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Consumer Voices

Thanks goes to all those people who are experiencing or have experienced mental illness who agreed to provide their story to our resources. Thanks also to those clinicians who facilitated the process of recording their perspectives.

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EVERYMIND

Welcome to

Mind Essentials

Mental Illness Nursing Documents For Nurses and Midwives

MIND Essentials will provide you with information and strategies to support people in your care who experience behaviours related to a range of mental health issues. MIND Essentials was developed by **Everymind** (formerly the Hunter Institute of Mental Health) with support from Hunter New England Health Nurse and Midwife Strategy Reserve Funding. It aims to support nurses and midwives in general health care settings who often have limited confidence or knowledge about clients with mental illness.

MIND Essentials has been produced in consultation with nurses and midwives in general acute and community settings, assistance from clinical experts in mental health and academic staff of the University of Newcastle.

You will have received a postcard and business card to keep as a reference and reminder about the availability of MIND Essentials. The resource is available online at **www.everymind.org.au** (follow the links to MIND Essentials). A printed copy is also available in your facility.

To help in your use and understanding of this resource, please note that it is divided into the following four sections:

Section 1: Information on caring for a person experiencing a mental illness.

Information on nine specific mental illnesses is presented in separate chapters of this section and includes:

- A case study providing a real-life example of how a person may present to a hospital or community setting.
- An explanation of the illness including associated symptoms, behaviours, causes and onset.
- Common reactions to nursing a person experiencing the mental illness.
- Appropriate goals when nursing the person.
- Practical tips for responding to the person.
- Treatment options.
- Referral suggestions and contacts.
- Links to other sites for more information.

The following mental illnesses are covered within this section:

- Anxiety
- Depression
- Eating disorders
- Personality disorders
- Dementia
- Mania
- Mental illness within the perinatal period
- Hallucinations
- Delusions

A factsheet on schizophrenia has also been included within this section.

Section 2: Information on caring for a person presenting with behaviours, features or symptoms that *may* be associated with the presence of a mental illness.

Information on three specific issues is presented in separate chapters of this section and includes:

- A case study providing a real-life example of how a person may present to a hospital or community setting.
- An explanation of the issue including associated symptoms, behaviours, causes and onset.
- Common reactions to nursing a person presenting with the issue.
- Appropriate goals when nursing the person.
- Practical tips for responding to the person.
- Treatment options.
- Referral suggestions and contacts.
- Links to other sites for more information.

The following issues are covered within this section:

- Suicidal thoughts or behaviour
- Aggressive or violent behaviour
- Intoxication

Section 3: Assessment tools

Provides information on a range of assessment tools that can be used to help inform a person's care and management plan.

The following assessment tools are included within this section:

- Psychosocial
- Suicide risk
- Drug and alcohol

Section 4: Consumers stories

Includes a range of stories about general hospital experiences by people with a mental illness, who have attended the hospital for reasons other than their psychiatric illness.

We encourage you to use these resources to improve your own knowledge and the nursing care you provide to people who have a mental illness.

Please note that this resource generally uses the term 'nurses' to refer to both nurses and midwives engaged in nursing care. All information in MIND Essentials is relevant to both nurses and midwives.

Additional Resources

***Australian Indigenous Health Infonet* - www.healthinfonet.ecu.edu.au**

Provides a range of Indigenous health information and contacts.

***beyondblue* – www.beyondblue.org.au or www.ybblue.com.au (youth website)**

Provides information on depression, suicide, anxiety, bipolar disorder and postnatal depression.

Black Dog Institute – www.blackdoginstitute.org.au

Provides information on depression (including the perinatal period) and bipolar disorder.

Mental Health Council of Australia – www.mhca.org.au

Mental health related information and factsheets.

Multicultural Mental Health Australia – www.mmha.org.au

Mental health information and factsheets in a range of languages.

National Drug and Alcohol Research Centre – http://ndarc.med.unsw.edu.au

Information about substance-use related disorders and their management.

Sane Australia – www.sane.org

Mental health related information, tips, links and online help.

Suicide Prevention Australia – www.suicidepreventionaust.org

Provides information on suicide and self-harm, suicide prevention and suicide postvention.

Please refer to the online version of MIND Essentials (www.himh.org.au) for the most up-to-date information on this resource.

Caring For The Person Experiencing an Anxiety Disorder

Case Study

You have visited Trang's home to deliver equipment and to change dressings for her grandmother, who is recovering from a fall. You notice that Trang is looking unwell, with shortness of breath, palpitations, chest pain and dizziness. She is only 24, and when you ask she says she has been under a lot of stress lately. She says she has experienced this before and is worried because her father died from a stroke. She tells you that this feels different from last time and she is frightened that she might die. The chest pain is much worse and she is complaining of numbness and tingling in her extremities. You ring her GP and he suggests that she go to hospital for an assessment. Trang has many symptoms that are characteristic of an anxiety disorder.

The following information could help you nurse a patient like Trang.

What is an anxiety disorder?

Anxiety disorders are a group of conditions marked by extreme or pathological anxiety or fear. They are the most common of the psychiatric disorders affecting 1 in 10 adults and have the potential to interfere with work, family and social life. They tend to be persistent and can be disabling.

Anxiety is a *normal* response to a threatening situation and can motivate us in a positive way, such as in sport or study. However, anxiety becomes a problem when it interferes with normal functions, is unrelated to an actual threat, causes physical symptoms and becomes intolerable to the person. Anxiety disorders often occur together with depression, other medical conditions and substance abuse. There are many different types of anxiety disorders which all have different symptoms. Characteristics of these disorders include:

- ***Generalized anxiety disorder:*** feelings of constant apprehension and a general tendency to be worried about many areas of life (e.g. health, work, and finances).
- ***Specific phobias:*** an intense fear of a specific object or situation that leads to avoidance of the fear-inducing trigger, and results in interference with normal living.
- ***Social phobia:*** the intense fear of being scrutinized, evaluated negatively or being the centre of attention and consequent avoidance of situations where this may occur.

- ***Obsessive compulsive disorder:*** repeated obsessions (thoughts) and compulsions (actions) that are time consuming and which seriously interfere with daily living. Typical compulsions involve rituals such as hand washing or checking behaviours.
- ***Post traumatic stress disorder:*** a reaction to a serious traumatic event (such as a car accident, natural disaster, physical abuse or sexual abuse) in which the person was extremely afraid or seriously injured. It is characterized by dreams or flashbacks in which the traumatic event is re-experienced, an avoidance of associated situations, increased vigilance and a numbing of emotional responsiveness.
- ***Panic disorder:*** recurrent and unexpected panic attacks that begin abruptly and result in the person experiencing a range of symptoms including: sweating, palpitations, shaking, shortness of breath, chest pain, choking, dizziness, feeling light-headed, abdominal pains and a fear of losing control or dying.

In addition, some people can be described as 'born worriers', which is referred to as ***trait anxiety***. Such people worry about seemingly minor matters, feel tense most of the time and are apprehensive or overly cautious in their approach to the world. They are likely to be more anxious than their peers in comparable situations. In the extreme, this may lead to more severe symptoms and the development of an anxiety disorder.

Causes of anxiety disorders

Anxiety problems originate when the automatic 'fight or flight' response becomes oversensitive. We have all observed an overly sensitive car alarm which goes off at the wrong time. Similarly, if the body's 'alarm' is too sensitive, the 'fight or flight' response will be triggered at the wrong time. If the anxiety alarm goes off too easily, the person will be more likely to become anxious in situations where other people would not feel anxious.

Anxiety disorders are usually caused by a combination of *biological*, *psychological* and *social* factors. They may develop as a result of a major stressor such as the death of a loved one, divorce, loss of a job, or the actual threat of death or physical harm. A disorder may also arise because of unhelpful thoughts and negative thinking patterns as a result of learned behaviour (e.g. an anxious parent may transmit that anxiety to his or her child). There also appears to be a major genetic component as a number of disorders have been found to run in families (e.g. panic disorder, obsessive compulsive disorder and some phobias). Research for specific genes, including those related to neurotransmitters such as serotonin and dopamine, continues.

Difficulties in diagnosis

Physical disease may present with symptoms that can easily be mistaken for anxiety. Cardiac arrhythmias may present with dyspnoea, palpitations, hyperventilation and only minor chest pain. Anxiety is also associated with temporal lobe epilepsy and phaeochromocytoma (adrenal tumour).

Other medical conditions (such as hyperthyroidism and hypoglycaemia) and substance abuse need to be considered in the diagnostic work-up. For example, drinking lots of coffee can lead to anxiety and panic attacks; amphetamines cause anxiety, irritability and tremulousness; and narcotic withdrawal is accompanied by anxiety. Actions of other drugs such as bronchodilators, calcium channel blockers (many antihypertensives) and pseudoephedrine need to be excluded as possible causes before a diagnosis of an anxiety disorder is considered.

A person's perspective on what it is like to experience generalised anxiety

"My mind just never shuts up. Do I look ok? Do they think I'm stupid? What if mum's had a stroke? My boss didn't smile at me this morning - I must have upset her. I worry all the time…about everything. And then I can't sleep because of the worry. And I'm hyper-sensitive to what others say or might think, or all the bad things that might happen. And I end up not doing things I want to do because they might go wrong. Or when I am doing things I want to do - I don't enjoy them because I'm worried about what might happen after. It controls my life even though I don't want it to."

Some reported reactions to people experiencing anxiety disorders

Nurses who have worked with people who have anxiety have reported the following reactions:

Disregard — When the level of anxiety is seen as being out of proportion to the issue, nurses may experience a lack of understanding. This may lead to a minimisation or disregard for the person's symptoms. For example, common beliefs expressed are 'It's all in her mind' or 'He should just get over it'.

Frustration — This can develop when the strategies you have tried are unsuccessful and the person continues to be distressed and anxious.

Anxiety — Sometimes caring for someone with severe anxiety or a panic attack can create a 'contagious' atmosphere, resulting in staff also becoming anxious.

Compassion fatigue — This is more likely to occur if the person has family or relatives who are also anxious and demanding due to their own frustration and apprehension about the person who is ill.

Goals for nursing the person experiencing an anxiety disorder

Appropriate goals for caring for a person with anxiety in a community or hospital setting include:

- Develop a relationship with the person based on empathy and trust.
- Promote an understanding of the features of an anxiety disorder.
- Promote effective strategies for coping with anxiety.
- Promote positive health behaviours, including medication compliance (if appropriate) and healthy lifestyle choices (e.g. diet, exercise, not smoking).
- Promote the person's engagement with their social and support network.
- Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- Support and promote self care activities for families and carers of the person with anxiety.

Responding to the person experiencing an anxiety disorder

- If appropriate, arrange for a review of the person's medication for anxiety and an initial or follow-up assessment if their care plan needs reviewing. A psychosocial assessment may be appropriate to undertake – see the MIND Essentials resource 'Conducting a psychosocial assessment'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is important to take this into account when formulating diagnosis and care plans. Aboriginal Liaison Officers and Multicultural Health Liaison Officers are available for advice and assistance in understanding these issues.
- Learn to identify the signs and symptoms of anxiety and panic, including triggers and mechanisms. Helping people to recognise the symptoms is also the first step in teaching them self-management techniques.
- Reassure the person that anxiety disorder is a real medical condition.
- A person with anxiety is often only just coping with their current circumstances, so be mindful of not placing too many demands on them.
- Avoid comments like 'Just relax', 'There's nothing to worry about' and 'Just pull yourself together'. It may be more helpful to provide a reassuring presence.
- Avoid statements such as 'Things can't be that bad' and 'Everything will be OK', as the person might feel that you do not really understand his or her problems. This may make the person unwilling to share other feelings.
- Encourage the person to test and challenge the accuracy of thoughts and assumptions.
- Help the person to challenge the beliefs that are causing the anxiety by helping them to identify alternative perspectives. For example, you could ask: 'How have you gotten through this before?'
- Encourage use of self management strategies such as relaxation and controlled breathing that can help manage an attack.
- Help the person to identify and develop a range of contacts for support and socialisation.
- Monitor recovery, compliance with medication and general physical health (including nutrition, weight, blood pressure and so on). Provide education on possible side effects to any medication (if appropriate) and work with the person to develop appropriate actions to address any issues.
- As appropriate, provide family members and carers with information about the illness, as well as reassurance and validation of their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.
- Be aware of your own feelings when caring for a person with anxiety. Arrange for debriefing for yourself or for any colleague who requires support or assistance – this may occur with a clinical supervisor or an employee assistance program counsellor (see below).

Employee Assistance Program counsellors are available for nurses in need of support and debriefing regarding any work related or personal matters. Contact numbers in your area can be found at:
http://intranet.hne.health.nsw.gov.au/hr/eap

Treatment of anxiety disorders

Many treatment options are available to help people manage their anxiety and to prevent it controlling their lives. Those who have had an anxiety disorder for many years may also need help to make lifestyle changes once the restrictions imposed by rituals or avoidance are no longer needed.

Monitoring for early signs of relapse is important, and early intervention may prevent full-blown symptoms returning. Regular revision of management techniques may also be helpful.

Counselling and psychological therapies

Various approaches may be used in combination. These can include cognitive behaviour therapy (CBT), desensitisation and problem-solving strategies. The approach will be tailored to the individual and type of anxiety.

Psychological therapies will usually include:

- ***Psycho-education about anxiety***, including information about signs and symptoms of anxiety, reassurance that the feelings do not mean that the person is going crazy or out of control and reaffirmation that anxiety is a normal physiological response (the 'fight or flight' response) in an abnormal situation.
- ***Behavioural techniques*** to help the person control the physical effects of anxiety (e.g. breathing and relaxation). For example, a basic technique to control hyperventilation is a simple breathing and relaxation exercise. Breathing in deeply (using the abdominal muscles) to a count of five, holding the breath for five and then breathing out to a count of five saying the word 'relax' reduces hyperventilation and relieves some of the physical symptoms. This technique needs to be practiced in a calm state in order to ensure that it can be used when needed. Relaxation can be practiced in a number of ways, including Tai Chi, meditation or yoga. Similarly, a simple progressive muscle relaxation technique teaches the person to be aware of muscle tension and how to release the tension following a systematic and progressive process. Nurses and midwives can assist a person to identify unhelpful strategies (such as the use of alcohol or avoidance) and promote relaxation activities such as: taking a warm bath, listening to music, going for a walk, playing sport or a game, watching a movie, etc.
- ***CBT techniques*** help the person learn to challenge the catastrophic thoughts that may be exacerbating or maintaining the fear. People learn to identify the links between activating events (A), the consequent feelings (C) and the thoughts or behaviours (B) that emerge between A and C. So that by changing the unhelpful thinking or behaviours at B a more positive outcome can be experienced.
  For example:

Original but unhelpful thought	*Alternative thought*
A I am invited to go to the movies	I am invited to go to the movies.
B I'm sure I'll have a panic attack and everyone will be watching and I'll make a fool of myself.	I've been before and really enjoyed myself. I can always sit in a seat near the door and do my breathing or relaxation and leave if I have to.
C 'There is no way I can go.'	'I would like to try to go.'

Medication

Medication options include antidepressants, usually the SSRIs and benzodiazepines. Benzodiazepines should generally only be used for short-term relief. Longer-term use of benzodiazepines may lead to tolerance and abuse, and they should be avoided where there is comorbid substance abuse. All medications should be withdrawn slowly to avoid withdrawal or discontinuation syndromes.

It has been shown that lifestyle factors such as overwork, nicotine intake and caffeine intake can exacerbate anxiety. Adjustments should be made to these where possible. A combination of medication and psychosocial strategies is often effective.

Discharge planning

Discuss referral options with the person and consider referrals to the following:

- GP
- Community Health Centre (CHC) for social work or psychology counselling. To access the contact numbers and details for your local Centre use the following link on HNE intranet: **http://intranet.hne.health.nsw.gov.au/services_and_facilities**
- Mental Health Services. Use the following link to obtain referral forms and contact numbers available on HNE intranet: **http://intranet.hne.health.nsw.gov.au/mental_health/adult_model_of_care/triage**
- Private service providers

Further reading

For more information, see the *Mental Health First Aid Manual* at **www.mhfa.com.au** Internet access required.

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Caring For The Person Experiencing
Depression

Case study

Phil is a 60 year old retired accountant. He has suffered from asthma most of his life. He has been admitted to hospital for treatment of pneumonia. He is taking medication for depression but despite this he appears very down. He reports that he has not been able to sleep, does not feel like eating and has not been interested in anything. He appears to be neglecting himself.

The following information could help you nurse a patient like Phil.

What is depression?

Depression is extremely common affecting 1 in 5 Australians over their life-time. Depression is a word often used to describe feelings of sadness and grief that all people experience at times. However, for a person to be clinically diagnosed with a depressive disorder, his or her symptoms are usually much more intense and must have been present for at least two weeks. Depression is commonly accompanied by feelings of anxiety or agitation.

Symptoms and types of depression

Depression is also referred to as a ***mood disorder***. The primary subtypes are ***major depression, dysthymia*** (chronic and usually milder depression), and ***atypical depression***.

Depression that begins or occurs during or after pregnancy is referred to as a type of perinatal mood disorder (which includes ante-natal and post-natal depression). See the MIND Essentials resource 'Caring for the person experiencing mental illness in the perinatal period' for more information.

Depression that occurs in conjunction with episodes of mania may be symptomatic of bipolar affective disorder. See the MIND Essentials resource 'Caring for the person experiencing mania' for more information.

Core symptoms of depression include:

- sleep disturbance
- appetite or weight changes
- dysphoria (a 'bad mood', irritability, sadness)
- anhedonia (loss of interest in work, hobbies, sex)
- fatigue (often manifesting as difficulty completing tasks)

- agitation or retardation, especially in the elderly
- diminished concentration, difficulty with simple tasks, conversations etc
- low self-esteem, feelings of guilt
- suicidal thoughts (present in two-thirds of people experiencing depression)

Children and adolescents may present with an irritable or cranky mood rather than as sad or dejected.

Causes, onset and course of depression

People may experience depression as a result of any one (or more) of a range of factors, including:

- biochemistry
- physical stress
- chronic or sustained illness
- seasonal influences
- genetic predisposition
- life stressors
- personality factors

Depression may have an acute or gradual onset and can be experienced any time over the life course.

Difficulties in diagnosis

Depression can be difficult to diagnose, as people may present complaining of physical problems, which may obscure a psychiatric diagnosis. Depressive disorders often coexist with and may be secondary to other psychiatric disorders. Particularly high rates of depression are found in people with alcohol-related disorders, eating disorders, schizophrenia and somatoform disorders (vague physical complaints with no physical basis). Determining which disorder is primary and which is secondary is often a difficult task.

Many of the people nurses care for, both young and old, are at risk of developing depression due to longstanding physical illness and disability. Further, depression can present as an early sign of dementia. It is important then for nurses to remain alert to this possibility.

See Table 1 in the MIND Essentials resource 'Caring for the person with dementia' for helpful information on the different features of depression and dementia.

A person's perspective on what it is like to experience depression

"When I am depressed I feel raw, extremely sensitive and trapped in a black hole. I feel tired all the time because I struggle to sleep. One of the worst times is in the early hours of the morning because I wake up all alone in the darkness and everyone and everything in my world is asleep. I find it so hard and hurtful when people tell me to 'pull myself together' because I simply don't have the energy to get out of the black hole I'm trapped in. I then feel like a failure because I can't pull myself together."

Some reported reactions to people experiencing depression

Nurses who have worked with people who are depressed have reported the following reactions:

Disregard — When depressive symptoms are seen as being able to be controlled, unacceptable or embellished, nurses may experience a lack of understanding. This may lead to a minimisation or disregard for the person's symptoms. For example, common beliefs expressed are 'It's all in her mind' or 'He should just get over it'.

Inadequacy — Nurses can feel inadequate if strategies are not helpful in making a quick impact on the depression.

Frustration — This can develop when suggested strategies by the nurse are unsuccessful and the person continues to feel hopeless and helpless.

