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Book 3: Palliative care within mental health: ethical practice

Chapter 23: Making sense: death, dying and mental health

Chapter 23

Making sense: death, dying and mental health

Dan Warrender and Scott Macpherson

Introduction

The causation of mental health problems remains burdened with an uncertainty which freely allows a variety of assertions to be made (Pilgrim 2014). It is therefore crucial, in this arena of confusion, that some sense be available. This chapter will bring together sociology, spirituality and philosophy, and describe the human need to seek meaning, arguing the crucial role of spirituality in making sense of mental distress. The concepts of death and dying will be explored with a view to introducing spirituality, before arguments are applied specifically to mental health and the professional's role in spiritual care.

Death

'It always ends. That's what gives it value'

From: Death: The Deluxe Edition © 2012 DC Comics. Written by Neil Gaiman. Courtesy of DC Comics.

Death. The concept is inescapably tied into systems of belief, which we the fragile and finite creatures of humanity use to make sense of the unknowable. Anyone reading this will only have had experience of death in the third person. We witness the death of others aware that the same inevitability waits for us all, able only to ponder the time we have left, and what if anything comes next. It is the final word and full stop to life, with a question mark on whether or not a new sentence follows.

Biologically speaking, death has been related to brain capacity and defined as the…

'…irreversible loss of the capacity for consciousness combined with the irreversible loss of the capacity to breathe' (Gardiner et al 2012, pp. i14).

The impact of these functions on life is empirically verifiable, and this definition has gathered consensus. Whilst the reasons that our biological processes may cease can vary dramatically, there is no variation in the fact that regardless of our thoughts or feelings on the matter, we will die. How people deal with this knowledge is then a matter for each individual.

The denial of death

It has been suggested that by the age of nine children will have an understanding that everyone (including themselves) will die, and furthermore realise that death is final (Upton 2010). This can be a huge burden for one so young. Nonetheless, despite the inevitability of death, it has been argued to have become a much more unfamiliar concept, particularly to younger generations (Sidell 1993).

Key Point 23.1

Denial has been described as:

'…cognitive acceptance of a painful event while the associated painful emotions are repudiated' (Bateman, Brown & Pedder 2010, pp.32).

It could certainly be argued that whilst we are all aware that one day we will die, we 'choose to forget' as we live our lives. Ignorance is bliss.

This idea of a 'death denial' was championed by the French historian Aries (1976), who claimed that historical cultures were much more at ease with death, and modern progress in medical science has forced a shift. Medical science can now save people in ways which were not previously possible, prolonging life, and contributing to the notion that death can be kept at bay by healthcare professionals (Beckett & Taylor 2016). Individuals in western culture are not as in tune with mortality as was once the case.

Social disengagement

The theory of social disengagement (Cumming & Henry 1961) posits a potential contribution to this denial, suggesting that the ageing populous participate in a functional disengagement from society, thus allowing them to process the fact that they are nearing the end of life. It has however, been debated as to whether this is indeed a psychological need of the ageing individual, or a justification for marginalisation by society. Kearl (1989) argued that social disengagement was an intentional marginalisation to remove the dying from society so 'the living' would not be faced with a reminder of their mortality and the inevitability of death. This idea profoundly shifts the purpose of disengagement from one of psychological benefit to the individual, to one which ostracises the individual to the perceived 'greater good' of society.

Whether we agree or disagree with Kearl's view the theory nonetheless retains its potential influence over a 'death denial' in society, as for whatever reason, society does keep the dying out of the way. Indeed, most people receiving end-of-life care in England will die in an acute hospital (National End-of-Life Care Intelligence Network 2010) rather than in their own homes and communities. Furthermore, there can be curious examination of the origin of the word ‘palliative’. Whilst in modern language it is associated with end of life care, the word actually comes from the Medieval Latin ‘pallitavus’, the verb ‘palliate’ meaning ‘to cloak’ (Oxford University Press 2017). It could certainly be argued that care homes and hospitals serve as a cloak, under which we can hide death, and for a moment forget our mortality.

Self-Assessment Exercise 23.1

Time: 20 minutes

Consider the statement

- What instantly comes to mind?
- Are we a society that hides or denies death?
- Write down your thoughts
- Do you perceive the word ‘cloak’ to refer ‘to hide’, or to offer protection?

