends or family drug use, which could be added here if relevant to Mr J

Health Issues: Sleeping problems are listed, with Mr J only sleeping a couple of hours each night, then laying awake for the rest of the night and feeling tired and lethargic during the day. Further information to be included here includes any previous accidents, diet and exercise and health problems in the family.

Cultural Background: Nothing is mentioned in the case study, so further information is required here.

6) Results of Mental Status Examination and Diagnosis

This is something not outlined in the case study, but would be included in the assessment.

7) Analysis

This section is written from the social worker (my) perspective and how it compares with the client. It describes how effectively the client is functioning, what factors are contributing to the issue, strengths and resources available to assist the client, obstacles and clients motivation and potential to benefit from treatment is also included.

Mr J has been referred following hospitalisation after what is allegedly the third suicide attempt. Mr J describes feelings of worthlessness and lack of pleasure in anything. Currently unemployed, he believes he is seen as a loser and a slacker as there is work available in the area. Mr J partakes in excessive alcohol consumption and daily marijuana use which helps him to forget about his life and chill out. However, it is during the alcohol intake phases that he finds himself becoming suicidal.

Mr J appears to have a supportive family, but tension is strong and patience wearing thin following some recent violent outbursts by Mr J where police have had to be involved. The family network is a strength for this client, and should be included in an intervention plan.

His parents comment on his intelligence and popularity whilst at school and it appears he maintains a friendship network. Mr J also states being able to talk to others and have fun whilst at school, so the possession of effective social skills is apparent. Mr J himself is aware

he has not reached any of his goals, which is something also to be considered in an intervention plan.

Whilst Mr J is currently unemployed, he has had work in the past, however short term it has been. This is a further strength and resource to draw on as he may have developed some skills from previous jobs. The availability of work in the area is also high, another resource to draw from.

Whilst Mr J indicates things could be better, he questions what benefit he could gain from seeing a mental health worker, so clients motivation could be questioned. Alcohol and drug use is also another obstacle to be addressed.

As already mentioned, the family support network appears strong, and, with intervention, the potential to benefit from treatment is strong.

8) Recommendations/Intervention Plan

Course of action: Mr J could benefit from some family therapy. The family appear supportive, but tensions are high and stress escalating. Family therapy could assist the family to understand more about Mr J and his current issues and diagnosis. Furthermore, education for the family could provide them with ways of coping and dealing with the issues, also with effective ways of supporting Mr J. Family therapy could aim to rebuild the slowly diminishing family ties.

An alcohol and drug program or counselling would also benefit. Alcohol and drug use puts Mr J at higher risks of mental illness and suicide. The assistance could take the form of

individual or group counselling, which includes education and information about the risks associated with his current drug and alcohol use. Mr J could benefit from referral to ATODS within the hospital, or to another service provider, such as the Bridges drug and alcohol programme. Whilst they are based in Bundaberg, they do outreach to the Agnes Waters area.

There is indication that Mr J has been prescribed anti-depressants in the past. Follow up with a psychiatrist for assessment for medication if he is no longer taking the medication could be beneficial. Further assessment of his sleeping patterns could also benefit, as regular and effective sleep each night would benefit.

Mr J would benefit from referral to a Job Capacity Assessment (JCA), with the aim of being referred to a Vocational Rehabilitation Service (VRS) such as CRS Australia. Again, whilst they are based in Bundaberg, they do outreach to Agnes Waters. The CRS Australia VRS runs for up to two years and addresses all the barriers to employment faced by a client. During the two years they can provide counselling support, access to education and training programmes, and referrals to other support providers. The ultimate goal of a programme with CRS Australia is paid employment.

The goals of the above intervention include a reduction or cessation of alcohol and marijuana use. Further goals include effective counselling in an attempt to get away from the feelings of worthlessness and despair faced by Mr J. Finally, the restoration of family relationships, and eventual paid employment is another goal. In order to see if goal attainment occurs, regular contact can be made with Mr J. Goals can be listed, with smaller tasks being allocated that can be regularly met in order to achieve the longer term goals. It is estimated that case management be provided for Mr J for a period of at least the next 12 months.

Jennie Vira

Mental Health Worker

Bundaberg Community Mental Health

(It is important for me to add here that the above recommendations/intervention plan be made in consultation with Mr J. Both the recovery movement, and the principles of social work such as client self determination and empowerment encourage client involvement at all levels. The above plan therefore, is a guide and could change following further conversations with Mr J).

Jennie,

This is excellent work on the psychosocial assessment. Knowledge is well applied to the case which assisted you to plan a well structured intervention plan.

Well done!

Regards

Lisa.