Hopelessness — This can develop when the nurse feels completely unable to help the person, and as a result, become convinced by the person's belief that nothing can be done to help them. Alternatively, the person's depression may cause the nurse to focus on his or her own sadness, leading to depression.

These feelings are more likely if nurses lack knowledge about depression or if they have unrealistically high expectations of their capacity to help. This is particularly true if a nurse sees the person for only a short period.

Goals for nursing the person experiencing depression

Appropriate goals for caring for a person with depression in a community or hospital setting include:

- Develop a relationship with the person based on empathy and trust.
- Promote the person's sense of positive self-regard.
- Promote effective coping and problem solving skills, in a way that is empowering to the person.
- Promote positive health behaviours, including medication compliance and healthy lifestyle choices (e.g. diet, exercise, not smoking).
- Promote the person's engagement with their social and support network.
- Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- Support and promote self care activities for families and carers of the person with depression.

Responding to the person experiencing depression

- If appropriate, arrange for a review of the person's medication for depression and an initial or follow-up psychiatric assessment if their care plan needs reviewing. A psychosocial assessment may be appropriate to undertake – see the MIND Essentials resource 'Conducting a psychosocial assessment'.
- Assess whether the person's helplessness or hopelessness are indicators of suicidal thinking. Refer to the MIND Essentials resource 'Caring for the person who is suicidal'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is important to take this into account when formulating diagnosis and care plans. Aboriginal Liaison Officers and Multicultural Health Liaison Officers are available for advice and assistance in understanding these issues.
- Encourage the person to talk about how he or she feels and respond with respect. Do not make or agree with any negative comments or behaviours that are self-defeating and gently challenge the person's negative assumptions by providing alternative perspectives. For example, you could ask: 'What would you say to a good friend in these circumstances?'
- Show empathy and support. However, avoid being overly sympathetic, as the person may feel that you are being condescending.
- Avoid statements such as 'Things can't be that bad' and 'Everything will be OK', as the person might feel that you do not really understand his or her problems. This may make the person unwilling to share other feelings.
- Encourage the person to carry out self-care, even though it may be easier for a nurse to do these things.
- Encourage the person to participate in purposeful activity and daily routine. Assure the person that the extra effort will be worth it in the long run.
- Point out any improvements in the person's condition (e.g. sleeping and eating patterns), as he or she may be unable to recognise these.
- Reinforce the person's strengths and positive attributes by encouraging the person to value his or her achievements, relationships and health.
- Encourage the person to increase self-esteem by being more compassionate towards himself or herself e.g. help them to identify small but important goals and ways of celebrating when they are reached.
- Help the person to identify and develop a range of contacts for support and socialisation. This may include helping the person to write a list of friends who could be contacted when extra support is needed or identifying interests that could be expanded upon by joining a group of like minded people e.g. arts groups, sports groups.
- Monitor recovery, compliance with medication and general physical health (including nutrition, weight, blood pressure and so on). Provide education on possible side effects to any medication (if appropriate) and work with the person to develop appropriate actions to address any issues.
- As appropriate, provide family members and carers with information about the illness, as well as reassurance and validation of their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.
- Be aware of your own feelings when nursing a person with depression. Arrange for debriefing for yourself or for any colleague who may require support or assistance – this may occur with a clinical supervisor or an employee assistance program counsellor (see below).

Employee Assistance Program counsellors are available for nurses in need of support and debriefing regarding any work related or personal matters. Contact numbers in your area can be found at:
http://intranet.hne.health.nsw.gov.au/hr/eap

Treatment for depression

With the modern therapies available, treatment of depression is highly successful. People who are depressed should not hesitate to contact their GP, who might help them to resolve the problem or, if necessary, refer them to a mental health professional.

The type of treatment depends on the type of depression and its severity. The following treatments may be used alone or in combination.

Counselling and psychological therapies

Counselling can assist people to sort out practical problems and conflicts and to help them understand the reasons for their depression. It may include specific types of intervention such as cognitive behaviour therapy (CBT), interpersonal therapy, family therapy and psychodynamic psychotherapy.

Psychosocial strategies including education, counselling and support for the person and his or her family can help with understanding, stress management and compliance with medication.

Medication

Antidepressant drugs help to relieve the depression, restore normal sleeping patterns and appetite, and reduce anxiety. They work by modifying the activity of neurotransmitter pathways. There are a number of categories of antidepressants, including:

- selective serotonin uptake inhibitors (SSRIs), e.g. sertraline, paroxetine
- serotonin or noradrenalin reuptake inhibitors (SNRIs), e.g. venlafaxine
- atypical antidepressants, e.g. nefazadone, mirtazepine
- tricyclics, e.g. amitriptyline, doxepin
- monoamine oxidase inhibitors, e.g. phenelzine, tranylcypromine

ECT

Electroconvulsive therapy (ECT), or 'shock therapy' as it is commonly known, is a safe and highly effective treatment for the most severe forms of depression. Many misconceptions remain regarding its use, possibly because sometimes it has been inaccurately depicted in the media. The procedure involves the use of short-acting anaesthesia, muscle relaxants and oxygen, and the person is carefully monitored throughout the procedure and during recovery.
The aim is to induce a highly modified seizure, which is thought to positively influence levels of neurotransmitters, leading to improvement in mood or reduction of psychotic symptoms.

ECT may be life-saving for those at high risk of suicide or who, because of the severity of their illness, have stopped eating and drinking and may die as a result.

Discharge planning

Discuss referral options with the person and consider referrals to the following:

- GP
- Community Health Centre (CHC) for social work or psychology counselling. To access the contact numbers and details for your local Centre use the following link on HNE intranet: **http://intranet.hne.health.nsw.gov.au/services_and_facilities**
- Mental Health Services. Use the following link to obtain referral forms and contact numbers available on HNE intranet: **http://intranet.hne.health.nsw.gov.au/mental_health/adult_model_of_care/triage**
- Private service providers

Further reading

For further information, see the *Mental Health First Aid Manual* at **www.mhfa.com.au** Internet access required.

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Caring For The Person Who Has An
Eating Disorder

Case study

Alina is 17 years old. She has been a dedicated athlete since early childhood. Alina was brought to the hospital after she fainted at school. She has been admitted to the adolescent ward and has been diagnosed as having anorexia nervosa. On discharge, her treatment will involve primary care services.

The following information could help you nurse a patient like Alina.

What is an eating disorder?

There are three eating disorder conditions (anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified) which are characterised by disordered eating patterns, abnormal perceptions of weight and appearance, and often obsessions with exercise and purging. Between 2-3% of adolescent and adult females experience an eating disorder. Anecdotally, the number of men presenting with eating disorders is rising.

Anorexia nervosa is characterised by a loss of at least 15% of body weight resulting from a range of the following: a refusal to consume sufficient food, despite extreme hunger; a disturbance of body image perception; an intense fear of becoming 'fat' and losing control, a tendency to exercise obsessively and a preoccupation with the preparation of food for others to eat. A significant proportion of people with anorexia nervosa will progress to other eating disorders, particularly bulimia nervosa. Anorexia nervosa is one of the top three chronic conditions of adolescence – it is 10 times more prevalent than diabetes, and only slightly less common than asthma. In addition, of the three eating disorder conditions, anorexia nervosa has the highest mortality rate.

The life of a person with ***bulimia nervosa*** is dominated by an obsessive control of their weight. This condition is characterised by eating binges that involve the consumption of large amounts of calorie-rich foods, during which the person feels a loss of personal control and self-disgust; attempts to compensate for binges and avoid weight gain by self-induced vomiting or abuse of laxatives or fluid tablets; and a combination of restricted eating and compulsive exercise. The person with bulimia is usually average or slightly above average weight for height and is often less recognisable than the person with anorexia. There may be evidence of dental erosion, electrolyte imbalance or swelling around the face due to irritation of the salivary glands.

Causes and onset of eating disorders

Actual causes remain disputed, with *biological, psychological* and *social* factors involved. A combination of risk and predisposing factors may be involved. For example, females are more likely to develop eating disorders than males. Some twin studies suggest a significant genetic component and chemical or hormonal imbalances (perhaps associated with adolescence) in the body could act as triggers. In about 70% of cases, onset follows a severe life event or difficulty.

Eating disorders are conditions that develop over time, sometimes over years. Both anorexia nervosa and bulimia nervosa often start with a period of food restriction of some kind, which gradually increases. The disorders have an average duration of 6 to 7 years, although some people never fully recover and continue to have abnormal attitudes to food and eating.

Symptoms and physical effects of eating disorders

Some of the typical behaviours associated with eating disorders include difficulties with activities that involve food; deceptive behaviours relating to food (e.g. pretending to have eaten); difficulties in expressing feelings; mood swings; changes in personality; depression; loneliness due to self-imposed isolation; a reluctance to develop personal relationships; and a fear of the disapproval of others should the illness become known, which is tinged with the hope that family and friends might intervene and provide assistance.

The physical effects can be very serious, but are generally reversible if the illnesses are tackled in the early stages. However, if left untreated, severe anorexia and bulimia can be fatal. Responding to early warning signs and obtaining early treatment is essential.

Many of the effects of anorexia are related to malnutrition and include a severe sensitivity to the cold; growth of down-like hair all over the body and an inability to think rationally and to concentrate. Bulimia is likely to cause erosion to dental enamel from excessive vomiting; swollen salivary glands; the possibility of a ruptured stomach and a chronic sore throat and gullet.

Both illnesses, when severe, can cause:

- kidney dysfunction
- urinary tract infections and damage to the colon
- dehydration, constipation and diarrhoea
- seizures, muscle spasms or cramps (resulting from chemical imbalances)
- chronic indigestion
- loss of menstruation or irregular periods (in females)
- strain on most of the body organs

Diagnostic issues

It is important that identification and screening of eating disorders occurs in primary care and non-mental-health settings. When screening, one or two simple questions should be considered for use with specific target groups (e.g. 'Do you worry excessively about your weight?'). Target groups for screening should include young women with relatively low body mass index (BMI); people with weight concerns when not overweight; women with menstrual disturbances or amenorrhoea; people with gastrointestinal symptoms or physical signs of starvation or repeated vomiting;

and children with poor growth. Young people with type 1 diabetes and poor treatment adherence should also be screened and assessed for the presence of an eating disorder.

A person's perspective on what it is like to have an eating disorder

"It is tormenting, exhausting, emotionally painful, draining and means that I live in fear daily. I have a sense that there is nothing positive or worthwhile about me, the numbers going down on the scales are the only glimmer of something that I can define as 'good' about myself. I NEED to hang onto this glimpse of 'goodness' (weight loss) because I cannot see any other reason why I deserve to exist."

Some reported reactions to people who have eating disorders

Nurses who have worked with people who have eating disorders have reported the following reactions:

Inadequacy

Nurses may feel inadequate when they are unable to help the person develop and maintain a healthy weight.

Frustration

Some nurses have difficulty interacting with and caring for people who appear to willingly starve themselves. It is not uncommon for nurses to report feeling disgusted at the illness and to perceive that the person has only themselves to blame and should 'pull themselves together'.

Struggle for power

When a nurse engages in activities that require a person to change their eating behaviours – despite the person's own potential resistance – this situation can set up a power struggle between the two. If there is not a consistent and accepted approach to the issues, there is also the potential for conflict to develop between care providers and with the person with the eating disorder.

Resentment

Nurses who make every effort to encourage a person with an eating disorder may experience feelings of resentment towards the person, especially if he or she attempts to deceive staff, for example by hiding food or secretly vomiting.

Goals for nursing the person who has an eating disorder

Appropriate goals for caring for a person with an eating disorder in a community or hospital setting include:

- Develop a relationship with the person based on empathy and trust.
- Promote the person's sense of positive self-regard.
- Encourage no further decrease in the person's weight and promote a slow increase of the person's weight to a healthy range.
- Promote positive health behaviours and an understanding of the side effects of an eating disorder.

- Promote the person's engagement with their social and support network.
- Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- Support and promote self care activities for families and carers of the person experiencing an eating disorder.

Responding to the person who has an eating disorder

- If appropriate, arrange for an initial or follow-up psychiatric assessment if their care plan needs reviewing. A psychosocial assessment may be appropriate to undertake – see the MIND Essentials resource 'Conducting a psychosocial assessment'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is important to take this into account when formulating diagnosis and care plans. Aboriginal Liaison Officers and Multicultural Health Liaison Officers are available for advice and assistance in understanding these issues.
- Be aware of the person's increased risk of self-harm and suicide. Assess whether they display any indicators of suicidal thinking. Refer to the MIND Essentials resource 'Caring for the person who is suicidal'.
- Ask the person about their concerns regarding the disorder and its treatment. Most people experience mixed feelings about their disorder and need to feel that acknowledging the disorder and accepting treatment will not lead to total loss of control.
- Talk with the person about self-perception. Try not to criticise or judge, but instead provide empathy while also giving your perception of the situation. Adopt a 'serious-but-friendly' attitude with comments like: 'I understand that you see yourself as fat, but people are very concerned about you being underweight.'
- To increase the person's self-confidence, encourage him or her to make independent decisions appropriate to the situation. This will enable the person to feel that he or she has control over the care.
- Encourage the person to verbalise positive feelings about his or her appearance and self.
- Encourage the person to become involved in activities that do not focus on food or physical activity.
- Encourage the person to start using relaxation techniques to counteract anxiety and tension associated with eating.
- Do not overreact if the person is hiding food or vomiting. Instead, discuss these issues openly. Try not to avoid the problem, but rather encourage the person to talk to you about feelings of guilt or anxiety if he or she has the urge to vomit.
- The person may deny problems with eating but may be able to relate to the consequences, such as poor concentration that affects work or study. Use this as an opportunity to talk gently about some of these consequences, for example malnutrition and the brain.
- As appropriate, provide family members and carers with information about the illness, as well as reassurance and validation of their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.

- Be aware of your own feelings when caring for a person with an eating disorder. Arrange for debriefing for yourself or for any colleague who may need support or assistance with feelings such as frustration, helplessness and anger – this may occur with a clinical supervisor or an employee assistance program counsellor (see below).

Employee Assistance Program counsellors are available for nurses in need of support and debriefing regarding any work related or personal matters. Contact numbers in your area can be found at:
http://intranet.hne.health.nsw.gov.au/hr/eap

Treatment for eating disorders

Changes in eating behaviour might be caused by a number of illnesses other than anorexia or bulimia, and so a thorough physical examination is the first step in treatment. Once the illness has been diagnosed, a range of health practitioners might be involved in treatment, as the illnesses affect people both physically and mentally. It is likely that the person will require treatment for a considerable time, often for a number of years. Psychiatrists, psychologists, nurses, physicians, dietitians, social workers, occupational therapists and dentists may all play a role in assisting a person to recover.

There has recently been a trend away from hospitalisation for people who have eating disorders. However, hospitalisation may be necessary for people who are severely malnourished from anorexia, have uncontrollable vomiting, have medical complications (e.g. fainting, cardiac abnormalities), have suicidal behaviour or who do not respond to outpatient treatment. The preferred method of treatment is a more flexible approach, which may involve short-term inpatient treatment, outpatient or day-patient treatment. Outpatient treatment is generally preferred for people with bulimia.

Therapies may include:

- assessment and treatment of underlying and comorbid psychiatric problems (e.g. depression, anxiety)
- individual or group psychological approaches aimed at increasing self-esteem, developing assertiveness skills and teaching anxiety management
- cognitive behaviour therapy aimed at correcting dysfunctional thinking patterns and assumptions about food, eating and body image
- family therapy aimed at teaching families to effectively communicate emotion, to set limits, to resolve arguments and to solve problems more effectively
- specific counselling (e.g. to deal with issues of sexual identity or sexual abuse) where indicated

Discharge planning

Discuss referral options with the person and consider referrals to the following:

- GP
- Community Health Centre (CHC) for social work or psychology counselling. To access the contact numbers and details for your local Centre use the following link on HNE intranet: **http://intranet.hne.health.nsw.gov.au/services_and_facilities**
- Mental Health Services. Use the following link to obtain referral forms and contact numbers available on HNE intranet: **http://intranet.hne.health.nsw.gov.au/mental_health/adult_model_of_care/triage**
- Private service providers

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Caring For The Person Who Has A Personality Disorder

Case study

Kiara is a 23 year old woman who has been brought to the emergency department by her sister after taking an overdose of her antidepressant medication and alcohol. She also has a number of superficial cuts to her arms. She reports that her boyfriend had just broken up with her because he said that he could not cope with her being so 'clingy'. She is extremely distressed and says that she wants to die and that she wants to leave the hospital. She is verbally abusive to the staff who are trying to treat her wounds and assess her level of risk from the overdose. Kiara has many of the common behaviours that are characteristic of a personality disorder.

The following information could help you nurse a patient like Kiara.

What is a personality disorder?

Personality disorders are used to describe a cluster of personality traits that significantly and negatively impact on a person's functioning and well being. The personality traits tend to be long standing and associated with unhelpful responses to life's challenges. Sometimes the personality traits will also cause the person a lot of distress.

Symptoms and types of personality disorders

There are ten specific personality disorders, which fall into three clusters with similar symptoms. The specific personality disorders include ***paranoid***, ***schizoid*** and ***schizotypal*** (Cluster A); ***antisocial***, ***borderline***, ***histrionic*** and ***narcissistic*** (Cluster B); and ***avoidant***, ***dependent*** and ***obsessive-compulsive*** (Cluster C). In general, these personality disorders are associated with problems in interpersonal relationships, a limited capacity to respond effectively to stress, limited availability of social support, higher health service use and a lower quality of life. Core symptoms of a personality disorder are:

- An enduring pattern of inner experience or behaviour that deviates markedly from the norm, and which is apparent in the person's thinking (the way they see themselves, others or events); affectivity (the range and intensity of their emotions); the way they relate to others (their social skills or relationships developed); and their impulse control.
- The pattern is seen in a broad range of personal and social situations, is persistent and has been apparent for a long time with onset in adolescence or early adulthood.
- The pattern leads to significant distress for the person, or impairment in functioning in social or work environments.

Approximately 6% of the adult population will meet the criteria for personality disorder over their lifetime. Two of the more common personality disorders likely to be encountered in the clinical setting are borderline personality disorder and anti-social personality disorder.

People with ***borderline personality disorder*** often present in crisis and may be highly emotionally aroused or intoxicated. They tend to view the world as 'dangerous and malevolent' and themselves as 'powerless, vulnerable and inherently unacceptable'. They often have or show: a high sensitivity to emotional triggers; inappropriate, intense anger or difficulty controlling anger; a strong fear of abandonment; dissociation; intense and unstable relationships; impulsivity seen with substance abuse, indiscriminate sexual activity, compulsive shopping or shoplifting; and frequent suicidal ideation and self harm (such as cutting). These symptoms usually begin by early adulthood and present in a variety of contexts. Borderline personality disorder also has high comorbidity with other mental illnesses such as depression, anxiety, bulimia and other personality disorders. Frequently there is a history of childhood abuse and neglect. People with borderline personality disorder will often present with a sense of chaos and frequently trigger strong emotional responses from service providers.

Anti-social personality disorder is characterised by a pervasive pattern of disregard for, and violation of, the rights of others including deceitfulness; irritability and aggressiveness; consistent irresponsibility; reckless disregard for the safety of self or others; and a lack of remorse. These behaviours begin in childhood or early adolescence and continue into adulthood. This group of clients tend to be younger and present in crisis, frequently intoxicated and may be highly emotionally aroused in crisis. A history of problems with the law is not uncommon. They can present with aggression and violence and may present challenges to those nursing them.

A person's perspective on what it is like to experience a personality disorder

"It is confusing, exhausting and so painful that you wish you had a physical injury that would validate having that much pain. It's like living in a world of ALL or NOTHING in utmost extremes. Anything and everything becomes about YOU. It's like knowing that you're severely defective in some way, but extremely self centred at the same time. You are a master at reading and researching what everyone is thinking about you and then reacting with extreme emotions that seem to come out of nowhere, whilst convincing yourself that this is all warranted and the 'right' thing to do. Add to that the overwhelming feelings of emptiness, obsessing with identity and self image and then harming yourself in endless ways in punishment for all of the above."