Social death

If disengagement is a prelude to biological death, then this process could perhaps be viewed as a form of social death. The treatment of people nearing death was originally presumed by Sudnow (1967) to be influenced by their perceived lessening social value. Once a human reaches a grand age, or receives a terminal diagnosis, they can be viewed to have more years behind them than in front, and society can effectively treat people as ‘already dead’. Currently social death has been described as having three key components (Králová 2015):

Box 23.1 - Social Death (Králová 2015)

- A loss of social identity

- A loss of social connectedness
- Losses associated with the disintegration of the body

Social disengagement of the ageing or dying population could be said to fit these criteria.

Key Point 23.2

Social identity can be lost through retirement from jobs and careers which have given definition to an individual's life. An ageing individual is more likely to see friends and loved ones around them die, leading to a loss of social connectedness.

Finally, the disintegration of the body comes with the natural process of ageing, and is irreversible. Whilst it is not fair to generalize the ageing population as socially dead, we can speculate as to how, for some individuals, this could seem to be the case. Social death and the marginalisation of any group is consistent with the ideas of stigma, discrimination and prejudice, and these can come from external sources or be internalised.

Externally, social death is evident when an individual is viewed as less socially valuable, and therefore is subject to behaviour from others which is prejudicial or discriminatory. An individual may receive less opportunities, and even be viewed with less hope by healthcare professionals. Internally, social death is a form of self-stigma whereby an individual begins to adopt the beliefs of society. This could mean older people potentially believing that they are too old to change as a result of both internalising societal stereotypes of old age and their cohort beliefs (beliefs held by groups of people of similar ages that are indicative of collective life experiences). These beliefs can have huge influences on self-esteem, self-efficacy and locus of control, which impact on how people live. Further implications can be people not asking for help for distress, or if they do seek help then having diminished hope for the outcomes of any treatment.

Whereas biological death is the end-of-life as we understand it, the narrative provided by society can contribute to huge changes within life which could be described as a social death. Both deaths are huge milestones, and all individuals will attempt to make sense of not only their changing place in the world, but their place in the universe.

Coming to terms with dying

The need to make sense of death and dying belongs not only to the individual concerned, but also to their families, carers and responsible health and social care professionals. Based on work with terminally ill people, Kübler-Ross (1969) introduced one of the most influential and universally recognised models of grief through which an individual themselves or others around them may make sense of dying. Palliative care at the end of life will involve spending time with individuals working through these stages, in their own way, and at their own pace, which is different for each individual.

Box 23.2 Five Stages of Grief Model (Kübler-Ross 1969)

1 Denial

2 Anger

3 Bargaining

4 Depression

5 Acceptance

This five-stage model suggests that a person begins their grief journey in denial, and being unwilling or unable to accept that what they have been told is true. There may be a rationalisation which views the news as a mistake, or seeks to avoid this offered truth. What follows is anger, whereby the news is realised as real yet not accepted as fair. During this phase the anger may be displaced, and without any objective ‘death avatar’ there may be a displaced channelling of anger towards professionals involved in care, or even anger at the spiritual concepts of gods or fate. Bargaining marks progress towards acceptance, however presents with a reluctance which looks to make deals. These deals may again be with healthcare professionals, gods or fate, and involve an individual offering to do their part in extending life. This may mean offering to change lifestyle to ‘appease’ health and social care professionals, or offering prayer to gods.

The stage where professionals can have the greatest impact is during depression. This will involve discussion which may vary from the practical to the metaphysical, as an individual processes the knowledge of their dying. The model completes with acceptance, a person having made their own sense of their situation, and having become ready to face their biological end. However, for a minority, acceptance does not always arrive.

Key Point 23.3

It must be acknowledged that the reality of this model (and indeed any model describing human experience) may vary hugely from individual to individual. Every human experience will be influenced by subjective traumas and varying degrees of stress vulnerability (Zubin and Spring 1977), and therefore responses to life events and circumstances will filter through an individual and be uniquely processed. Whilst the five-stage model has been criticised for being too rigid, Kübler-Ross did acknowledge that these stages may not have a linear narrative, may present concurrently and have varying longevity (Torn and Greasley 2016). Furthermore, whilst a useful look at the emotional processes of grief or coming to terms with death and dying, the model cannot be viewed in isolation. The spiritual dimension is vital.