Some reported reactions to people with personality disorders

Nurses who have worked with people who have personality disorders have reported the following reactions:

Apprehension

The number of crisis situations and level of emotional intensity associated with the events can make a nurse feel that they are always 'on the edge' waiting for something else to happen.

Anxiety

Some nurses report experiencing anxiety due to the unpredictable, stressful or apparently manipulative behaviour associated with some of the personality disorders.

Dislike

People with personality disorders often have difficulties in interpersonal relationships and may have limited capacity to connect with others, adapt to change or cope with environmental demands. This can mean their company is not engaging and may trigger specific feelings of dislike and a desire to avoid them.

Inconsistency of care

The fact that some staff may wish to avoid or appease the patient can lead to inconsistency of care. This can in turn lead to conflicts arising between staff members.

Intensity of Feelings

People often report having a strong emotional response (positive and negative) to people with personality disorders. It is important to reflect on why and which 'buttons' have been pushed, and if this is affecting your own capacity to maintain an appropriate level of emotional distance and connection.

Goals for nursing the person with a personality disorder

Appropriate goals for caring for a person with a personality disorder in a community or hospital setting include:

- Develop a relationship with the person based on empathy and trust, whilst also maintaining appropriate boundaries.
- Ensure duty of care responsibilities are appropriately addressed, with regards to treatment for the presenting medical and physical issues and by remaining alert to suicide risk.
- Promote effective and functional coping and problem solving skills, in a way that is empowering to the person.
- Promote the person's development of and engagement with their support network, including access to appropriate service providers.
- Ensure good collaboration and communication with other staff members and service providers treating the person to ensure consistency in treatment and approach.
- Support and promote self care activities for families and carers of the person with the personality disorder.

Responding to the person with a personality disorder

- If appropriate, arrange for a review of the person's medication and an initial or follow-up psychiatric assessment if their care plan needs reviewing. A psychosocial assessment may be appropriate to undertake – see the MIND Essentials resource 'Conducting a psychosocial assessment'.
- Be alert to and regularly monitor suicide risk. Refer to the MIND Essentials resource 'Caring for the person who is suicidal'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is important to take this into account when formulating diagnosis and care plans. Aboriginal Liaison Officers and Multicultural Health Liaison Officers are available for advice and assistance in understanding these issues.
- Ensure the presenting medical or physical issues are appropriately addressed. It can be easy to minimise these issues or be distracted by other more demanding behaviours the person may present with.
- Identify a strength and something you like about the person with the personality disorder and focus on this. This can be helpful in balancing the ease at which dislike can be developed in response to any presenting disengaging behaviours.
- Develop an understanding of the person's history or experiences and consider how this may have contributed to the development of certain personality traits.
- It is important to try and understand why a person is behaving the way they do. Validation is like empathy but also involves letting the person know that their behaviours are understandable given their past experiences and the current situation. For example, 'It sounds like it's really hard for you knowing what to do with those feelings now, when you've never really had a role model for how to manage them'.
- When the person is distressed, you may want to validate their experience and use soothing, reassuring words and actions.
- When a person is angry, validation of the person's experience is an important first response, however it is important to maintain safety and set limits around what is acceptable in expressing anger. Leave the situation if feeling threatened.
- Maintain hope and be clear on the issues that you can help with.
- It is important to recognise that the effects of any treatment for personality symptoms may take awhile – but even a small improvement in distressing symptoms can make a significant difference to the person experiencing them.
- For people who have a personality disorder, self-harm is often a coping strategy. It is important not to judge a person for self harming. However, before the event, it may be possible to encourage and facilitate the use of more adaptive strategies for managing their emotional state. For example, helping the person to identify some activities that help them feel better.
- When appropriate, work with the person to identify any particular areas they would like assistance with, and support them to access the appropriate treatment or support services they need.
- Identify supports the person can call on in times of stress.
- Ensure a team approach to care is developed that it is agreed upon, written down and accessible by all staff. Include in this clear limits and responses to crisis presentations.

- Ensure there has been a clear decision made and recorded about the use of psychotropic medications.
- Be clear, but non punitive, in setting behavioural limits and consequences and make sure the limits are followed through.
- It is important to recognise that people with personality disorders can often be living in unstable or unsafe environments and can be disorganised or impulsive. Thus, written instructions and follow up phone calls can be useful as they may not be able to take in information if they are presenting in a crisis or a highly emotional state.
- It can be challenging to tease out psychiatric co-morbidities and treat separately in the general medical setting. People with personality disorders often have multiple co-morbidities. Consultation liaison psychiatry services can be helpful, where available. Similarly, it may be opportune to give information about Drug and Alcohol services, but remember that people may be pre-contemplative in regards to changing their maladaptive behaviours.
- As appropriate, provide family members and carers with information about the illness, as well as reassurance and validation of their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.
- When likely to be involved with a person with a personality disorder for a longer duration, ensure that you have identified your own support network, supervision or peer consultation process. This group can help you reflect on which of your own 'buttons' are being pushed and how best to maintain self care.
- Be aware of your own feelings when caring for a person with a personality disorder. Arrange for debriefing for yourself or for any colleague who may need support or assistance – this may occur with a clinical supervisor or an employee assistance program counsellor (see below).

Employee Assistance Program counsellors are available for nurses in need of support and debriefing regarding any work related or personal matters. Contact numbers in your area can be found at:
http://intranet.hne.health.nsw.gov.au/hr/eap

Treatment of personality disorders

There is varied use of supportive, cognitive, behavioural and interpersonal techniques to address the issues associated with personality disorders. While there are some treatments for certain types of personality disorders that have been shown to be effective in reducing unhelpful behaviour or affective experiences (e.g. dialectical behaviour therapy for borderline personality disorder), there are no generic treatments appropriate for all types of personality disorders. Psychological and pharmacological treatments are generally used for specific symptoms, behaviours or experiences and can be brief or long-term in duration.

Psychosocial strategies including education, counselling and support for the person and his or her family can help with understanding, stress management and compliance with medication.

Discharge planning

Discuss referral options with the person and consider referrals to the following:

- GP
- Community Health Centre (CHC) for social work or psychology counselling. To access the contact numbers and details for your local Centre, use the following link on the HNE intranet:
  http://intranet.hne.health.nsw.gov.au/services_and_facilities
- Mental Health Services. Use the following link to obtain referral forms and contact numbers available on the HNE intranet:
  http://intranet.hne.health.nsw.gov.au/mental_health/adult_model_of_care/triage
- Private service providers

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Caring For The Person With Dementia

Case study

Harry is an 85 year old man who has been brought to hospital following a fall from a ladder in his back yard. He lives with his wife, Alice, in their own home. He had been attempting to clean out the gutters following a storm. He is not sure how he got to hospital and is not good at providing other health or family history. On a Mini Mental Status Examination he scored 17 out of 30, which is well under the cut-off score of 24 out of 30. This indicates that he has possible cognitive impairment. His dislocated shoulder has been reduced under anaesthesia following two unsuccessful attempts at closed reduction. He has not eaten or taken any fluids since returning to the ward. You become concerned that when his wife leaves after the evening meal, he becomes restless and begins to experience difficulty responding to directions.

The following information could help you nurse a patient like Harry.

What is dementia?

Dementia is the term used to describe the symptoms of a large group of illnesses that cause a progressive decline in a person's functioning. It is a broad term used to describe a loss of memory, intellect, rationality and social skills. It is estimated that dementia affects 6.5% of all Australians aged 65 and over.

Symptoms and types of dementia

In the early stages of dementia, people function relatively normally with some support. As dementia progresses, more specific symptoms occur (such as difficulty with speech and language, poor judgement and lack of insight). Difficulty with personal care tasks (such as bathing) and other everyday tasks (such as cooking, shopping and managing money) may become apparent. Often there are enduring changes in personality and behaviour as well.

People with dementia can be perceived to be aggressive, uncooperative and unpredictable. They may also present with hallucinations and delusions. These 'behaviours of concern' and others can best be classified as 'behavioural and psychological symptoms of dementia'. All the signs and symptoms are a result of progressive damage to the brain. For example, damage to the limbic system is associated with memory dysfunction, unstable mood and personality changes. The behaviours are not the result of deliberate attempts to be difficult or to upset carers.

Dementia can be caused by a number of disease processes. Approximately 60% of people with dementia have ***Alzheimer's disease*** and about 20% have ***vascular dementia***. Dementia related to ***Parkinson's disease*** is also common, and ***excessive alcohol consumption*** is another prevalent cause. Other illnesses (such as ***multiple sclerosis***, ***HIV/AIDS***, ***Huntington's disease*** and ***Creutzfeldt-Jacob disease***) are less common causes.

Onset and course of dementia

In Alzheimer's disease, the onset is insidious, generally occurring after the age of 55 and increasing in frequency of occurrence with advancing age. Dementia is a terminal illness, and failing brain function and increasing physical disability lead to total dependence on others for all care. Palliative care measures towards the end of life are appropriate for people with dementia.

Difficulties in diagnosis

It is important to understand the difference between dementia, delirium and depression. Depression and delirium are treatable conditions that present as similar to dementia. Remember that all three conditions can be present and that dementia increases the risk for delirium. Common precipitating factors for delirium include infection, medication interactions and surgery.

Differentiating between dementia, delirium and depression (the three Ds) requires skilled assessment. The differences and similarities are outlined in Table 1.

Table 1 *The features of dementia, delirium and depression*

	Dementia	Delirium	Depression
Thoughts	• Repetitiveness of thought • Reduced interests • Difficulty making logical connections • Slow processing of thoughts	• Bizarre and vivid thoughts • Frightening thoughts and ideas • Often paranoid thoughts	• Often slowed thought processes • May be preoccupied by sadness and hopelessness • Negative thoughts about self • Reduced interest
Sleep	• Often a disturbed 24 hour clock mechanism (later in the disease process)	• Confusion disturbs sleep (may have a reverse sleep-wake cycle) • Nocturnal confusion • Vivid and disturbing nightmares	• Early morning waking or intermittent sleeping patterns (in atypical cases, too much sleep)
Orientation	• Increasingly impaired sense of time and place	• Fluctuating impairment of sense of time, place and person	• Usually normal
Onset	• Usually gradual, over several years • Insidious in nature	• Acute or subacute (hours or days)	• Usually over days or weeks • May coincide with life changes
Memory and Cognition	• Impaired recent memory • As disease progresses, long term memory also affected • Other cognitive deficits such as in word finding, judgement and abstract thinking	• Immediate memory impaired • Attention and concentration impaired	• Recent memory sometimes impaired • Long-term memory generally intact • Patchy memory loss • Poor attention
Duration	• Months or years and progressive degeneration	• Usually brief – hours to days (but can last months in some cases)	• At least two weeks (but can be several months to years)
Course throughout a day	• May be variable depending on type of dementia	• Fluctuates – usually worse at night in the dark • May have lucid periods	• Commonly worse in the morning with improvement as the day continues
Alertness	• Usually normal	• Fluctuates – lethargic or hypervigilant	• Normal
Other	• May be able to conceal or compensate for deficits (early)	• May occur as a consequence of a drug interaction or reaction, physical disease, psychological issue or environmental changes	• Often masked • May or may not have past history

(NSW Department of Health, 2006)

A perspective on being the partner of a person with dementia

"My wife's dementia was insidious. It snuck up on us slowly and then took over every aspect of our life, requiring her to be cared for in a nursing home. She became extremely scared and anxious and everyday when I left the nursing home she would cry out 'don't leave me.' It was heartwrenching to leave her but even more distressing to know that ten minutes after leaving, she wouldn't even remember that I had been there with her. I felt helpless watching her decline."

Some reported reactions to people with dementia

Nurses who have worked with people with dementia have reported the following reactions:

Frustration and helplessness — This results from lack of improvement in a person with irreversible symptoms, as well as the constant need to repeat instructions, break down tasks step by step and answer repetitive questions.

Impatience — Nurses report decreased patience and tolerance in providing care when people with dementia are negative, hostile, impulsive or slow to respond.

Anger — People with dementia may show little insight into their loss of ability, and this can be interpreted as choosing not to accept help or being resistive to care. This can lead to feelings of anger in nurses.

Goals for nursing the person with dementia

Appropriate goals for caring for a person with dementia in a community or hospital setting include:

- Develop a relationship with the person based on empathy and trust.
- Provide an environment that supports a flexible but predictable routine.
- Maintain a safe environment for the person, yourself and other staff.
- Promote the person's engagement with their social and support network.
- Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- Support and promote self care activities for families and carers of the person with dementia.

Responding to the person with dementia

The following guidelines will assist in nursing a person with dementia.

- If appropriate, arrange for a review of the person's medication and an initial or follow-up psychiatric assessment if their care plan needs reviewing. A psychosocial assessment may be appropriate to undertake – see the MIND Essentials resource 'Conducting a psychosocial assessment'.

- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is important to take this into account when formulating diagnosis and care plans. Aboriginal Liaison Officers and Multicultural Health Liaison Officers are available for advice and assistance in understanding these issues.
- Explain to the person who you are, what you want to do and why.
- Smile. The person is likely to take cues from you, and will mirror your relaxed and positive body language and tone of voice.
- Move slowly. You may have a lot to do and be in a hurry, but the person is not. (Imagine how you would feel if someone came into your bedroom, pulled back your blankets and started pulling you out of bed without even giving you time to wake up properly).
- If the person is resistive or aggressive but is not causing harm, leave him or her alone. Give the person time to settle down and approach the task later.
- Distract the person by talking about things he or she enjoyed in the past and by giving him or her a face washer or something to hold while you are providing care.
- Do not argue with the person. The brain of a person with dementia tells the person that he or she cannot be wrong.
- If the person is agitated, maintain a quiet environment. Check noise levels regularly and reduce them if necessary by turning off the radio and television.
- Provide orientating cues such as a clock and a calendar.
- Give the person a comfortable space. Any activity that involves invasion of personal space increases the risk of assault and aggression.
- Always provide care from the side (not the front) of the person. If you stand in front, you are easily hit or kicked if the person becomes aggressive.
- Be vigilant if the person is climbing out of bed. Refer to your workplace policy on restraint. If you cannot work out a reason for this behaviour, you might walk with the person or engage him or her in an activity. This helps to maintain his or her mobility, and eventually he or she may tire and go back to bed. Encourage family or volunteers to help with this.
- Monitor compliance with medication and general physical health (including nutrition, weight, blood pressure and so on).
- Monitor food and fluid intake and elimination - dehydration or constipation can exacerbate confusion.
- People with dementia are at increased risk of developing delirium, so be aware of risk factors for delirium (such as medication interactions, infection and the postoperative period).
- As appropriate, provide family members and carers with information about the illness, as well as reassurance and validation of their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.
- Be aware of your own feelings when nursing a patient with dementia. Arrange for debriefing for yourself or for any colleague who may need support or assistance – this may occur with a clinical supervisor or an employee assistance program counsellor (see below).

Employee Assistance Program counsellors are available for nurses in need of support and debriefing regarding any work related or personal matters. Contact numbers in your area can be found at:
http://intranet.hne.health.nsw.gov.au/hr/eap

Treatment for dementia

In general, non-pharmacological approaches are first-line treatment for behavioural and psychological symptoms of dementia. If symptoms are moderate to severe and impact on the person's (or the carer's) quality of life or functioning, medication may be indicated, often in conjunction with non-pharmacological interventions. The person with dementia, as well as his or her family and carers, will need support, education and counselling to help them understand and cope with what can be a devastating illness. A problem-solving approach that is preventative rather than reactive may help to identify situations that trigger a particular behaviour, which can then be avoided or modified.

Non-pharmacological strategies

Non-pharmacological strategies need to be based on an understanding of the individual's strengths and deficits. A 'catastrophic reaction' may result when the person's ability to cope is exceeded by the demands of the caregiver. This may be in the form of aggression or other distressed behaviour.

Communication strategies should include using clear, plain language and short sentences that convey one idea at a time. Use of gestures, pictures and body language can enhance the effectiveness of the message. It is helpful to use the 'ABC' model. This looks at the ***A***ctivating event before the ***B***ehaviour emerged and the **C**onsequences of the event. Documenting these can provide clues to patterns of behaviour and the triggers for these.

Pharmacological strategies

Currently there is no cure for Alzheimer's disease, but drugs such as cholinesterase inhibitors (e.g. donepezil, galantamine and rivastigmine) may help to slow the progress of the disease in the early stages. Memantine, which inhibits the release of glutamate (a neurotransmitter), is indicated for more advanced disease and may be used in conjunction with a cholinesterase inhibitor.

Antipsychotic medication is most effective in the treatment of psychotic symptoms (such as hallucinations and delusions) and behavioural symptoms (such as physical aggression). Newer antipsychotic medications appear to be at least as effective as conventional neuroleptics, but have fewer side effects. Those with strong extrapyramidal effects (such as muscle rigidity, tremor and Parkinsonism) may be avoided in favour of those with sedating qualities.

When the person is severely agitated, and as a result, distressed or representing a danger to himself, herself or others, sedation (a waking calm) is indicated. However, care needs to be taken to avoid oversedation (drowsiness), which ironically increases confusion and exposes the person to other risks such as falls, immobility, hypotension and reduced engagement. Benzodiazepines with lower toxicity and shorter half-life (e.g temazepam, oxazepam) are preferred to longer-acting agents (e.g. diazepam, nitrazepam).

Antidepressant medications are underused in people with dementia, despite the common occurrence of depression in dementia and the documented therapeutic value of these drugs. (Note that some people may present as agitated when suffering a depressive disorder).

Discharge planning

Discuss referral options with the person and consider referrals to the following:

- Aged Care Assessment Teams (ACAT) – HNE Staff directory **http://search.hne.health.nsw.gov.au/staff/**
- Dementia Advisory Services – see DADHC website **http://www.dadhc.nsw.gov.au/dadhc/Older+People/**
- Mental Health Services (including Mental Health Service for Older People). Use the following link to obtain referral forms and contact numbers available on HNE intranet: **http://intranet.hne.health.nsw.gov.au/mental_health/adult_model_of_care/triage**
- Alzheimer's Australia NSW **http://www.alzheimers.org.au/** or The Hunter Dementia and Memory Resource Centre (02) 4962 7000, for information, education, support and counselling.

Further reading

The Specialist Mental Health Services for Older People Orientation and Resources intranet page includes information on behavioural and psychological symptoms of dementia, delirium, depression, psychosis, legal issues and end of life care. Use the following link to gain access to this page:

http://intranet.hne.health.nsw.gov.au/mental_health/services_and_facilities_pages/smhsop_clinical_orientation_and_resources

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Caring For The Person Experiencing
Mania

Case study

Yousef is 40. He has been brought to the emergency department with cuts to his arms, chest and face, which he received as a result of a fight in a bar. His friend has advised that Yousef has bipolar disorder, and that he looks like he is 'on the way up'.

Staff have concluded that a psychiatric assessment of Yousef is needed to determine whether admission for psychiatric reasons is required. Yousef is to be kept in the emergency department until this can be arranged, which could be several hours. During this time, he finds it extremely difficult to stay in bed and is constantly wandering around the ward into other rooms. When he is in bed, he is constantly ringing the buzzer. He is frequently found talking to other patients, staff and visitors about his wonderful new invention and trying to get them to invest in a company that he is planning to set up.

The following information could help you nurse a patient like Yousef.

What is mania?

Mania is a state of extreme physical and emotional elation.

Symptoms and types of mania

A person experiencing mania or a ***manic episode*** may present with the following symptoms:

- *Elevated mood.* The person feels extremely 'high', happy and full of energy; he or she may describe the experience as feeling on top of the world and invincible. The person may shift rapidly from an elevated, happy mood to being angry and irritable if thwarted.
- *Increased energy and overactivity.* The person may have great difficulty remaining still.
- *Reduced need for sleep or food.* The person may be too active to eat or sleep.
- *Irritability.* A person in a hypomanic or manic state may become angry and irritated with those who disagree with or dismiss his or her sometimes unrealistic plans or ideas.
- *Rapid thinking and speech.* The person's thoughts and speech are more rapid than usual.

- *Grandiose plans and beliefs.* It is quite common for a person in a hypomanic or manic state to believe that he or she is unusually talented or gifted or has special friendships with people in power. For example, the person may believe that he or she is on a special mission from God.
- *Lack of insight.* A person in a hypomanic or manic state may understand that other people see his or her ideas and actions as inappropriate, reckless or irrational. However, he or she is unlikely to personally accept that the behaviour is inappropriate, due to a lack of insight.
- *Distractibility.* The person has difficulty maintaining attention and may not be able to filter out external stimuli.

Episodes that are characterised by the above, but are not associated with marked social or occupational disturbance, a need for hospitalisation or psychotic features are called ***hypomanic episodes***.

Causes, onset and course of mania

A person may experience mania as a result of a range of factors, including:

- stressful events
- genetic factors
- biochemical factors (neurotransmitter abnormalities or imbalances)
- seasonal influences
- bipolar affective disorder (BAD)

For individuals living with bipolar affective disorder (also called bipolar disorder and formerly called manic depressive psychosis) they will experience recurrent episodes of depression and mania, of which the symptoms are not due to substance use or other general medical conditions. The manic or depressive episodes are usually separated by lengthy periods where the person is well.

The average age for the first manic episode is in the early twenties; however, for some, episodes begin in adolescence. The first episode rarely occurs after the age of 50. Manic episodes in adolescence are more likely to include psychotic features and may be associated with school truancy, antisocial behaviour, school failure or substance abuse. Lifetime prevalence is about 1%.

Manic episodes begin suddenly and with a rapid escalation of symptoms over a few days. They may follow psychosocial stressors or a major depressive episode.

Difficulties in diagnosis

Symptoms similar to those in a manic phase may be due to the effects of antidepressant medication, electroconvulsive therapy or medication prescribed for other physical illnesses (e.g. corticosteroids) and are not included in this diagnostic category.

A person's perspective on what it is like to experience mania

"I am feeling ten foot tall, bulletproof and experiencing a high I'd imagine you could attain only on the strongest drugs…I place my head in my hands and my mood starts morphing from hilarity into a cosmic scramble of visions from history."

Craig Hamilton in Broken Open

Some reported reactions to people experiencing mania

Nurses who have worked with people who have mania have reported the following reactions:

Amusement — It is quite common for staff to react to the person's acting out and exuberance with amusement. It is important to ensure that respect for the person is maintained at all times.

Irritation — A person experiencing mania might not be compliant with hospital routines or personal health care. This can cause nurses to feel irritated or even angry with the person.

Embarrassment — Some nurses report feeling embarrassed at what they perceive as an apparent lack of control in the person's behaviour. This embarrassment can be particularly acute if this behaviour is conducted in the presence of others, who might expect the nurse to intervene.

Discomfort — When a person is manic, he or she can sometimes be verbally abusive and make personally demeaning comments. This can cause further distress among staff, who may feel uncomfortable nursing the person.

Goals for nursing the person experiencing mania

Appropriate goals for caring for a person with mania in a community or hospital setting include:

- Develop a relationship with the person based on empathy and trust.
- Ensure that the person remains free from injury.
- Assist the person to decrease their agitation and hyperactivity.
- Promote an understanding of the features and appropriate management of mania, such as mood regulation strategies or behaviours.
- Promote positive health behaviours, including medication compliance and healthy lifestyle choices (e.g. diet, exercise, not smoking).
- Promote the person's engagement with their social and support network.
- Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- Support and promote self care activities for families and carers of the person with mania.

Responding to the person experiencing mania

- If appropriate, arrange for a review of the person's medication for mania and an initial or follow-up psychiatric assessment if their care plan needs reviewing. A psychosocial assessment may be appropriate to undertake – see the MIND Essentials resource 'Conducting a psychosocial assessment'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is important to take this into account when formulating diagnosis and care plans. Aboriginal Liaison Officers and Multicultural Health Liaison Officers are available for advice and assistance in understanding these issues.

- Tell the person what is expected of him or her, but be realistic. For example, if the person needs to pace, facilitate this in an area that does not disrupt others. Encourage respect for the personal space of others, and also show respect for the person experiencing mania.
- Encourage and support any ideas the person has that are realistic and in keeping with his or her health care regime.
- It is possible for people to experience a mixed episode in which mood can alter rapidly between euphoria, sadness and irritability. Suicidal thoughts and psychotic features may be present. Ensure your ongoing assessment includes asking about thoughts of self-harm. For further information, see the MIND Essentials resource 'Conducting a suicide risk assessment'.
- Provide the person with consistent limits. Make sure all staff are clear about these and that they reinforce set limits. Give the person clear, simple directions. It is far more effective to suggest alternative strategies, because the person will be easily distracted, rather than directly forbid an action.
- Encourage the person to organise and slow his or her thoughts and speech patterns, by focusing on one topic at a time and asking questions that require brief answers only.
- If his or her thoughts and speech become confused, try to cease the conversation and sit quietly together to help him or her calm down.
- Avoid verbal confrontations with the person, who is likely to have minimal tolerance.
- Limit the person's interactions with others as much as possible and remove any external stimulation (e.g. noise) where possible. Attempt to provide an area that is private, quiet and dimly lit. However, be careful to avoid completely isolating the person.
- Encourage the development of regular sleeping patterns, and remove distractions during normal sleeping periods.
- Monitor recovery, compliance with medication and general physical health (including nutrition, weight, blood pressure and so on). Provide education on possible side effects to any mood stabilising medication (such as lithium carbonate or sodium valproate) and work with the person to develop appropriate actions to address any issues.
- If lithium has been prescribed, be aware of signs of toxicity (e.g. vomiting, diarrhoea, tremors, drowsiness, muscle weakness, ataxia). Lithium has a narrow therapeutic margin and requires regular monitoring of blood levels.
- The person may find it hard to sit down long enough to take adequate food and fluids. Offer food and drinks that can be taken 'on the run', such as sandwiches. It is important to monitor fluid intake, especially if lithium has been prescribed, because dehydration will exacerbate lithium toxicity.
- As appropriate, provide family members and carers with information about mania, as well as reassurance and validation of their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.
- Be aware of your own feelings when caring for a person experiencing mania. Arrange for debriefing for yourself or for any colleague who may need support or assistance – this may occur with a clinical supervisor or an employee assistance program counsellor (see below).

Employee Assistance Program counsellors are available for nurses in need of support and debriefing regarding any work related or personal matters. Contact numbers in your area can be found at:
http://intranet.hne.health.nsw.gov.au/hr/eap

Treatment of mania

Careful assessment to rule out organic conditions is an important first step in the management of mania. Often hospitalisation is required for someone who is acutely psychotic.

Both mood-stabilising agents such as lithium carbonate or sodium valproate and an antipsychotic may be needed to treat psychotic symptoms, agitation, thought disorder and sleeping difficulties. Benzodiazepines may be useful to reduce hyperactivity. Treatment with lithium alone may have a relatively slow response rate (up to 2 weeks after a therapeutic blood level is established), so that adjunctive medication such as sodium valproate is usually required. Regular monitoring of blood levels for lithium and valproate is essential because of the potential for toxicity.

Hypomania may be managed with lithium or valproate and benzodiazepines. Doses can be lower than for mania, and may prevent progression to a manic episode.

Maintenance therapy needs to be based on an assessment of severity, recurrences and risks of ongoing use of medication.

Psychosocial strategies including education, counselling and support for the person and his or her family can help with understanding, stress management and compliance with medication.

Discharge planning

Discuss referral options with the person and consider referrals to the following:

- GP
- Mental Health Services. Use the following link to obtain referral forms and contact numbers available on HNE intranet:
  http://intranet.hne.health.nsw.gov.au/mental_health/adult_model_of_care/triage
- Private service providers

Further reading

For information on antipsychotic medication, see the MIND Essentials resources 'Caring for the person experiencing delusions' or 'Caring for the person experiencing hallucinations'.

See also the *Mental Health First Aid Manual* at **www.mhfa.com.au**
Internet access required.

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Caring For The Person Experiencing Mental Illness In The Perinatal Period

A woman in the perinatal period may have a pre-existing clinical diagnosis of mental illness (e.g. bipolar affective disorder) or may develop a mental illness specific to this period (e.g. postnatal depression). When caring for women in the perinatal period, please read this information in conjunction with the MIND Essentials resource that is relevant to the specific presenting mental illness.

◆ Case study

Sunita is 32 and in the third trimester of her second pregnancy. She presents to the midwife at her local hospital for her final antenatal appointment. Sunita appears withdrawn and anxious and mentions that she has been struggling to sleep for the past few weeks. As part of the normal routine for a final antenatal appointment, the midwife asks Sunita to complete the questions on the Edinburgh Depression Scale (EDS) – a screening tool for identifying people at risk of depression in the perinatal period. Sunita obtains a high score, which indicates that she is either currently experiencing depression or at high risk of developing depression, and so further assessment and monitoring is required.

The following information could help you nurse a patient like Sunita.

What is the perinatal period and why is mental illness relevant?

Perinatal mental health refers to the emotional well-being of a woman, her partner and their infant from conception until 24 months postpartum. This period represents a transitional life stage that can be associated with increased vulnerability to mental health disturbance. A major concern during this change is the health and welfare of the developing foetus and of the infant.

Women in the antenatal and postnatal period are vulnerable to having or developing the same range of mental disorders as other adults. The range and course of the majority of these disorders is as for other adults. However, sometimes the nature and treatment of mental disorders occurring in the perinatal period can differ because of the higher vulnerability to mental illness during this transitional life stage, the changing risk to benefit ratio that affects decisions around psychotropic medication use, and the potential increased impact on the family unit during this period. In addition, women who have already had mental health problems are more likely to become ill during the perinatal period than at other times.

Severe mental illnesses may develop much more quickly or be more serious after giving birth than at other times. Sometimes women stop medication when pregnant or breastfeeding, and this may make an illness return or become worse. Also, the risk of developing perinatal mental health disorders is higher for women who have a history of depression, have experienced recent life stresses, have a low level of partner support, have experienced abuse or neglect, have a tendency to worry, have low self-esteem or have an unwanted pregnancy.

What is the normal response to birth?

Between 3 and 10 days after giving birth, almost 80% of Australian women experience a very common reaction known as the 'baby blues'. This is ***not*** a mental illness. The major symptom of the 'baby blues' is feeling particularly emotional and overwhelmed, which is primarily caused by changes to hormone levels throughout the pregnancy and the significant demands of the new role as a mother. The 'baby blues' usually disappear after a few days and do not require any specific treatment other than support from family, friends and clinical staff.

What are the types of mental illness seen in the perinatal period?

While the 'baby blues' is considered a normal reaction to birth, there are two serious mental illnesses that can develop in and are specific to women in the perinatal period – ***antenatal*** or ***postnatal depression*** and ***anxiety***, and ***postnatal psychosis***.

Antenatal and postnatal depression and anxiety

Antenatal depression may develop in the lead-up to the birth and affects approximately 1 in 10 Australian women; postnatal depression can develop from 1 month to 1 year after birth and affects almost 1 in 6 Australian women. Women experiencing either of these conditions will display the same symptoms as those displayed by a person with depression. These include:

- lowered mood
- feelings of sadness, hopelessness or helplessness
- appetite, weight or sleep disturbance
- diminished concentration
- low self-esteem
- feelings of guilt
- suicidal thoughts

Postnatal psychosis

Postnatal psychosis can emerge in the first few weeks following the birth. This condition is rare; it is estimated that it affects 1 in 500 Australian women. The symptoms of postnatal psychosis include hallucinations, delusions, paranoia and thought disturbance. Such symptoms indicate a psychiatric emergency requiring immediate medical assistance.

Other disorders

It is important to note that the partner of a woman in the perinatal period is at an increased risk of developing depression due to a range of factors. These include the increased and changed demands, vulnerabilities or depression of the new mother, which may adversely impact the partner's emotional state.

Difficulties in diagnosis

While the nature of some mental illnesses may change during the perinatal period, it is generally recommended that for the purpose of diagnosis, health workers follow the usual diagnostic guidelines (e.g. DSM IV, ICD 10). However, specific caution is recommended around symptoms that may be influenced by context (e.g. sleep disturbance, loss of libido, anxious thoughts about infant).

A person's perspective on what it is like to experience postnatal depression

"It surprised me how this overwhelming feeling just crept over me and wouldn't leave. It was such an isolating experience and being hormonal, sleep deprived and generally just having such high expectations of myself to always cope, I couldn't see and didn't know what was normal any more. I was just trying to survive the onslaught of this 24 hour job, getting to the next feed or the next sleep. The birth bit felt so easy and then I was straight back out into society without the support and checks that I felt I was offered in the prenatal period. I felt desperately alone and helpless. It was only when someone took the time to ask some questions about how I was feeling that I began to see just how overwhelmed and depressed I was."

Some reported reactions to people experiencing mental illness in the perinatal period

Nurses who have worked with people experiencing mental illness in the perinatal period have reported the following reactions:

Worry

When a mother or mother-to-be is struggling to manage the symptoms of a mental illness, the nurse may also develop feelings of worry and concern about how the woman and family will cope or if they are able to cope with the demands of a new baby.

Other responses

A range of other reactions may occur, as described in other MIND Essentials resources, depending on the type of mental illness presented. In particular, those reactions described in the MIND Essentials resource 'Caring for the person experiencing depression' may be relevant.

Goals for nursing the person experiencing mental illness in the perinatal period

See the goals described in the other MIND Essentials resources for specific types of mental illness where relevant. In addition, when caring for someone during the perinatal period, be mindful of the following goals:

- Develop a relationship with the person based on empathy and trust.
- Promote an understanding of the features of common reactions to pregnancy and childbirth as well as mental illnesses specific to the perinatal period.

- Promote effective strategies for coping with the mental illness in the perinatal period.
- Identify the degree to which there is a risk of anomalous parenting as a result of the mental illness and follow usual protocols if there are risks identified.
- Promote the person's engagement with their social and support network.
- Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- Support and promote self-care activities for partners, families and carers of the person experiencing the mental illness.

Responding to the person experiencing mental illness in the perinatal period

- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is important to take this into account when formulating diagnosis and care plans. Aboriginal Liaison Officers and Multicultural Health Liaison Officers are available for advice and assistance in understanding these issues.
- Ask if the woman and her partner (if relevant) have a history of mental health problems and how they are currently managing.
- Provide education about the 'normal' feelings experienced in the usual antenatal and postnatal circumstances.
- Provide realistic expectations for parenting and self-care. These can help a family develop more resilience.
- Help the woman and family identify early warning signs that would indicate when something may not be 'right'. Provide details of who they could go to for help.
- Reassure the woman and her family that mental illness does not mean that she will necessarily struggle with the parental role.
- Help the person and her partner or family identify the likely parental role issues that may be impacted on by the mental illness.
- After negotiation with the woman, include the partner or family in discussions around treatment options and supports.
- Most families during the perinatal period are accessing a variety of services. Be consistent with communication and develop agreed plans of care to ensure collaborative working relationships.
- In assessing parenting, consider:
    - the degree to which the woman is fulfilling or has the capacity to fulfill the parenting role (e.g. attending to the child's physical, intellectual, social and emotional needs)
    - the impact of the mental illness on the woman's functioning
    - the capacity of the other parent (if relevant) to support the family
    - the style of partnership between the parents (if relevant)
    - the child's functioning
    - any environmental stress
    - the availability of support to the family
- Referral to mental health practitioners should be considered if a high score is obtained when conducting the Edinburgh Depression Scale (EDS).

- As appropriate, provide family members and carers with information about the illness, as well as reassurance and validation of their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.
- Be aware of your own feelings when caring for a person with a mental illness in the perinatal period. Arrange for debriefing for yourself or for any colleague who may need support or assistance – this may occur with a clinical supervisor or an employee assistance program counsellor (see below).

Employee Assistance Program counsellors are available for nurses in need of support and debriefing regarding any work related or personal matters. Contact numbers in your area can be found at:
http://intranet.hne.health.nsw.gov.au/hr/eap

Treatment of mental illness in the perinatal period

Standard treatments for mental health disorders should be provided to women in the perinatal period when they are indicated on clinical grounds. However, potential risks to the foetus need to be considered, and the woman must be informed of these should treatment be recommended. Safety of the woman and her infant is paramount, but untreated psychiatric illness can also have serious consequences.

Medication

There is little evidence to suggest that pharmacological treatments have any differential benefit in the perinatal period compared with other adult populations. However, there is a shifting risk to benefit ratio with an increased risk to the foetus or infant arising from teratogenic and neurodevelopmental risks associated with the use of psychotropic medication. These risks are relative and need to be balanced carefully against the likely benefits of treatment and risks of an untreated mental disorder. There may also be changes in the pharmacokinetics of drugs when used in pregnancy, or the degree to which side effects can be tolerated. More information can be found on **www.motherisk.org** or by contacting Mothersafe on 1800 647 848.

Discharge planning

Discuss referral options with the person and consider referrals to the following:

- GP, who can refer to Perinatal Psychiatry if required
- Community Health Centre (CHC) for social work or psychology counselling. To access the contact numbers and details for your local Centre, use the following link on the HNE intranet:
  http://intranet.hne.health.nsw.gov.au/services_and_facilities
- Mental Health Services. Use the following link to obtain referral forms and contact numbers available on the HNE intranet:
  http://intranet.hne.health.nsw.gov.au/mental_health/adult_model_of_care/triage
- Private service providers

Further reading

For more information, see the following:

beyondblue at **www.beyondblue.org**
Internet access required.

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Caring For The Person Who Is Hallucinating

For further information see also the following MIND Essentials resources – 'Caring for the person experiencing delusions' and 'Schizophrenia factsheet'.

Case study

Jarrah is 19 years old. He has been admitted to hospital due to an exacerbation of his asthma. His GP has notified the ward that he has recently been diagnosed with schizophrenia. Upon admission to the ward, staff have reported that Jarrah has been observed staring intently at the wall and occasionally seems to be talking to someone when there is in fact no one in the room with him. Having ascertained that this behaviour is not related to his asthma or to any treatment for asthma, the staff have concluded that he may be having hallucinations related to his schizophrenia.

The following information could help you nurse a patient like Jarrah.

What are hallucinations?

Hallucinations are sensory experiences that occur in the absence of an actual external stimulus. They occur while the patient is awake and at a time and place where no one else has a similar validating experience. Hallucinations are very real to the person experiencing them. Illusions are different from hallucinations; an illusion is a misperception of a real external stimulus, for example misinterpreting a coat hanging on a door as a person. Around 3 in 100 people will experience psychosis (losing touch with reality through hallucinations, delusions or disorganised thoughts) at some point in their lives.

Symptoms and types of hallucinations

While most hallucinations are ***auditory***, these are not the only kind. It is not uncommon for hallucinations to be ***visual*** or even ***tactile*** (touch). Sometimes, people experience ***olfactory*** (smell), ***gustatory*** (taste) and ***kinaesthetic*** (bodily or movement sense) hallucinations.

Hypnagogic hallucinations (which can occur on falling asleep) and ***hypnopompic*** hallucinations (which can occur on waking up) are common in the general population, with prevalence estimates of 37% and 12.5% respectively. Individuals with mood, anxiety and psychotic disorders experience hypnagogic and hypnopompic hallucinations at greater rates than the general population.

Hallucinations may be accompanied by varying degrees of anxiety and distress. The level of anxiety relates to the degree of influence the hallucination has on the person's behaviour. At the lowest level, the person may be preoccupied but able to manage thoughts and emotions, and able to interact with others. At a moderate level, severe anxiety occurs, and the hallucinatory experience feels repulsive and frightening. The person begins to feel out of control and embarrassed, and withdraws from others. At the extreme level, the person may experience a degree of panic, feel threatened by their thoughts and compelled to follow commands. The person will find it difficult to follow directions or may be unable to pay attention to more than one thing at a time.