Spirituality

Spirituality and religion are familiar terms in day to day language, though these two concepts are often confused and require distinction and definition. Generally well understood, religions are formal and organised belief systems, shared with others and focusing around one or more deities (Swinton 2001). Spirituality is inclusive of religious belief systems, although is altogether more subjective and unique to the individual. This breadth of scope has benefited spirituality in its distinction from religion, although it has nevertheless led to a plethora of definitions and left the term somewhat vague (Reinert and Koenig 2013). Beginning to unravel the concept, spirituality has been usefully categorised into five key attributes which have presented in past definitions (Martsolf and Mickley 1998).

Box 23.3 Spirituality Key Components (Martsolf and Mickley 1998).

- Meaning – finding purpose in existence and making sense of life situations
- Value – beliefs and standards which become principles and a way of living
- Transcendence – experience and appreciation of a dimension beyond the self
- Connecting – relationships with the self, others and higher powers
- Becoming – the unfolding of a life and personal narrative.

These attributes provide an individual with a framework through which they can make sense of a complex world, and even more complex universe.

Reflective Practice Exercise 23.1

Time:

- Consider your own spirituality in relation to these five attributes
- How would you describe your experience of each of these attributes to another person?

Alongside Martsolf and Mickley's key components, two words which usefully refine the essence of spirituality are 'beyond' and 'between' (Kurtz and White 2015). The beyond relates to a vertical connection which pulls upwards and outwards. This includes transcendence, whereby an individual can appreciate a dimension higher than the self. This dimension may be religious, in terms of a deity or god, but may even be an idea. The 'higher' aspect of beyond is not synonymous with some deity, heaven or god, but simply something experienced and appreciated as being higher than the self. This incorporates the concepts of meaning, value and transcendence, and may be defined as a goal, an ideology, a calling or a purpose.

Key Point 23.4

Considering what people may be driven to achieve and their reasons for doing so, we can highlight the spirituality in healthcare professionals which may potentially involve their higher dimension as the compassion and drive to help others, perhaps through a sense of moral duty or social justice, and a desire to change the world, even if only for one individual at a time.

The connecting to the higher dimension is realised through action which demonstrates the ideals.

‘Between’ posits the horizontal aspect of spirituality, with connections between an individual and other people expressed as mutual and collaborative relationships. Humans are social animals, and our basic needs to connect with others cannot be overstated.

Key Point 23.5

The value of social relationships and interactions with families, friends, carers and colleagues can provide the sense of belonging so crucial to human experience.

These interactions allow an expression of the self. Through others we see ourselves, and we can surely question how much we would know about ourselves and our place in the world without other people to act as our mirror. The concept of becoming can be realised as ‘beyond’ and ‘between’. Each overlaps and complements the other, with a return to the example of health and social care professionals highlighting their interconnectedness. The higher dimension and beyond may be evidenced as the values, ideology and moral duty which inspires the dedication to the career, whilst the between is expressed through the connections, relationships and the day-to-day interactions with individuals. In this way, the beyond relies on the between as a vessel for its expression.

Taking the above ideas into account, this chapter defines spirituality as an individual’s unique experience in applying meaning, value and purpose to existence, the self and life events, which develops into a personal narrative through which sense is made of their place in the world and beyond.

Death and mental health

The concepts of death and mental health may at first seem strange bedfellows. However, in terms of social theory, care and treatment, they do have common ground and can provide useful analogy. Whilst mental health care is not curative, it is not often referred to as 'palliative' given the association of this term with the end-of-life.

Key Point 23.6

There are arguments to not only suggest that palliation is appropriate as a definition and approach to mental health care, but that it relates to our entire understanding of it.

The rest of this chapter will apply the concepts of death, death denial and social death to the understanding of mental health diagnosis and distress, emphasise the importance of spirituality in making sense of mental health, as well as being a paramount aspect of care and treatment. There will be a reworking of the Kübler-Ross model to explore making sense of mental health, which includes key principles in the provision of spiritual care.

The denial of mental health

As discussed, there may be a denial of death in day to day living allowing people to enjoy life, and contributing to the subject itself being somewhat taboo. This taboo status is shared with mental health, with this aspect of our holistic wellbeing often existing in the dim lit corners of society. Similarly, as people 'choose to forget' death and view it only as the business of the dying, mental health is in contention for the same denial, being viewed as an issue only for those in mental distress. Nonetheless, just as we value life as it always has an end, we so too should value good mental health, as it cannot be taken for granted.