Causes of hallucinations

People may experience hallucinations due to a range of causes, including:

- imbalance in brain chemistry
- extreme starvation
- schizophrenia
- post-traumatic stress disorder
- delirium
- substance use and withdrawal
- dementia
- fever
- psychotic depression
- obsessive compulsive disorder

Difficulties in diagnosis

It is important to establish the likely cause of the hallucinations. Even when a person has a diagnosis of mental illness such as schizophrenia, in the hospital setting it is important to regularly assess whether the hallucinations could be due to other causes.

A person's perspective on what it is like to experience hallucinations

"From the minute I woke up until I went to sleep, or at least tried to sleep, I could hear the voices. Sometimes they were in the background muttering away and other times they'd be screaming at me saying horrible stuff. It was like I was constantly the centre of attention in a group when all I wanted was to be left alone."

Some reported reactions to people who are hallucinating

Nurses who have worked with people who are hallucinating have reported the following reactions:

Disregard Nurses may assume that complaints of physical discomfort are part of the hallucination and so may not take the time to investigate the problem.

Amusement A common (but unhelpful) reaction to a person who is hallucinating is for a nurse to be amused at his or her behaviour.

Anxiety Some nurses report experiencing anxiety due to the person's unpredictable behaviour.

Inadequacy Nurses may feel that it is beyond the range of their skills to effectively intervene.

Avoidance A nurse might experience a desire to avoid such patients due to a lack of confidence, insufficient knowledge or difficulties in engaging with the person.

Goals for nursing the person who is hallucinating

Appropriate goals in a community or hospital setting when caring for a person who is hallucinating include:

- Develop a relationship with the person based on empathy and trust.
- Promote an understanding of the features and appropriate management of hallucinations.
- Promote effective coping strategies for anxiety, stress or other emotions which may act as triggers for hallucinating.
- Promote positive health behaviours, including medication compliance and healthy lifestyle choices (e.g. diet, exercise, not smoking).
- Promote the person's engagement with their social and support network.
- Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- Support and promote self care activities for families and carers of the person experiencing hallucinations.

Responding to the person who is hallucinating

- If appropriate, arrange for a review of the person's medication for hallucinations and an initial or follow-up psychiatric assessment if their care plan needs reviewing. A psychosocial assessment may be appropriate to undertake – see the MIND Essentials resource 'Conducting a psychosocial assessment'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is important to take this into account when formulating diagnosis and care plans. Aboriginal Liaison Officers and Multicultural Health Liaison Officers are available for advice and assistance in understanding these issues. This is particularly important for apparent psychotic experiences in people who identify as Aboriginal or Torres Strait Islander.
- Watch for cues that the person may be hallucinating. These include watching an empty space in the room with eyes darting back and forth, speaking to an invisible person, talking to himself or herself, and appearing to listen to someone when no one is speaking.
- If your relationship is appropriate, directly ask the person whether he or she is hallucinating. For example, you could say: 'Are you hearing voices now? Is it a man's or a woman's voice? What are they saying to or about you?' It is not appropriate or necessary to repeat this questioning frequently.
- It may be difficult for the person to concentrate on what you are saying because of the distraction of the hallucinations. Without being condescending, speak clearly and keep sentences simple.
- Do not respond as if the hallucinations are real. For example, do not argue back to voices that the person may be hearing.
- Do not deny the person's experience, but suggest your own perceptions. For example, you could say: 'I understand that you are feeling worried now. I don't see or hear anything, but I can understand that it may be difficult, worrying or unpleasant for you'.
- Remember that a person who is hallucinating is often able to distinguish between the hallucinations and reality; in such cases, the person can understand the conversations you are having.

- Help the person to identify symptoms, symptom triggers and symptom management strategies. For example, it may be helpful to ensure that the person has a well lit room and that extraneous noise is kept to a minimum. Explain unfamiliar equipment and noise in the environment and let the person know what the normal routine is.
- Help the person to cope with auditory hallucinations by providing diversions. For example, you could make conversation or do simple projects or physical activity with the person.
- Help the person to compare his or her thoughts and ideas with those of others to see if the impressions are similar (reality testing).
- Hallucinations can take weeks, even months, to diminish fully, even if the person does respond to antipsychotic medication. Once the person has responded to medication and other treatment, he or she can live a full and normal life. Encourage the person to look forward to this.
- Monitor recovery, compliance with medication and general physical health (including nutrition, weight, blood pressure and so on). Provide education on possible side effects to any medication and work with the person to develop appropriate actions to address any issues.
- As appropriate, provide family members and carers with information about hallucinations, as well as reassurance and validation of their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.
- Be aware of your own feelings when caring for a person experiencing hallucinations. Arrange for debriefing for yourself or for any colleague who may need support or assistance – this may occur with a clinical supervisor or an employee assistance program counsellor (see below).

Employee Assistance Program counsellors are available for nurses in need of support and debriefing regarding any work related or personal matters. Contact numbers in your area can be found at:
http://intranet.hne.health.nsw.gov.au/hr/eap

Treatment of hallucinations

Psychosocial strategies and antipsychotic drugs may both be an important part of the person's management regime. Psychosocial strategies including education, counselling and support for the person and his or her family can help with understanding, stress management and compliance with medication. Given that compliance with antipsychotic drugs may be an issue, you may need to provide close supervision. Discussion with the person about non-compliance may elicit suspicions. If so, inform the treating doctor, who may need to consider alternative treatment.

Adverse effects to antipsychotic medication can occur. These may include:

- sedation
- anticholinergic effects - such as dry mouth, urinary retention and constipation
- extrapyramidal effects - which include dystonias (painful muscle contractions or jerking movements that may cause airway obstruction), Parkinsonism (tremors, shuffling gait) and akathisia (restlessness, inability to sit still)

- orthostatic hypotension (fall in blood pressure when standing)
- tardive dyskinesia (repetitive involuntary movements, usually irreversible)
- agranulocytosis
- photosensitivity
- lowered seizure threshold
- Neuroleptic Malignant Syndrome (NMS) - a life-threatening condition that can occur in up to 1% of people taking antipsychotics (symptoms include fever, extreme muscle rigidity and altered consciousness; can occur hours to months after commencing or increasing drug therapy)

Neuroleptic Malignant Syndrome needs to be treated as a MEDICAL EMERGENCY
requiring cessation of the antipsychotic medication, reduction of body temperature, and cardiovascular, renal and respiratory support.

Management of minor side effects may involve altering the dose, change of medication or symptomatic management with monitoring and patient education. More severe side effects (such as dystonia) can be treated with an anticholinergic agent such as benztropine given IM or IV.

Discharge planning

Discuss referral options with the person and consider referrals to the following:

- GP
- Mental Health Services. Use the following link to obtain referral forms and contact numbers available on HNE intranet:
  http://intranet.hne.health.nsw.gov.au/mental_health/adult_model_of_care/triage
- Private service providers

Further reading

See also the *Mental Health First Aid Manual* at **www.mhfa.com.au**
Internet access required.

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Caring For The Person Experiencing Delusions

For further information see also the following MIND Essentials resources – 'Caring for the person experiencing hallucinations' and 'Schizophrenia factsheet'.

Case study

Lisa is 35 years old. She has been brought to hospital after being hit by a car on a pedestrian crossing. It has been established that she has no serious injuries apart from a severe laceration requiring stitches and a torn knee ligament. Lisa has paranoid delusions. She thinks that there are people who want to hurt her and that staff are involved in plotting against her with these people. Her care plan includes referral to community health for wound care and follow-up with mental health services on discharge.

The following information could help you nurse a patient like Lisa.

What are delusions?

Delusions are false fixed beliefs out of keeping with reality. They are beliefs that are not shared within the person's culture or religion. For example, believing that you are possessed by a spirit is an accepted and respected state if you believe in Voodooism or Pentecostalism; however, in other social circumstances such a belief would be viewed as a delusion. It is a delusion if you believe that you are, for example, captain of the Australian hockey team when in fact you are not.

Delusions are held with total conviction and cannot be altered by the presentation of facts or by appeal to logic or reason. They may be understood as attempts to make sense of abnormal internal experiences such as hallucinations or feelings of anxiety or distress. Around 3 in 100 people will experience psychosis (losing touch with reality through hallucinations, delusions or disorganised thoughts) at some point in their lives.

Types of delusions

Several types of delusions exist. These include delusions of ***grandeur*** (belief of exaggerated importance), ***persecutory*** delusions (belief of deliberate harassment and persecution), ***reference*** delusions (belief that the thoughts and behaviour of others are directed towards oneself) and ***somatic*** delusions (belief that part of the body is diseased, distorted or missing).

Causes of delusions

People may experience delusions due to a range of illnesses or other causes, including:

- brain chemistry imbalance (delirium)
- problems with perception
- mood disorders
- psychotic disorders (including substance-induced psychosis)
- organic disorders (such as dementia)

A person's perspective on what it is like to experience a delusion

"When I was travelling home on the bus from high-school once, I sat in my seat convinced that the people behind me had machines that could read my mind. Everytime the people on the bus laughed, I thought they were laughing at my thoughts. The bus trip took half an hour and so I desperately tried to think of nothing for the whole time, but it didn't work and I became even more distressed."

Some reported reactions to people experiencing delusions

Nurses who have worked with people who are experiencing delusions have reported the following reactions:

Disregard — Nurses may assume that complaints of actual physical discomfort are part of the delusions and so may not take the time to investigate the problem.

Confusion — Sometimes a person with delusions will treat the nurse as though the nurse is someone else. This can be very confusing as to know how to react appropriately.

Anxiety — Some nurses report feelings of anxiety when nursing people experiencing delusions due to their unusual beliefs.

Inadequacy — Nurses may feel that it is beyond the range of their skills to effectively intervene.

Avoidance — A nurse might experience a desire to avoid such patients due to a lack of confidence, insufficient knowledge or difficulties in engaging with the person.

Goals for nursing the person experiencing delusions

Appropriate goals for caring for a person with delusions in a community or hospital setting include:

- Develop a relationship with the person based on empathy and trust.
- Promote an understanding of the features and appropriate management of delusions.
- Promote effective coping strategies for anxiety, stress or other emotions which may act as triggers for a delusion.

- Promote positive health behaviours, including medication compliance and healthy lifestyle choices (e.g. diet, exercise, not smoking).
- Promote the person's engagement with their social and support network.
- Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- Support and promote self care activities for families and carers of the person experiencing delusions.

Responding to the person experiencing delusions

- If appropriate, arrange for a review of the person's medication for delusions and an initial or follow-up psychiatric assessment if their care plan needs reviewing. A psychosocial assessment may be appropriate to undertake – see the MIND Essentials resource 'Conducting a psychosocial assessment'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is important to take this into account when formulating diagnosis and care plans. Aboriginal Liaison Officers and Multicultural Health Liaison Officers are available for advice and assistance in understanding these issues. This is particularly important for apparent psychotic experiences in people who identify as Aboriginal or Torres Strait Islander.
- In your initial assessment, ask the person to talk about the delusions and obtain details by asking the following questions: 'Who is trying to hurt you? Could you think why? How might this happen?'
- Validate any part of the delusion that is real. For example, depending on the situation, you could say: 'Yes, there was a doctor at the nurse's desk, but I did not hear him talking about you.'
- Do not maintain that what the person is thinking is wrong. Instead, show that you respect his or her point of view regardless of whether you agree, and give your own understanding or impression of the situation. Listen quietly until there is no further need to discuss the delusion.
- Do not expect that rational thinking will have an effect on the person's delusions. If you debate the delusion, the person may expand the details to counter your argument or include you in the delusion.
- Try not to take the person's accusations personally, even if they are directed at you.
- Let the person know that you recognise the feelings that can be evoked by the delusions. For example, you could say: 'It must feel very frightening to think that there is a conspiracy against you.' Respond to the underlying feelings and encourage discussion of these rather than the content of the delusion.
- Try to identify triggers and establish if the delusions are related to stress, anxiety or other feelings or emotions. Try to make this gentle questioning, not an interrogation.
- Through observing, try to notice any interactions or events that seem to increase the person's anxiety and delusions (these could include television, radio or particular visitors). Promote problem-solving by helping the person work out ways in which he or she can cope more effectively with stressors. It may be useful to remove or substitute certain items in the room to eliminate potential for misperception or misidentification.

- Develop a symptom management strategy. This could involve encouraging the person to talk about things that are based in the immediate reality. Suggest that it would be helpful to discuss other subjects based in the 'here and now'. Encourage participation in reality-based physical activities where possible.
- Monitor recovery, compliance with medication and general physical health (including nutrition, weight, blood pressure and so on). Provide education on possible side effects to any medication and work with the person to develop appropriate actions to address any issues.
- Assess the delusions daily to determine changes in their frequency and intensity, and document any changes. Disorientation to time and place may suggest that the person sustained a brain injury.
- As appropriate, provide family members and carers with information about delusions, as well as reassurance and validation of their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.
- Be aware of your own feelings when caring for a person experiencing delusions. Arrange for debriefing for yourself or for any colleague who requires support or assistance – this may occur with a clinical supervisor or an employee assistance program counsellor (see below).

Employee Assistance Program counsellors are available for nurses in need of support and debriefing regarding any work related or personal matters. Contact numbers in your area can be found at:
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Treatment of delusions

Psychosocial strategies and antipsychotic drugs may both be an important part of the person's management regime. Psychosocial strategies including education, counselling and support for the person and his or her family can help with understanding, stress management and compliance with medication. Given that compliance with antipsychotic drugs may be an issue, you may need to provide close supervision. Discussion with the person about non-compliance may elicit suspicions. If so, inform the treating doctor, who may need to consider alternative treatment.

Adverse effects to antipsychotic medication can occur. These may include:

- sedation
- anticholinergic effects - such as dry mouth, urinary retention and constipation
- extrapyramidal effects - which include dystonias (painful muscle contractions or jerking movements that may cause airway obstruction), Parkinsonism (tremors, shuffling gait) and akathisia (restlessness, inability to sit still)
- orthostatic hypotension (fall in blood pressure when standing)
- tardive dyskinesia (repetitive involuntary movements, usually irreversible)
- agranulocytosis
- photosensitivity
- lowered seizure threshold

- Neuroleptic Malignant Syndrome (NMS) - a life-threatening condition that can occur in up to 1% of people taking antipsychotics (symptoms include fever, extreme muscle rigidity and altered consciousness; can occur hours to months after commencing or increasing drug therapy)

Neuroleptic Malignant Syndrome needs to be treated as a MEDICAL EMERGENCY
requiring cessation of the antipsychotic medication, reduction of body temperature, and cardiovascular, renal and respiratory support.

Management of minor side effects may involve altering the dose, change of medication or symptomatic management with monitoring and patient education. More severe side effects (such as dystonia) can be treated with an anticholinergic agent such as benztropine given IM or IV.

Discharge planning

Discuss referral options with the person and consider referrals to the following:

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- Private service providers

Further reading

For further information, see the *Mental Health First Aid Manual* at **www.mhfa.com.au** Internet access required.

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FACT SHEET:

SCHIZOPHRENIA

For further information see also the following MIND Essentials resources - 'Caring for the person experiencing hallucinations' and 'Caring for the person experiencing delusions'.

What is schizophrenia?

Schizophrenia is an illness that affects the normal functioning of the brain; it interferes with a person's ability to think, feel and act. A person with schizophrenia typically experiences changes in behaviour, perception and thinking that can distort his or her sense of reality. When a person loses touch with reality, he or she is experiencing a psychosis.

Schizophrenia usually first appears in people aged between 15 and 25 years, although it can appear later in life. It affects approximately 1% of the population. About 25% of people who have schizophrenia experience a complete recovery, 40% experience recurrent episodes of acute illness and 35% remain chronically disabled.

What are the symptoms of schizophrenia?

The onset of illness may be rapid, with acute symptoms developing over several weeks, or it may be slow, developing over months or even years. During onset, the person often withdraws from others, may become depressed and anxious and may develop unusual ideas or extreme fears. Noticing these early signs is important for early access to treatment. Early recognition and effective early treatment is vital to the future well-being of people with schizophrenia.

Core symptoms of schizophrenia can be described as ***positive*** or ***negative***. In this case, 'positive' does not mean good, but refers to the psychotic symptoms that show the person has lost touch with reality. Negative symptoms are less obvious but have a profound effect on day-to-day living. Impairments in cognition and degrees of functional disability are common. Cognitive deficits involving memory, planning ahead and maintaining focus interfere with vocational ability and impact on treatment and rehabilitation.

Positive symptoms

- *Delusions* – false beliefs that are foreign to the person's background and that cannot be altered with logic or reason. The content is usually influenced by cultural or individual factors, and may include ideas of a persecutory, grandiose or religious nature.
- *Hallucinations* – sense perceptions that have no external stimuli. These can occur in any of the senses (taste, smell, sight, hearing and touch). Most commonly people experience voices that no one else can hear.
- *Thought disorder* – lack of logic in thoughts and dialogue. The person's speech may be difficult to follow, with him or her jumping from topic to topic with no logical connection. The conversation may head off the topic altogether and be very hard to follow.

Negative symptoms

- *Loss of drive* – loss of motivation to begin and complete tasks. This can interfere with activities of daily living such as personal care, cooking, work or study. This is a result of the impact of the illness on brain function, not simply laziness.
- *Blunted emotions* – greatly reduced ability to express emotion. This may be accompanied by a lack of, or inappropriate response to, happy or sad occasions.

Other

It is important to note the following:

- Social withdrawal may occur as a result of a combination of the above symptoms, leaving the person lonely and isolated, unable to work or pursue leisure activities.
- Lack of insight, because some experiences are so real, can mean that it is common for people with schizophrenia to deny that they are ill and therefore refuse to accept treatment.

What causes schizophrenia?

No single cause of schizophrenia has been identified, but a number of different factors are believed to contribute to the onset of the illness in some people. Some of these are discussed below.

Genetic factors	A predisposition to schizophrenia can run in families. In the general population, only 1% of people develop the illness. However, if one parent suffers from schizophrenia, the children of the family have a 10% chance of developing the condition (and a 90% chance of not developing it).
Pregnancy and birth complications	Foetal abnormalities possibly related to trauma or infection have been identified as contributing factors.
Brain structure abnormalities	Imaging has identified changes such as enlarged ventricles, decreased blood flow, decreased metabolic activity, cerebral atrophy and decreased volume of temporal lobes (including the hippocampus and the thalamus) as being associated with schizophrenia.

Biochemical factors	Certain biochemical substances in the brain (especially a neurotransmitter called dopamine) are believed to be involved in this condition. One likely cause of this chemical imbalance is the person's genetic predisposition to the illness. The roles of glutamate and serotonin are also being explored further.
Family relationships	No evidence has been found to support the suggestion that family relationships cause the illness. However, some people with schizophrenia are sensitive to any family tension, which for them may be associated with relapses.
Environment	It is well recognised that stressful incidents often precede the onset of schizophrenia. Predisposed individuals may be susceptible to the stress-vulnerability model of illness. Stress impacts on brain structure and can result in reduction in the size of the hippocampus.

Myths, misunderstandings and facts

There is much stigma associated with and much misinformation about schizophrenia. This often increases the distress to the person and his or her family. Myths, misunderstanding, detrimental stereotypes and negative attitudes surround the issue of mental illness and in particular schizophrenia. They result in stigma, isolation and discrimination.

Some common questions about schizophrenia are discussed below.

Do people with schizophrenia have split personalities?

No. Schizophrenia refers to the change in the person's mental function, where thoughts and perceptions become disordered. People with schizophrenia do not have multiple personalities.

Are people with schizophrenia intellectually disabled?

No. The illness is not an intellectual disability. However, neurocognitive impairment can occur and this may affect memory, attention and planning skills, which are needed for work or study. Difficulty coping with day-to-day activities (such as managing money, problem-solving and attention to self-care) can have an impact on the person's independence. For some people with persistent symptoms, difficulty with new learning and planning requires graded rehabilitation strategies. Others are able to function normally when well.

Are people with schizophrenia dangerous?

No. People with schizophrenia are generally not dangerous when receiving appropriate treatment. However, a minority of people with the disorder become aggressive when experiencing an untreated acute episode, because of their hallucinations or delusions. Usually the aggressive behaviour is directed toward the self, and the risk of suicide can be high.

Are people with schizophrenia addicted to their drugs?

No. The medication helps reduce the severity of the symptoms. The specific medications for treatment of schizophrenia are not addictive.

What treatment is available?

The most effective treatment for schizophrenia involves education, medication, psychological strategies and rehabilitation in the community. Positive symptoms in 80-90% of people will respond to antipsychotic medication; however, the impact on the person's family as well as his or her sense of identity, lifestyle and work options also need to be considered to aid relapse prevention and recovery.

It is important to regularly review progress and monitor side effects. Comorbid substance use, mood or anxiety disorders should also be actively treated. Suicide risk should be monitored. Relapses are common in the first five years after the first episode of psychosis.

A multidisciplinary team of psychiatrists, mental health nurses, social workers, occupational therapists and psychologists can assist with understanding and managing these problems.

Psychological strategies

Education about schizophrenia and its treatment is essential. This may also include recognition of the role alcohol and other drugs can have in triggering an episode. A key preventative strategy is to help the person and his or her family to recognise the early warning signs and to seek appropriate help according to a well-designed management plan.

Cognitive rehabilitation or remediation may be helpful for people with cognitive impairment.

Counselling using a cognitive behavioural approach may assist the person to understand and cope better with psychotic symptoms. Other strategies may include stress management, advice on diet and exercise and teaching problem-solving and social skills.

Medication

Antipsychotics are effective for many symptoms, especially the positive symptoms of schizophrenia, but may take 2-3 weeks to work. Negative symptoms may benefit from the addition of psychosocial strategies. Older antipsychotics often caused distressing side effects such as Parkinsonism, akathisia (restlessness) and a risk for tardive dyskinesia (involuntary movements that may be irreversible). Newer drugs appear to be better tolerated and present a lower risk of side effects. It is recognised that part of relapse prevention is adherence to ongoing treatment with appropriate medication. Compliance can be an issue for people who lack insight or for young people who may reject the idea of being a 'psychiatric patient'. Sexual dysfunction and weight gain can compound this problem.

To help increase compliance, details of after-care regimes need to be explained clearly to both the person and his or her family or carers. Referral to community mental health services should be made prior to discharge from acute care. The therapeutic relationship established with a case manager may provide reassurance and monitoring of medication issues as they arise.

Further reading

For more information on antipsychotic medication, refer to the MIND Essentials resources 'Caring for the person experiencing delusions' or 'Caring for the person experiencing hallucinations'.

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Caring For The Person Who Is Suicidal

For further information see also the following MIND Essentials resource – 'Conducting a suicide risk assessment'.

Suicidal thoughts and behaviours are not unique to mental illness, although they do occur at a higher rate for those with mental illness compared to the general population. This resource provides an overview of responding to suicidal behaviour, regardless of whether that behaviour presents in context with mental illness or not.

Case study

Sarah is a person you have been seeing with relapsing and remitting multiple sclerosis. She has not yet started to improve and is struggling to regain her independence. She is in a lot of pain and says that she thinks she needs stronger pain relief. She tells you today that soon you won't have to worry about having to shower her any more. She apologises for being such a burden and comments that it must be awful for you to have to provide such intimate care. She says that she hates to think about a future where there is no dignity, when she can no longer toilet herself or is put in a nursing home. She talks to you about her family, who live interstate, and about how she was left with very little since her divorce. After talking with her some more, you contact her GP, who admits her to hospital for further assessment and observation.

The following information could help you nurse a patient like Sarah.

Why might a person be suicidal?

While increased suicide risk may be associated with certain psychiatric disorders (such as mood disorders, substance abuse and schizophrenia), anyone can be vulnerable to suicidal thoughts and behaviours when confronted by difficult circumstances. The thoughts and behaviours are most likely to occur when a person feels helpless (that there is nothing they can do to help their situation) or hopeless (the situation is perceived as being unlikely to change). Thus, suicidal thoughts and behaviours can be understood as being indicative of a person's coping resources being overwhelmed. Vulnerability to suicidal thoughts and behaviours can also be influenced by a person's sense of empowerment, their relationships with family members, religious beliefs and other reasons for living. People who perceive that they have few reasons

for living may consider suicide as a coping strategy, independent of their mental state. Approximately 11% of the Australian adults report having experienced suicidal ideation or engaged in suicidal behaviour at some stage in their life.

A person's perspective on what it is like to feel suicidal

"When I am not too bad it is just the feeling that everything is so painful inside of me that I just don't want to exist any more – I just want the world to stop and for it all to be over. When I am worse, I feel like I am a pretty rotten person and the world would be better off without me. I get these intrusive ruminating thoughts such as 'I wish I was dead' and 'I don't deserve to live'. No matter how hard I try I can't turn them off and I hate them. I find the thoughts quite scary as I really want to live in a lot of ways, especially for my children, but I am frightened that one day I will get so depressed I will act on these impulses."

Some reported reactions to people who are suicidal

The following reactions have been reported by nurses who have worked with people who are suicidal:

Anxiety — Some nurses feel very anxious when caring for a suicidal person. This may be related to managing the risks of suicide, including recognising warning signs and being able to respond effectively. It may also be linked to concerns about 'saying the wrong thing' or feeling guilty or being blamed for a person taking his or her own life.

Avoidance — Feelings of uncertainty may cause the nurse to avoid the person. This can occur more frequently in those who feel a lack of confidence, are inexperienced with suicidal thoughts or behaviours or have limited exposure to appropriate training.

Moral conflict — Most people have strong feelings about suicide. For some, strong religious beliefs against suicide can affect how the person is perceived and treated.

Conflict with the person — Nurses are usually responsible for the restoration of health and maintenance of life. They may feel conflicted when needing to care for someone who does not value this goal.

Anger — Some nurses feel anger towards the person, seeing the person as undeserving of the resources being used to keep him or her alive.

Goals for nursing the person who is suicidal

Immediate and short-term goals in community and hospital settings when caring for the person who is suicidal are:

- Provide a safe environment for the person at risk and yourself.
- Develop a relationship with the person based on empathy and trust.
- Promote the person's sense of hope and positive self-regard.

- Promote effective coping and problem solving skills, in a way that is empowering to the person.
- Promote the person's engagement with their social and support network.
- Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- Support and promote self care activities for families and carers of the person who is suicidal.

Responding to the person who is suicidal

It is critical for a preliminary suicide risk assessment to be conducted – refer to the MIND Essentials resource 'Conducting a suicide risk assessment' for further information. This assessment will allow you to identify the need for an initial or follow-up psychiatric assessment.

The following may also be relevant:

- Provide a safe, secure and closely observed area for the person to limit their access and opportunity to harm themselves.
- Maintain open communication and personal contact. This will help the person feel that he or she is not alone and without hope.
- Do not be overly cheerful or tell the person to 'cheer up'. Also, do not try to talk the person out of feelings of despair, as this has the potential to expand his or her sense of isolation. The person may come to believe that you are insensitive or cannot understand his or her situation.
- Do not agree with the person's despair, but communicate that you recognise his or her feelings. For example, you might say: 'You describe a world that seems empty and dark. Is that how it feels for you?'
- Acknowledge the losses and stresses that the person sees in life and validate his or her feelings. Talk about how these can lead to an illness such as depression. Discuss the likelihood of recovery and avoid arguments about the value of life versus death.
- Point out that when the person begins to feel better, he or she is more likely to see the value of personal accomplishments, future opportunities and relationships. Explain that when someone is experiencing hopelessness and depression, he or she is more likely to belittle or devalue these aspects of life.
- Discuss the events and feelings that have led to the person's negative beliefs. Point out situations where he or she can still make a positive impact. Stress that the current situation may not go on forever.
- Remember that by spending time with the person, you can communicate that you think his or her life is important.
- Encourage the person to solve problems. He or she may be feeling overwhelmed and as such may be having difficulty thinking about options for the future. Help the person to identify underlying conflicts, problems and obstacles and encourage him or her to work through these.
- Provide a balanced point of view in order to counteract the harsh self-judgements that the person may be presenting. Suggest positive options for the future and constructive interpretations. Point out any of the person's thinking that seems to be unrealistic, all-or-nothing or perfectionist, and offer alternative perspectives.

- Consider organising a referral to a social worker. This may help address any obvious environmental stressors and may increase the level of support the person receives.
- A person's cultural background may have specific relevance for their attitudes towards suicide or the way in which their community or family will support them. Aboriginal Liaison Officers and Multicultural Health Liaison Officers are available for help and advice about these issues.
- As appropriate, provide family members and carers with information about suicidal behaviour, as well as reassurance and validation of their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.
- Be aware of your own feelings. Nursing a suicidal person can be very stressful for you and your colleagues. Review the person's condition with your colleagues. Arrange for debriefing for yourself or for any colleague who may be particularly affected by dealing with the issue of suicide – this may occur with a clinical supervisor or an employee assistance program counsellor (see below).

Employee Assistance Program counsellors are available for nurses in need of support and debriefing regarding any work related or personal matters. Contact numbers in your area can be found at:
http://intranet.hne.health.nsw.gov.au/hr/eap

Interventions for suicidal thoughts and behaviours

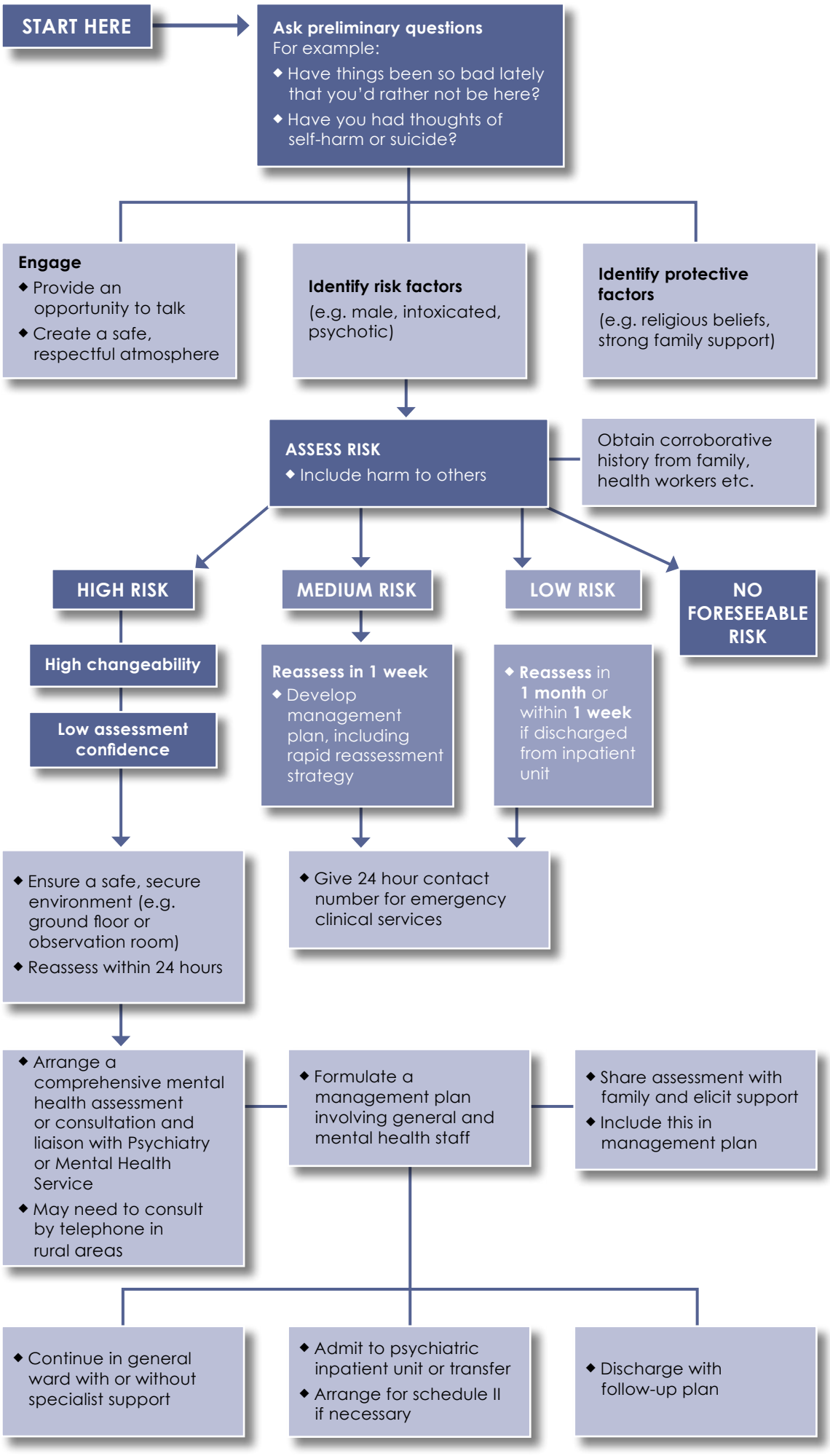
In the past, 'no-suicide' or 'keep safe' contracts were often made, where the person with suicidal thoughts or behaviours agreed and signed a document promising not to harm themselves. However, there is no evidence that these are of value as clinical or risk management tools. While they may aid the therapeutic alliance, they are not substitutes for ongoing supervision and monitoring of a person assessed as at risk of suicide.

As shown in the flowchart below, suicide risk assessment (see the MIND Essentials resource 'Conducting a suicide risk assessment' for more information) can help guide the type of intervention and care provided to someone who is suicidal.

In general, treatment for suicidal thoughts or behaviours will depend upon the context. Immediate interventions will focus on ensuring a person's safety, potentially by providing containment and increased nursing observation to limit access or opportunity for the person to hurt themself.

As described in the NSW Health (2004) document, longer term interventions should aim to address the issues underlying the cause of the suicidal thoughts or behaviours. This may include access to treatment for mental illness (e.g. depression) or substance use. Longer term interventions will also usually focus on addressing psychological and emotional issues to reduce distress and increase coping skills; as well as development of a relapse prevention plan. Education on illness and risk management should also be provided to the person and carers. A focus on addressing other vulnerability factors (e.g. anger management, housing problems, financial problems, isolation) may also be indicated.

Suicide Risk Assessment Model (adapted from NSW Health, 2004)



Discharge planning

Discuss with the person and consider referrals to one or more of the following options:

- GP
- Community Health Centre (CHC) for social work or psychology counselling. To access the contact numbers and details for your local Centre, use the following link on the HNE intranet:
  http://intranet.hne.health.nsw.gov.au/services_and_facilities
- Mental Health Services. Use the following link to obtain referral forms and contact numbers available on the HNE intranet:
  http://intranet.hne.health.nsw.gov.au/mental_health/adult_model_of_care/triage
- Private service providers

Further reading

For more information, see the *Mental Health First Aid Manual* at **www.mhfa.com.au** Internet access required.

Also see the following direct links to relevant guidelines and recommendations for specific health care settings:

http://www.health.nsw.gov.au/pubs/2005/pdf/general_hosp_ward.pdf

http://www.health.nsw.gov.au/pubs/2005/pdf/emergency_dept.pdf

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Caring For The Person Who Is
Aggressive or Violent

Aggression and violence are not unique to mental illness, nor are they necessarily common features or symptoms of mental illness. However they can be associated with mental illness, because of the higher likelihood of experiencing emotional states that can precipitate episodes of aggression or violence (e.g. periods of confusion, distress or high emotional arousal). This resource provides an overview of suggestions for responding to aggression or violence, regardless of whether the behaviour presents in context with mental illness or not.

Case study

Sean has been brought to the emergency department by an ambulance after he was found unconscious in a shopping centre. He is 38 years old and has been misusing alcohol over many years. He is known to some of the staff of the department because of many previous visits, usually due to injuries he has suffered as a result of his heavy drinking. He has often presented as a very aggressive man, and it is noted on his file that on one occasion he hit one of the staff and the police had to be called. He lives with his mother, who has frequent visits from community nurses due to her chronic ill health.

The following information could help you nurse a patient like Sean.

Why are some people aggressive or violent?

Aggression or violence can occur when people have inappropriate skills for dealing with feelings of frustration, fear and anxiety; or as an expression of these feelings by people who are unwell. These behaviours may be present in a person experiencing acute or chronic pain; or in a person who primarily has a physical disorder (such as drug or alcohol withdrawal, stroke, head injury or Alzheimer's disease). Aggression or violence may also be a result of the effect of some therapeutic medications (e.g. corticosteroids). Some neurological disorders have been associated with changes in personality that may also result in violence. In some cases, an increased risk of violence and impulsive behaviour resulting in violence may be associated with people with active psychotic symptoms (who may be responding to command hallucinations or delusions), people with substance-abuse disorders and those with comorbid substance-abuse and psychiatric disorders. Both men and women can display aggressive or violent behaviour.

Aggression may give people a feeling of power in order to compensate for feelings of inadequacy and anxiety. Aggressive and hostile people often have limited ability to deal with their frustrations, and their aggression sometimes allows them to have their own way and thereby appear to have their needs met.

About 50% of people with pre-assaultive behaviours (such as verbal aggression, high activity level and invasion of personal space) never go on to assault staff. It is important to develop an awareness of common 'triggers' in your work environment that are likely to set off physical aggression. One of the strongest triggers is when the person perceives that he or she is being treated unfairly or without respect.

A person's perspective on what it is like to experience aggression

"I just get so angry. People act like idiots and I can just feel myself blowing up - and I'll give them warning signs to stop but they just don't. And even when I don't want to, sometimes I'll throw my weight around and people end up scared or in a direct confrontation with me. It's worse too when I've been drinking. So at the end of the day, I've done the wrong thing because I couldn't explain or work towards what I wanted in a better way."

Some reported reactions to people who are aggressive or violent

Nurses who have worked with people who are aggressive or violent have reported the following reactions:

Anger

Ironically, aggressive or violent behaviours can cause a nurse to experience similar feelings of rage and anger, as they may come to resent being treated abusively by the person. This may result in a subconscious or even a conscious desire to punish the patient.

Desire to appease

A desire to appease the person may develop as staff attempt to avoid confrontation. This may be the reaction of someone who has personal problems dealing with anger and who may wish to 'buy peace' at any price.

Avoidance

Fear of being hurt or spoken to aggressively can lead to a nurse wanting to avoid the person. However, if staff members do not intervene when appropriate, an aggressive or violent situation may become out of control.

Inconsistency of care

The fact that some staff may wish to avoid and others appease the person may lead to inconsistency of care. This in turn can lead to conflicts arising between staff members.

Goals for nursing the person who is aggressive or violent

Appropriate goals in a community or hospital setting when caring for a person who is aggressive or violent include:

- Ensure the safety of one's self, other staff and other people.
- Ensure that the person remains free from injury.

- Develop a relationship with the person based on empathy and trust.
- Promote effective coping and management strategies for frustration, fear and anxiety, which may be acting as triggers for an aggressive or violent episode.
- Promote the person's engagement with their social and support network.
- Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- Support and promote self care activities for families and carers of the person who is aggressive or violent.

Responding to the person who is aggressive or violent

The appropriate response to aggression will depend on a number of factors including: the nature and severity of the event; whether the aggressor is a patient, visitor or intruder; and the skills, experience and confidence of the staff member(s) involved.

NSW Health (2001) recommends that health staff have four main options for **immediate management of aggression**:

1 Verbal de-escalation or distraction
2 Medication or sedation
3 Physical restraint
4 Use of security staff or police

A combination of these strategies is often required.

Remember:

- Never attempt to disarm a person yourself – this requires the expertise of police or security.
- Never threaten or challenge the person.
- The best single predictor of violence is a history of violence.

Please refer to this policy for further information.

Make sure you are ***fully aware of policies and procedures*** in your place of work for dealing with potentially dangerous situations in both a community and hospital setting. Part of orientation to any new position is to thoroughly understand the policies and procedures relating to aggressive incidents and to ensure that mandatory training requirements for your area of work are completed.

Below are some other suggestions that may be helpful to consider when responding to the person who is aggressive or violent.