It could be argued that the much trumpeted and widely recognised one in four statistics (that one in four people will experience a mental health condition throughout their lifetime) has brought mental health out from the shadows. Despite criticism of the validity of the evidence base which has contributed to this statistic (Ginn and Horder 2012), it is used extensively with the aim of shifting the denial of mental health and making it relevant to all. However, despite the best of intentions, the statistic still carries the obvious implication that three in four of us will not be affected by mental health issues.

Key Point 23.7

It is difficult to describe human existence without mental health as a fluctuating state of wellbeing, which would be highly unlikely to remain ‘perfect’ throughout a lifetime.

Nonetheless the one in four statistic implies that some of us, in fact many more of us than not, will remain mentally healthy. While the statistic is well intended, it does not go far enough. A personal subjective idea of our own mental health is something we all have, and just as we will all die, we will all experience a fluctuation in the quality of our own mental health throughout our lifetimes. It could be debated that the idea of mental health being an issue only for a select group of people is actually counterproductive, allowing a socially visible mark of difference, and contributing to stigma, discrimination and prejudice.

Social death and mental health

One probable reason for the denial of mental health by individuals may have its roots in how those in mental health distress have been treated by society. Historically treatment has ranged from the brutal to the misguided, often rooted in fear, apprehension and misunderstanding. From the fifteenth to the eighteenth century, estimates of up to 100,000 people were labelled and burned as witches, likely people in mental distress who became unfortunate victims of the social norms and superstitions of the era (Scull 2016). In Western society mental health is now better understood, and difference in behaviour or disclosure of difficulties thankfully no longer a life or death concern. Nonetheless, despite the progress, it can still be difficult for individuals to open up about their experiences of mental distress for fear of the social death associated with it. In addition to mental distress, the social death described by Králová (2015) alludes to a societal stigma and discrimination which may be influenced by diagnosis or behaviour.

The validity of psychiatric diagnosis has been challenged for many years, with diagnosis criticised as unscientific and oppressive (Szasz 1961). The need for a shared language has potentially overshadowed the uniqueness of individuals, who may have the same clinical labels, but vastly different causal pathways and responses to treatment. Despite the questionable validity of diagnoses, what is evident is their potential sociological impact. A diagnosis is a tangible mark of difference in society, whereby an individual is labelled as different from others.

Even without a diagnosis however, when mental distress presents as behaviour out-with social and cultural norms, this itself can be enough to stigmatise. ‘Normal’ and ‘stigmatised’ are ultimately perspectives within a social script, with deviance not related to behaviour itself, but how behaviour relates to social norms (Curra 2014). The unfortunate cycle is that if diagnosis is a mark of difference, and deviance is different from social norms, then deviance can become diagnosis. As social norms can always shift, so too (and do) mental health diagnoses. Whether or not social death relies on diagnosis or behaviour, there is the chance that the two will always converge and present as a mark of difference, and legitimise social disengagement.

Stigma has been described as “a mark or sign of disgrace usually eliciting negative attitudes to its bearer” (Thornicroft 2007, pp.192), and though people may no longer be labelled as witches, challenges remain. Attitudes tend to have three key components; cognitive, affective and behavioural (Hogg & Vaughn 2008). Stigma towards people with mental health distress or diagnoses begins with a belief, not necessarily based on any evidence, with common misconceptions such as people being considered less socially valuable, less able to work, and likely to be violent and dangerous. These beliefs may lead to a negative evaluation of individuals, with feelings such as anger, fear or apprehension. The final element of a stigmatised attitude presents in behaviour, evidenced in discrimination and the consequential imposed social disengagement. This stigma has been described as having a ‘double misfortune’, as not only is there a societal misunderstanding of mental health and resulting discrimination, but individuals themselves may develop self-stigma, whereby they adopt negative attitudes about themselves and have lessened self-efficacy and self-esteem (Corrigan & Watson 2002, pp.35). Therefore, stigma in mental health can also fit Králová’s (2015) definition of social death, with losses in social identity and social connectedness, and with society still largely favouring a medical model, mental illhealth being viewed as part of the body’s disintegration.

Taking all of this into account, it is clear that when an individual comes to make sense of their mental distress, they also need to make sense of the sociological implications.

Spirituality for mental health

Spirituality has been described as the fundamental dimension of peoples’ overall health and well-being (Fisher 2011). One could argue that this is true especially and essentially for mental health where there remains so much debate around causation and effective treatment. The onset of mental distress and the receiving of a diagnosis can be difficult times for the individual, families and carers as well as professionals involved. One of the challenges is that similar to death and dying, mental distress does not have an established curative model of care.

Key Point 23.8

Care of the dying individual is palliative in nature as there is no reversing the dying process. It could be argued that there is no established method for the reversing of some forms of mental distress, although as with end-of-life care, this does not mean there is no appropriate and helpful role for professionals.

Death is commonly viewed as either an end or a transition. Either it is an end biologically with nothing remaining other than in the memories of others, or a transition to an afterlife or some other dimension. Socially, mental distress has been seen by some as an end, however with a growing focus on counter ideas such as recovery it can be viewed much more positively as a transition. Recovery in mental health, has been defined by the Scottish Recovery Network (2016) as an achievable, unique and personal experience, focused on a person’s strengths and described individually as a journey or a destination. This entails an individual living a good life, as defined by them, in spite of any mental health difficulties they may experience. Mental distress may range from one short-lived episode with a return to relative ‘normality’ as defined by an individual, to a chronic and enduring condition which has huge and lasting impacts on all aspects of a person’s life. Either scenario still benefits from a recovery focus, and requires the spiritual dimension to facilitate understanding.

The ideas from recovery neatly match the notion of a transition, and relate well to spirituality and how spiritual care should be delivered. The spiritual transition model for mental health (*see* Box 23.2), influenced by the Kübler-Ross process of grief, collects the ideas and concepts discussed throughout this chapter, and hypothesises a process of making sense of mental distress. This model collates spiritual, philosophical and sociological ideas to posit a framework through which professionals may aid individuals in mental distress.

Warrender and Macpherson’s ‘spiritual transition model’

This model proposes that beginning with the onset of mental health distress, an individual may move through five stages as they make a spiritual transition, adapt to their mental health distress and live a self-defined meaningful and satisfying life. Again, recognising the uniqueness and impossibly dynamic nature of human experience, this model is to be viewed as a framework to provoke discussion and aid understanding, not as universal truth.

Box 23.4

Warrender and Macpherson’s Spiritual Transition Model

1 Onset/Crisis

2 Confusion

3 Making sense

4 Acceptance

5 Adaption

Stage 1 – Onset/Crisis

The first stage of the model marks the onset or crisis point of mental distress. For some this may be an acute, sharp and sudden onset, and for others a slow deterioration in their experience of their own mental state. Regardless of the mental health issue, the onset stage is where mental distress is experienced at its most difficult for the individual. Self-efficacy may be impaired, and there may be the further challenge of whether the person has insight into their condition, as with a psychotic episode, for example. At this stage, a person may feel their own sense of crisis, and require urgent referral, acute care or other emergency intervention. Crisis has been usefully defined as

'…a self-limiting moment outside of any person's normal manageable range' (Mental Health Foundation 2002)

…and it is self-limitation which defines this stage. Whilst helping individuals in making sense should always be a key element of any professionals' care delivery, the gravity of mental health distress for some means that this may be difficult at this stage. Professionals should liaise with families and carers, communicate with empathy, carry out appropriate risk assessments and ensure safety.

It is recognised that for some people, crisis and distress may not be unique events, but a constant, chronic and enduring experience. In cases such as these, one could argue that the baseline has moved beyond onset, and an individual could then be in the process of making sense.

Stage 2 – Confusion

At the end of the onset and crisis and before making sense, we need to consider the array of issues which may need to be made sense of. People who had perhaps been in a 'mental health distress denial' could be faced with the devastating realisation of their own fragility. Many people regain insight to find themselves in hospital, and can have the uncomfortable process of learning their own story through the accounts of others, perhaps families, carers or professionals. People may carry shame or embarrassment on finding they have compromised their own values through unintended actions driven by their mental state. Furthermore, the experience of mental distress may challenge existing spiritual or religious beliefs, and open up many questions.