To consider prior to face-to-face contact:

- The fact that a person has been known to be violent in the past is good reason to take extra care. However, it does not mean that the person will be aggressive on any particular occasion. Do not prejudge the situation.

- Determine whether a male or female member of staff will have a more calming influence on the person. At times, the presence of a man is too threatening. At others, it is reassuring that a male may have greater physical control over the situation. A male may see a female member of staff as nurturing and supportive and be less likely to try to hurt her.
- Communicate to co-workers when you are entering the person's room or cubicle.
- Communicate to co-workers when you are visiting a person's home and attend with a colleague if possible.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is important to take this into account when formulating diagnosis and care plans. Aboriginal Liaison Officers and Multicultural Health Liaison Officers are available for advice and assistance in understanding these issues.

During face-to-face contact:

- Remain calm. This will communicate that you are in control. Speak in a calm, firm voice (slowly with measured tones) without emotional response or yelling.
- If the person is standing, ask him or her to sit down and tell you what is causing the frustration. Sit down with the person (do not remain standing). Sometimes it may help the situation if you sit down first.
- If the person is out of control, attempt to move him or her to a private area to prevent escalation and reduce embarrassment. Be sure, however, not to isolate yourself. For example, you might say: 'I want to hear what you're upset about. Let's go to the visitor's room or sit outside so we can talk.'
- To protect yourself in a person's room or cubicle, ensure you have clear access to the exit door in case the person becomes agitated or wants to leave. Leave the door to the room open and pull the curtain if privacy is necessary. This will avoid the person feeling trapped and will also ensure your protection. Work with a colleague if possible.
- To protect yourself when visiting a person at home, you may encourage the person to sit outside to talk.
- Power struggles can result in violence, so do not force a person who is agitated to have blood taken or to go for tests. Instead, prioritise what care must be administered, and place your focus on that. Ensure that all procedures are explained to the person and that his or her permission has been gained prior to carrying them out.
- Regularly orientate yourself to the situation and your role. This can help de-escalation and will help you maintain your focus.
- Encourage the person to articulate his or her feelings by clarifying and reflecting on your own understanding of them. Use non-confronting eye contact, ask questions and restate in your own words what you understand the person is trying to tell you.
- If you are reflecting the person's feelings, ensure that you do this in regard to a specific issue. Saying something like 'I can see that you are very angry' may make the person even angrier. Avoid this by saying something like 'It seems like this long wait is really frustrating you. Is there anything we can do to help?'

- Recognise and accept that the person has a right to express anger, and that expression of anger towards you does not mean that you are doing a bad job. Avoid reacting defensively and taking things personally; instead, try to look for the feelings that are behind the behaviour. Reinforce to other staff the person's right to express angry feelings.
- Avoid verbal confrontations. Reassure the person that you are there to help.
- Avoid becoming emotional or defensive in your responses. Try to focus, instead, on issues in the here and now. Let the person know that you are interested in what he or she has to say.
- Recognise that in some situations where people are frustrated or fearful, there may be little a nurse can do to help except to allow expressions of anger and listen empathetically.
- Distinguish between verbal aggression and a person's customary language. Some people use swear words and slang as part of their everyday language and may not have the intention of being aggressive or offensive.
- If appropriate, encourage the person to speak with a mental health worker or social worker, or to accept medication voluntarily. Try dialogue such as: 'It seems that things are a bit out of control at the moment. Will you let us help you? Taking this medication will help calm things down.'
- If appropriate and in an ongoing role with the person, help them to identify triggers and any appropriate management strategies. It is important to do this when the person is calm and open to discussion of the issues. If the person has a mental illness it may be important to consider to what degree the symptoms of the mental illness are contributing to the tendency towards aggression and violence.
- Gather other history from family or friends to help understand why the person is acting this way.
- As appropriate, provide family members and carers with information about aggression and violence, as well as reassurance and validation of their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.
- Be aware of your own feelings when caring for a person who is aggressive or violent. Arrange for debriefing for yourself or for any colleague who may need support or assistance – this may occur with a clinical supervisor or an employee assistance program counsellor (see below).

Employee Assistance Program counsellors are available for nurses in need of support and debriefing regarding any work related or personal matters. Contact numbers in your area can be found at:
http://intranet.hne.health.nsw.gov.au/hr/eap

Post-incident response

If a situation does escalate to an act of violence, when the incident is concluded, staff should be provided with clear guidelines regarding support services and the option of time out from duties. Operational debriefings should be set up and coordinated. Contact can be made with the Employee Assistance Program. Contact numbers in your area can be found at **http://intranet.hne.health.nsw.gov.au/hr/eap**

Further action: Build up your confidence with training

A Hunter New England Health training course is available in the 'Prevention and Management of Violence and Aggression'. For further details phone: (02) 4924 6816 to speak with the training manager.

Training workshops in 'Mental Health Emergencies' are conducted by The Association for Australian Rural Nurses and Midwives. For further details phone: (02) 6162 0340 or view the program brochure at: **http://www.arnm.asn.au/images/pdf/FlyerMH08.pdf**

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Caring For The Person Who Is Intoxicated

For further information see also the following MIND Essentials resource – 'Conducting a drug and alcohol assessment'.

Intoxication and substance use are not unique to mental illness, nor are they necessarily common features or symptoms of mental illness. However use of substances by people with mental illness is higher than the general population. This resource provides an overview of suggestions for responding to the person who is intoxicated or drinking or using drugs regularly, regardless of whether that behaviour presents in context with mental illness or not.

Case study

Colin has been in hospital several times in the last 6 months. He was admitted for treatment of an abscess on his left arm. You notice that he has a runny nose and is sweating, even though the room is cool. He is complaining of abdominal cramps and seems very anxious. When you begin compiling his admission history, he appears uncomfortable with the questions about his drug and alcohol use. You notice that he has dilated pupils and is becoming quite agitated with your questioning. After some gentle questioning, he starts to tell you about his difficulty finding work, the break-up of his marriage and his addiction to heroin.

The following information could help you nurse a patient like Colin.

What is substance abuse and intoxication?

Use of substances can be viewed across a spectrum ranging from ***non-use*** to ***safe***, ***hazardous*** and ***harmful use***, and ***abuse*** and ***dependence***. In general, ***safe use*** of a substance is a level of use that is unlikely to have harmful effects, while ***dependence*** indicates that person's ability to control the use of a substance is reduced, as evidenced by a craving to take it, a change in behaviour (where the use of the substance takes priority over other activities), tolerance (where higher doses are needed to achieve the desired effect), withdrawal symptoms and where use is continued despite harmful consequences. Substances that have the potential for abuse are both legal drugs (such as prescription drugs, tobacco and alcohol) and illicit drugs (such as cannabis, heroin and amphetamines).

A person is ***intoxicated*** when he or she is in a state of being affected by one or more psychoactive drugs. The aim of drug and alcohol assessment is to identify the level, frequency and associated risk of reported drug or alcohol use in order to assist in care planning. Please see the MIND Essentials resource 'Conducting a drug and alcohol assessment' for more information.

'Dual diagnosis' is a term used when a person presents with both a substance use and a psychiatric disorder. This is quite common. Substances are often used to self-medicate; for example, a person may use alcohol to help him or her cope with distress or depression. Conversely, substance use may cause a disorder; for example, psychosis can result from cocaine use. It can be difficult to distinguish between the two disorders, but it is important that both conditions are assessed and treated appropriately.

Predisposing factors for substance abuse

No one factor is the 'cause' of substance abuse. A combination of *biological, psychological, sociocultural* and *pharmacological factors* may predispose a person to substance abuse and dependence.

Evidence from adoption, twin and animal studies indicate that heredity is significant in the development of alcoholism. Personality features (including poor impulse control, limited problem solving skills and high level of negative mood states) evident in children as young as 3 years have been identified as potential indicators for future substance abuse. In adolescence, increased risk-taking and sensation-seeking behaviour can include drug and alcohol use. There are also significant rates of dual diagnosis – those presenting with a mental illness and substance abuse. Some studies have shown that substance use among people with first-episode psychosis was twice that of the general population. Cultural acceptance, ready availability and price are likely to influence the pattern and level of use of alcohol and other drugs. Further, use of an addictive drug for a sufficient period will produce changes in brain chemistry, particularly along the dopaminergic reward pathways. This produces a desire for continued re-administration of the drug. These factors interact with environmental factors and attitudes to influence which people experiment or use substances across the spectrum.

Some facts about substance use

- In Australia approximately 90% of men and 75% of women drink ***alcohol***; 20% of men and 10% of women are in the hazardous or harmful consumption categories. Australia and New Zealand have the highest per capita intake of alcohol in the English-speaking world. In Australia, misuse of alcohol causes 5.5% of all deaths and 4% of hospital bed days.
- About 7% of Australians take a daily dose of ***sedatives*** or ***hypnotics*** such as the benzodiazepines. Many people taking a benzodiazepine for more than 2 weeks will experience symptoms of withdrawal when they stop.
- ***Cannabis*** is the most widely used illicit drug in developed countries. Two in three Australians between 18 and 30 have tried it. In Western countries, 3% of people aged 18-40 use cannabis every day.
- ***Opiates*** have a lifetime prevalence of 1% in Western countries, but in Australia, the USA and southern Europe there is a prevalence of 4-6%. Health-related costs and death rates are relatively high due to overdose, suicide, homicide and infectious diseases such as HIV and hepatitis. One in four users dies within 10-20 years of active use.

- ***Amphetamines***, ***cocaine*** and ***prescribed stimulants*** are commonly abused. Amphetamines have been used in the past as prescription drugs for appetite suppression and weight loss, as antidepressants and by long-distance drivers and students to stay alert. An Australian survey in 1998 found that 9% of those surveyed admitted to using amphetamines, 4% cocaine and 5% ecstasy.
- ***Hallucinogens*** like LSD or psylocibin (magic mushrooms) have been used by approximately 10% of Australians.
- ***Inhalants*** (e.g. petrol, glue, cleaning fluids) are often used by males with limited education and poor socioeconomic background. Inhalants can be highly neurotoxic and lead to significant disability.

More than one substance is often used at the same time. This can lead to difficulty managing overdose or withdrawal.

A person's perspective on what it is like to be addicted to substances

"I would do anything to get on – things I would never do when not using, I would do when using. Nothing else mattered. I was always frustrated and the only thought I would have was how am I going to feel better today. Using is horrific, it is horrible….there is no word to describe it."

Some reported reactions to people who are intoxicated

Nurses who have worked with people who are intoxicated have reported the following reactions:

Disapproval	Substance abuse is often seen as a moral issue rather than a health issue.
Intolerance	Substance abuse can be seen as a self-inflicted problem that the person could easily stop if he or she really wanted to.
Anger or disinterest	These feelings can arise from trying to care for people who present frequently, who deny they have a problem or who can be manipulative, non-compliant, aggressive or hostile.

Goals for nursing the person who is intoxicated

- Ensure intoxication is the accurate diagnosis for the person's condition and appropriately manage their withdrawal symptoms (if applicable).
- Develop a relationship with the person based on empathy and trust.
- Provide a safe environment for the person and ensure they remain free from injury.
- Ensure the safety of one's self, other staff and other people.
- Promote healthy lifestyle behaviours and establish interest in addressing any issues, thoughts or situations that may underlie substance or alcohol use.
- Promote the person's engagement with their social and support network.

- Ensure effective collaboration with other relevant service providers, through development of effective working relationships and communication.
- Support and promote self care activities for families and carers of the person who is intoxicated.

Responding to the person who is intoxicated

It is important for a drug and alcohol assessment to be conducted – refer to the MIND Essentials resource 'Conducting a drug and alcohol assessment'. This assessment will help to inform a care and management plan.

For guidelines regarding immediate management of intoxication and substance use, please refer to the NSW Health resource, 'Nursing and midwifery clinical guidelines – Identifying and responding to drug and alcohol issues' which can be accessed at: **http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_001.pdf**

The following are also relevant to responding to someone who presents with intoxication:

- Any person presenting as incoherent, disoriented or drowsy should be treated as if suffering from a head injury until diagnosed otherwise.
- Ensure that an accurate medical history and substance use history are taken. All other causes for the person's condition must be considered. (Remember that a misdiagnosis of intoxication instead of ketoacidosis can be fatal).
- Look for risk factors for withdrawal. These include frequent and regular use, duration of use and time and date of last dose.
- Manage withdrawal symptoms by monitoring vital signs, ensuring adequate fluids, monitoring signs of withdrawal and administering prescribed medication as indicated. Provide a low-stimulus environment away from bright light and noise where possible.
- Observe for signs of worsening intoxication or withdrawal. Use appropriate screening tools and withdrawal scales to monitor the person. An alcohol withdrawal scale is specific for the assessment of alcohol withdrawal and should not be used for any other withdrawal syndrome.
- Treat intoxicated people with respect. Speak slowly and simply and give information clearly. Move them to a quiet place if possible.
- Observe for suicidal behaviour both while the person is intoxicated and if withdrawing. Increased impulsivity, the physical symptoms of withdrawal and the disinhibition produced by intoxication can heighten the risk of self-harm.
- Be aware that for older people with medications (including sedatives such as benzodiazepines) there is an increased risk of falls, confusion and delirium.
- The person may have clinical symptoms of overdose, intoxication or withdrawal and may be responding to hallucinations or delusions that place the person and the carers at risk of injury. The person may also be experiencing delirium or dementia (see the MIND Essentials Resource 'Caring for the person with dementia' for more information). Regardless, the person requires close observation and reduced stimulation.

Responding to the person reporting drug or alcohol use

For those people presenting with concerning levels of drug or alcohol use, the following suggestions may be helpful:

- Be accepting and non-judgemental. This will provide the first step in engaging with the person.
- Ensure a consistent approach based on the above principle. If you repeatedly dismiss or fail to respond to the person's requests, you may contribute to high levels of frustration that result in arguments, threatening behaviours and seeking of drugs from other sources.
- Examine your own expectations. This can clarify your own feelings, beliefs, attitudes and responses to people who are using drugs or alcohol.
- Be realistic about your expectations. Accept that the person will need repeated intervention over a long period. Substance use disorders are often chronic relapsing conditions.
- Try to empathise with the person's view of life without substances. People self-medicate for lots of reasons, including past abuse or trauma and major mental health problems (such as psychosis or depression). Substance abuse should be considered a comorbid issue for some people with a mental illness and appropriate assessment and treatment should be sought.
- Be prepared to set limits on needy or demanding behaviour. Encourage honesty and challenge manipulative behaviour. Do not 'give in' to unreasonable demands or behaviour, as this can promote denial.
- Ensure referral to an appropriate drug and alcohol or mental health service is made. Consider child protection issues and report or refer these as indicated.
- As appropriate, provide family members and carers with information about intoxication, as well as reassurance and validation of their experiences with the person. Encourage family members and carers to look after themselves and seek help or support if required.
- A person's cultural background is important in understanding the context of their drug or alcohol use. Aboriginal Liaison Officers and Multicultural Health Liaison Officers are available for help and advice about these issues.
- Be aware of your own feelings when caring for a person who is intoxicated. Arrange for debriefing for yourself or for any colleague who may need support or assistance – this may occur with a clinical supervisor or an employee assistance program counsellor (see below).

Employee Assistance Program counsellors are available for nurses in need of support and debriefing regarding any work related or personal matters. Contact numbers in your area can be found at:
http://intranet.hne.health.nsw.gov.au/hr/eap

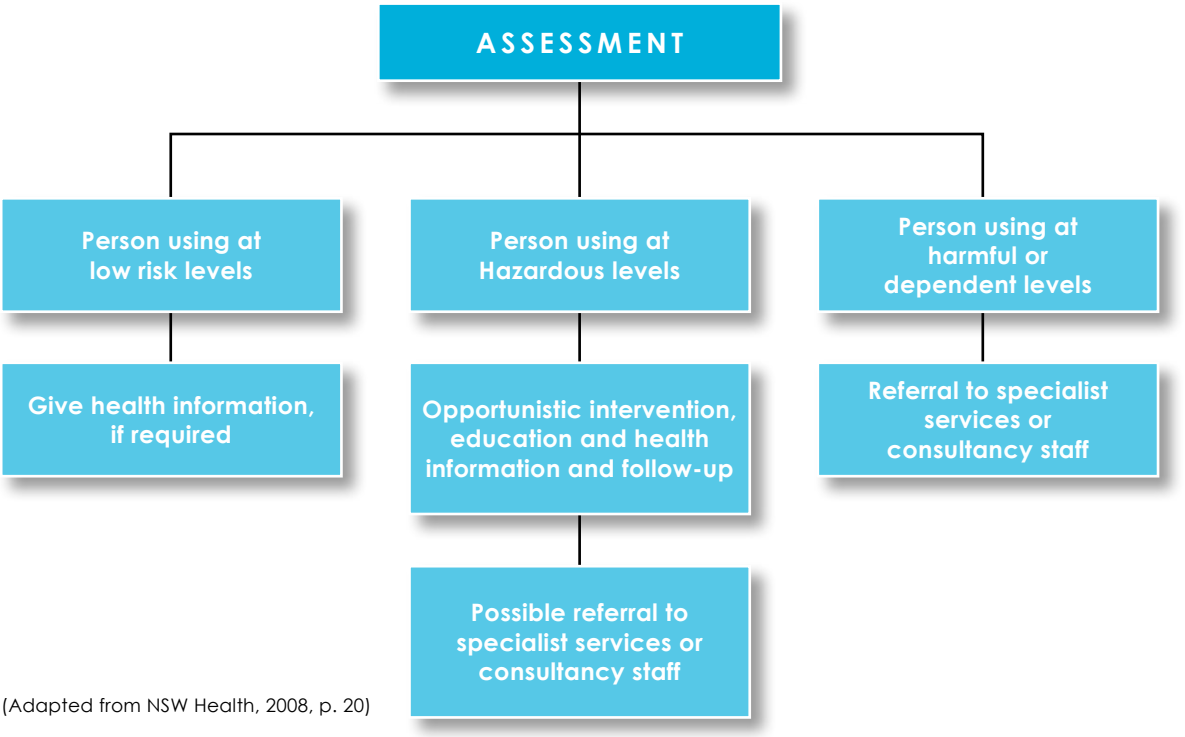
Treatment of intoxication and drug or substance use

Most people will need to acknowledge that they have a substance abuse problem before any changes can be made. Brief or early intervention techniques for people at risk of harm can be used by nurses to help people take this first step. People with more entrenched dependence usually require more intensive treatment.

However, to identify the most appropriate treatment for substance use, an assessment of the drug and alcohol use must be completed. Refer to the MIND Essentials resource 'Conducting a drug and alcohol assessment' for details on drug and alcohol assessment.

The drug and alcohol assessment will help determine the level at which a person is using drugs or alcohol, which is then used to identify the best treatment option, as outlined in the flowchart below.

Figure 1: Drug and Alcohol Assessment Overview



(Adapted from NSW Health, 2008, p. 20)

Treatments often consist of both pharmacological management and counselling. Non pharmacological supports will usually focus on maintaining the person's motivation to 'stay clean' or 'stay sober' and assisting the person to develop coping strategies for times when drugs or alcohol would usually be used. Pharmacological treatments usually focus on managing the withdrawal symptoms, cravings or addressing comorbid presenting symptoms (e.g. depression). Support groups such as Alcoholics Anonymous or Narcotics Anonymous are also useful to a number of people.

Discharge planning

Discuss referral options with the person and consider referrals to the following:

- GP
- Community Health Centre (CHC) for social work or psychology counselling. To access the contact numbers and details for your local Centre use the following link on HNE intranet: **http://intranet.hne.health.nsw.gov.au/services_and_facilities**
- Drug and Alcohol Services – some facilities will have co-located drug and alcohol services. Contact numbers are as follows:

Hunter	4923 2060
New England	1300 660 059
Manning: Local callers only	1300 662 263
All other callers	6592 9631

- Mental Health Services – when the substance use is comorbid with mental illness. Use the following link to obtain referral forms and contact numbers available on HNE intranet:
  http://intranet.hne.health.nsw.gov.au/mental_health/adult_model_of_care/triage
- Private service providers

Further information

See also the NSW Health resource – 'Nursing and midwifery clinical guidelines – Identifying and responding to drug and alcohol issues' at:
http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_001.pdf

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Conducting a Psychosocial Assessment

Psychosocial assessment is an important part of any nursing assessment and helps to inform a care and management plan. People often present with more than a set of medical or surgical problems and psychological or social factors may affect their recovery or compliance with treatment. The purpose of a psychosocial assessment is to clearly articulate specific problems in a person's life that may have a physical or psychological impact.