Confusion may be related to the social implications of mental distress or diagnosis. Individuals may wonder how their mental health will affect their relationships with others, their place in society, and even question their place in the universe. This relates both to the beyond and the between, as connections with others may have been impacted by mental distress, and may cause anxiety regarding social death. People may come out of crisis to find very different landscapes in terms of their understanding of themselves, others, their place in society and the universe at large.

Stage 3 – Making sense

Spirituality should not be seen as the exclusive role of hospital chaplains and religious figures, and should be a core consideration in the role of all professionals. It is important to first emphasise that a person's spiritual story is constructed by the individual and for them. Swinton (2005) describes the role of spirituality as the…

'...need to find satisfactory answers to the meaning of life, illness and death'.

The 'satisfactory' nature of these answers is to the individual, not the professional, and relates perfectly to the subjectivity of spirituality where people make their own sense in their own way. This does not mean however that professionals should avoid the issue. Whilst there should be no prescribed model of religious or spiritual belief and open acknowledgement that professionals will not have the answers, spirituality should be raised by asking at the very minimum, the question; "how do you make sense of what has happened"? Helping an individual find meaning and make sense of their mental health is not about providing the answers, rather it is evidencing the commitment to hear their story, and willingness to discuss the beyond, the between, and related spiritual concepts.

The making sense stage may vary vastly in its longevity, it may be revisited, and it may take place across a lifetime. A key role of professionals should be to address this aspect of mental health by acting as a catalyst, beginning the conversations that sets people on their own journeys of self-definition and spiritual growth. Then, upon finding their own sense in mental distress, a person may arrive at acceptance.

Stage 4 – Acceptance

Acceptance of mental distress as part of life is a hugely important step in spiritual growth. Whereas Kübler-Ross (1969) cites acceptance as the readiness to die, and an acceptance that the dying process cannot be reversed, this model posits acceptance as the recognition that mental health distress is a core aspect of the human experience, and that mental health care and treatment is not curative. A person need not be a passive recipient of standardised care (which should always be person centred), or accept clinical diagnoses or opinions which have debatable validity and can change. People should however aim to reach a point where they can make peace with their own fragility to mental distress, and recognise this as not being a stigmatising mark of being less than human, but as a defining feature of being human.

Stage 5 – Adaption

Acceptance is not the final stage as, unlike people who are dying, people in mental health distress have transitions, not ends. Therefore, in continuing to live, there must be a process of adaption. Acknowledging that there is no cure, people must adapt to circumstances which may include chronic mental health difficulties. A new self-paradigm will include a spiritual dimension of becoming, which includes mental health as part of a personal narrative as well as more tangible means of remaining in control of one's own mental state. This may include development of coping mechanisms, adjustment to living conditions and ensuring social connectedness. Adaption is in full harmony with the recovery movement which has a strong presence in mental health policy.

Conclusion

Mental health, alongside death, is a human experience without cure which we all share. Whilst care and treatment often have positive effects for people, there is no clear and established pathway for diagnosis and treatment that will be universally beneficial to all. Mental health care and treatment should, therefore, always include the spiritual dimension, where people are encouraged and given the space to discuss how they themselves make sense of their mental distress.

Key Point 23.9

Discussing spirituality will always be both palliative and person centred, and has a crucial role in finding subjective meaning in a life which comes without reason or rule.

The experience of mental distress could be described as a spiritual transition, and professionals should be mindful of this process and recognise this as a key that may unlock a person's recovery.

Self-Assessment Exercise 23.2

Time 45 minutes

Case Study 23.1

Dean is a 23-year-old man who lives with his parents and younger sister. He has a job as a business support assistant for an information technology (IT) company which he has had for the past three years. Over a period of a year, Dean has experienced a series of psychotic episodes, having visual and auditory hallucinations and taking a significant amount of time away from work. For each episode he was admitted to an acute mental health ward where his psychosis was managed using medication and constant observations to assess risk. Dean is given a diagnosis of schizophrenia by his consultant psychiatrist, and informed that there is no cure for his condition but that it can be managed through medication and ongoing review by nursing and medical staff.

Points to consider

- How may Dean and his family feel on hearing there is no cure for his condition?
- Considering the five components of spirituality, what are the spiritual implications of Dean's symptoms and diagnosis for him and his family?
- How might you feel when offering treatment to individuals that will not cure their symptoms or condition?
- Who should deliver spiritual care?

- How may spiritual care be delivered to Dean across a variety of mental health care contexts?

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