Important elements of the assessment are:

- Establish a rapport with the person.
- Obtain an understanding of the current illness and its impact.
- Identify recent life changes and stressors.
- Identify the person's strengths (e.g. positive coping strategies, connectedness with others, ability to seek help).
- Obtain any previous psychiatric history.
- Take a lifestyle history (including diet, exercise, drug and alcohol use, social support and relationships).
- Have the person undertake a Mental Status Examination (MSE).
- Corroborate information (e.g. clarify details with family or close friends).

It is important to include both protective factors and vulnerabilities. Assessments often tend to focus on a person's vulnerabilities (i.e. the things that put the person at risk), but it is also important to identify protective factors (i.e. the things that increase or contribute to the likelihood of recovery).

Documentation should include:

- reason for presentation or admission
- psychiatric history
- medical history
- medication (drug, dose, prescriber, compliance, allergies)
- current forensic (legal) issues
- social situation (housing, family, finances, culture, religion)
- violence or abuse (including any related to children in the person's care, with awareness of reporting requirements)

- the Mental Status Examination - MSE (an objective assessment of emotional, cognitive and behavioural domains; see below)
- substance use
- current level of function
- suicide risk assessment

A standardised assessment tool can help facilitate the process; however, it can be more informative if the history is gathered more informally, allowing the nurse to explore issues as they arise. Observe the person's non-verbal communication as well. It may take time to develop your own personal style of gathering information and to be comfortable with this.

The Mental Status Examination (MSE)

The Mental Status Examination (MSE) is an important component of a thorough assessment and may be viewed as the psychological equivalent of the physical examination. It is especially important for neurological and psychiatric evaluations. Its purpose is to evaluate, quantitatively and qualitatively, a range of mental functions and behaviours at a specific point in time. The MSE provides important information for diagnosis, assessment of the course of a disorder and a disorder's response to treatment.

Major components of the MSE

The following elements should be covered as part of the MSE:

Appearance	Age, sex, race, body build, posture, eye contact, dress, grooming, manner, attentiveness to assessor, distinguishing features, prominent physical abnormalities, emotional or facial expression, alertness
Behaviour	Attitude towards situation and assessor – Is the individual friendly, hostile, guarded, cooperative, uncommunicative, seductive?
Motor	Psychomotor retardation, agitation, abnormal movements, gait, catatonia
Speech	Rate, rhythm, volume, amount, articulation, spontaneity
Mood	Internal feeling or emotion
Affect	External observation of mood – stability, range, appropriateness, intensity
Thought content	Suicidal ideation, homicidal ideation, depressive cognitions, obsessions, ruminations, phobias, ideas of reference, paranoid ideation, magical ideation, delusions, overvalued ideas
Thought process	Attention (also relevant in cognition), associations, coherence, logic, stream, perseveration, neologism, thought blocking; can be useful to document a verbatim example of disorganised speech
Perception	Hallucinations, illusions, depersonalisation, derealisation, déjà vu
Intellect	Global impression (average, above average, below average); level of educational achievement
Cognition	Orientation (time, place, person), memory, concentration, attention
Sensorium	Level of consciousness, degree of awareness of surroundings
Insight	Awareness of illness

Adapted from Zimmerman (1994).

Documenting the content of the MSE

The following entries are a collection of possible responses or examples under each domain and are *not* representative of an assessment of any specific individual.

Appearance

Mr White is a middle-aged man who is overweight and appears older than his stated age. On presentation he was dishevelled, with torn shirt, soiled jeans and bad body odour. He had a reddened complexion and a broken nose. He sat slumped in the chair throughout the interview.

Behaviour

She was flirtatious and overfamiliar even though this was the first contact. She constantly smiled and winked at the interviewer.

Motor

He was unable to remain seated and constantly fidgeted. Movements seemed uncoordinated and he had a constant mild tremor.

Speech

There was minimal spontaneous speech; answers were brief. She speaks softly and slowly. Speech is easy to follow even though there are long pauses.

Mood

Reports feeling miserable over the last few months and finding it hard to concentrate on his current assignment.

Affect

Looks sad, rarely smiles or changes expression. Voice is monotonous and there is little reaction to attempts at humour. Affect is appropriate and in keeping with her description of recent events.

Thought content

He believes that the antenna on the neighbour's roof is relaying messages from the local RAAF base directly into his brain. He feels he needs to wear a bike helmet to protect himself from these thoughts being implanted, but fears that it is not working because he has had a lot of headaches lately. He is starting to feel desperate and helpless to stop this intrusion and has started to think that ending his life would be preferable to being possessed by aliens.

Thought form

Disordered speech, e.g. 'When you saw the hill, the village colours are depassing and God is for the saying water'.

Perception

She describes voices conducting a running commentary of her interactions with other people while at school. They often tell her to swear at the teachers, but so far she has resisted.

Intellect

Tertiary educated.

Cognition

Orientation: Unaware of time or place.

Memory: Some short-term deficits. Long-term appears accurate.

Concentration, attention: Able to count backwards from 100 by 7; difficulty explaining abstract thinking such as 'A rolling stone gathers no moss'.

Sensorium

Conscious, alert and responsive.

Insight

He understands that it is unusual to be able to communicate with God, whose voice he can hear, but cannot think of any other reason why he could hear something that his friends can't; demonstrates partial insight.

Terms that can be useful in completing the MSE

Anhedonia – diminished capacity to experience pleasure

Attention – ability to concentrate on a task for an appropriate amount of time

Blunted affect – flattening of emotions reflected in a lack of facial expression and lack of eye contact

Clang association – use of words that rhyme or sound alike in an illogical, nonsensical way

Clanging – use of a word for its sound rather than its meaning

Compulsion – a preoccupation that is acted out (e.g. hand washing related to fear of contamination)

Confabulation – unconscious filling of gaps in memory with imagined information

Déjà vu – the feeling that the situation or event has happened before

Delusions – false, fixed beliefs inconsistent with a person's cultural or spiritual beliefs

Depersonalization – alteration in the perception or experience of the self where the person may feel as though he or she is an observer of his or her thoughts or body

Derealisation – alteration in perception of the external world so that it seems strange or unreal

Echolalia – meaningless repetition of words or phrases

Echopraxia – involuntary repetition of movements the person has observed in others

Flight of ideas – rapid succession of incomplete and poorly connected ideas

Loose associations – ideas not connected by logic or rationality

Neologisms – made-up words that have no meaning to others

Obsessions – intense preoccupations; recurrent or persistent thoughts

Phobia – an irrational or disproportionate fear of objects or situations

Thought blocking – a sudden internal interruption of the person's train of thought

Word salad – illogical word groupings; an extreme form of loose associations

Informing treatment

A psychosocial assessment should inform care planning and assist in identification of appropriate treatment options. When making referrals to mental health services it is useful to include the psychosocial assessment documentation with the referral.

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Conducting a Suicide Risk Assessment

For further information see also the following MIND Essentials resource – 'Caring for the person who is suicidal'.

A full psychiatric assessment is recommended whenever there is serious concern about a person being suicidal. However, the nurse needs to decide whether referral is appropriate and in some cases the risk of suicide is not obvious. Thus, conducting a suicide risk assessment is a crucial first step in identifying the need for an initial or follow-up psychiatric assessment.

There is no known clinical assessment tool that predicts with total certainty whether or not a person will attempt suicide. The nurse therefore has to make a reasonable decision based on the evidence available. The assessment model presented below is designed to help the nurse collect the most relevant information. The model highlights six areas that should be explored with either the person or family members or friends.

When to assess a person for suicide risk

It is appropriate to assess a person's suicide risk when he or she:

- is brought to hospital with injuries that may be self-inflicted
- shows any sign of suicidal or self-destructive thinking or behaviour
- is severely depressed

If a person is known to have previously attempted suicide, it is appropriate to assess his or her suicide risk:

- on initial contact
- on admission to hospital
- on the occasion of any noteworthy clinical change (e.g. new symptoms, mental status changes, new stressors)
- before discharge

How to assess a person's suicide risk

Step 1: Engage with the person's feelings and emotions, ask about suicidal thoughts or plans and be non-judgemental and respectful

- An assessment of current thoughts about suicide needs to be undertaken. Almost all people considering suicide have given some indication of their intention, and a number of them have been seen by a GP or health worker in the days, weeks or months preceding the attempt.
- ***Don't be afraid to ask*** – contrary to popular thought, asking about suicide does not prompt someone to take action; rather, it may be a way of acknowledging how serious the person's situation is. This can be helpful in itself. Ask questions such as: 'Just how bad have things become for you?' or 'You've said that sometimes it feels like there is no point any more. Does that mean you have been thinking about hurting yourself or even taking your own life?'
- Indications of suicide intent may be overt or covert. A person may make statements such as: 'I wish I were dead' or 'Life isn't worth living any more'. The intention may be more vague, with comments such as: 'It's OK now, soon everything will be fine'. Behavioural signs may include giving away treasured items, ensuring pets are looked after or contacting and saying goodbye to friends.
- Consider the increased risk presented by the person's mental state. Those at greater risk may be depressed, psychotic or impulsive. There may also be elements of guilt, shame or hopelessness related to a recent event (e.g. loss of job, divorce, ill health). Ask about the frequency of suicidal thoughts, their intensity and how much control the person feels he or she has over them.

Step 2: Ask if the person has made any plans

- Ask if the person has a plan to end his or her life. Consider how detailed the plan is and the degree of determination expressed about dying.
- Ask about access to the means the person has described. Does the person have a gun or medication? Has he or she planned where to jump from? Has the person thought about when – when no one is home or the family have gone on holidays?
- Try to find out if the person has recently been finalising arrangements or giving away possessions. Is someone else concerned about the person's health or safety?
- Assess if there are any thoughts of harm to someone else.
- A person is at high risk of suicide if he or she has a specific plan that involves using a highly lethal method to which he or she has access. People who are psychotic, however, are also at high risk regardless of detailed planning because of poor impulse control, impaired judgement and grossly impaired thinking.

Step 3: Ask about any previous attempts

- For people who have previously attempted suicide there is a five-fold increase in risk of subsequent attempts. Ask about the circumstances, method, intent and lethality. For example, you could ask: 'What did you do when you attempted suicide before?', 'What did you want to achieve at that time?' and 'How long ago was the attempt?'

Step 4: Ask about drug and alcohol use

- Assess the person's recent alcohol and drug use, particularly what alcohol and drugs the person uses and how intoxicated he or she becomes from this use. People who have a high level of alcohol and drug use and often or always become intoxicated should be considered at higher risk.

Step 5: Ask about social supports

- A person's support network of both family and friends is also an important factor. Studies have shown that adolescents with less supportive networks or little social contact with these networks are at a higher risk of attempting suicide.
- Social support needs to be assessed in terms of the amount of support available as well as the quality of the support that is given. People who live alone may be at greater risk when they are suicidal because there may be less chance of rescue.
- Talking to family and friends may help with understanding how the person usually copes, what supports exist and any other risk factors not already identified. It is also important to determine the willingness and ability of the network to provide support.

Step 6: Ask about reasons for hope and other protective factors

- Ask questions about the person's reasons for living, such as what he or she lives for or how he or she views the future. People showing little hope for the future are at a higher risk. You could ask: 'What kind of future do you see for yourself?' or 'Can you see things getting any better?'
- It is also useful to ask about the person's willingness to accept help or if he or she believes that help is possible.

Reviewing the assessment

Some questions you may want to ask yourself are:

- How confident am I in my assessment? (e.g. low, medium, high confidence)
- Which factors mainly informed my assessment? (e.g. mental health problems, what the person said)
- Are there any questions relating to these factors that I should have asked?
- Are there any dimensions that I missed altogether?
- Can I identify any assumptions based on my own values that may not be appropriate for this person?
- What actions will I take?
- What follow-up will I do?
- Is there anyone I have met recently who would have benefited from the opportunity to talk about suicidal thoughts?
- How possible has it been for me to engage effectively with people whose lives are very different from my own (e.g. people living in poverty or with different sexual identity or with chronic illness)?

(Adapted from Commonwealth Government Department of Health and Ageing and Government of South Australia, 2007)

Where to next?

Once you have conducted the assessment, carefully document the findings. The MHOAT documentation (see appendix 1 on next page) provides a NSW Health form that is appropriate for guiding and documenting suicide risk. It may also be appropriate to speak with someone about the assessment. Dealing with suicidal people is stressful, and it helps to review your assessment with a colleague or manager and agree together on an appropriate course of action. The suicide risk assessment should help inform care planning. See the MIND Essentials resource 'Caring for the person who is suicidal'.

Further reading

For more information, see the *Mental Health First Aid Manual* at **www.mhfa.com.au** Internet access required.

Also see the following direct links to relevant guidelines and recommendations for specific health care settings:

http://www.health.nsw.gov.au/pubs/2005/pdf/general_hosp_ward.pdf

http://www.health.nsw.gov.au/pubs/2005/pdf/emergency_dept.pdf

http://www.health.nsw.gov.au/pubs/2005/pdf/justice_longbay.pdf

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Appendix I: MH-OAT Form

The following is from the MH-OAT document for suicide risk assessment and may be a useful way of recording your assessment.

Name: DOB: MRN:

Suicide risk assessment guide:

Issue	High risk	Medium risk	Low risk
'At risk" Mental State - depressed - psychotic - hopelessness, despair - guilt, shame, anger, agitation - impulsivity	Eg. Severe depression; Command hallucinations or delusions about dying; Preoccupied with hopelessness, despair, feelings of worthlessness; Severe anger, hostility.	Eg. Moderate depression; Some sadness; Some symptoms of psychosis; Some feelings of hopelessness; Moderate anger, hostility.	Eg. Nil or mild depression, sadness; No psychotic symptoms; Feels hopeful about the future; None/mild anger, hostility.
Suicide attempt or suicidal thoughts - intentionality - lethality - access to means - previous suicide attempt/s	Eg. Continual / specific thoughts; Evidence of clear intention; An attempt with high lethality (ever).	Eg. Frequent thoughts; Multiple attempts of low lethality; Repeated threats.	Eg. Nil or vague thoughts; No recent attempt or 1 recent attempt of low lethality and low intentionality.
Substance disorder - current misuse of alcohol and other drugs	Current substance intoxication, abuse or dependence.	Risk of substance intoxication, abuse or dependence.	Nil or infrequent use of substances.
Corroborative History - family, carers - medical records - other service providers / sources	Eg. Unable to access information, unable to verify information, or there is conflicting account of events to that of those of the person at risk.	Eg. Access to some information; Some doubts to plausibility of person's account of events.	Eg. Able to access information / verify information and account events of person at risk (logic, plausibility).
Strengths and Supports (coping & connectedness) - expressed communication - availability of supports - willingness / capacity of support person/s - safety of person & others	Eg. Patient is refusing help; Lack of supportive relationships / hostile relationships; Not available or unwilling / unable to help.	Eg. Patient is ambivalent; Moderate connectedness, few relationships; Available but unwilling /unable to help consistently.	Eg. Patient is accepting help; Therapeutic alliance forming; Highly connected / good relationships and supports; Willing and able to help consistently.
Reflective practice - level & quality of engagement - changeability of risk level - assessment confidence in risk level	Low assessment confidence or high changeability or no rapport, poor engagement.		- High assessment confidence / low changeability; - Good rapport, engagement.
No (foreseeable) risk: Following comprehensive suicide risk assessment, there is no evidence of current risk to the person. No thoughts of suicide or history of attempts, has good social support network.			

Is this person's risk level changeable? **Highly Changeable** ❒ **Yes** ❒ **No**

Are there factors that indicate a level of uncertainty in this risk assessment? Eg: poor engagement, gaps in/ or conflicting information. **Low Assessment Confidence** ❒ **Yes** ❒ **No**

If **'yes'**, please specify.

Document your risk assessment details and plan here: Include self harm and risk to others, vulnerability to sexual / physical / financial harm, consider religious and spiritual beliefs that may influence risk.

Overall suicide risk rating: ❒ **High risk** ❒ **Medium risk** ❒ **Low risk** ❒ **No (foreseeable) risk**

Risk of harm to others: ❒ **High risk** ❒ **Medium risk** ❒ **Low risk** ❒ **No (foreseeable) risk**

If any risk noted above, please tick 'ALERTS' box on front page.

Staff Name: Signature: Designation: Date:

CONDUCTING A

DRUG AND ALCOHOL ASSESSMENT

For further information see also the following MIND Essentials resource – 'Caring for the person who is intoxicated'.

Drug and alcohol assessment helps inform a care and management plan. It initially focuses on the cause of the presenting intoxication and secondarily aims to establish the person's drug and alcohol use frequency, level and risk.

Key elements of assessment

A drug and alcohol assessment should include the following steps:

- Exclude underlying physical illness.
- Consider comorbid psychiatric illness.
- Consider whether the person has used one or more drugs.
- Assess quantity, frequency, duration of use and route of administration for each drug.
- Note the date and time of the last dose.
- Establish whether the person is presenting often.
- Ask what the person wants.
- Determine whether the person is intoxicated and getting worse, is sobering up, or in withdrawal.

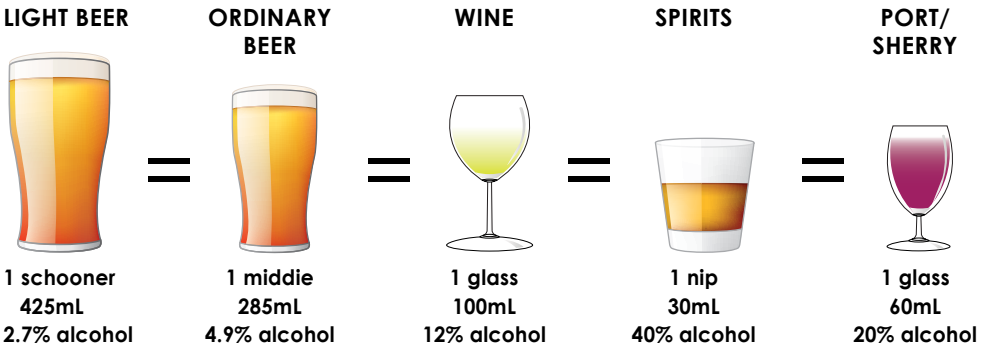
Levels of use and other definitions

The drug and alcohol assessment will help establish where the person's use is on the substance use spectrum, as described below. This will help establish the level of use and risk associated with the person's drug and alcohol use.

Safe use of a substance is a level of use that is unlikely to have harmful effects. This will be different for different drugs. For example, there is no safe level of nicotine use and harmful effects can occur even with low levels of use of substances such as cannabis and prescription analgesics and benzodiazepines.

For ***alcohol***, the following has been identified by the National Health and Medical Research Council (NHMRC) as representing low-risk drinking levels:

- The low-risk level for women is a maximum of 2 drinks per day.
- The low-risk level for men is a maximum of 4 drinks per day.
- Both men and women should have at least 2 alcohol-free days per week.
- People with an alcohol use disorder or any condition exacerbated by alcohol should be advised to cease their use of alcohol. All people at risk of alcohol withdrawal should be advised to cease using alcohol, but only with medical support.
- Note that 1 standard drink contains 10 grams of alcohol. Therefore:
    - 1 middie contains 10 grams of alcohol (1 standard drink).
    - 1 schooner contains 15 grams of alcohol (1.5 standard drinks).
    - 1 can of beer contains 13 grams of alcohol (1.3 standard drinks).
- Common standard drinks are shown in the following diagram:



There is no safe level of ***nicotine use*** and ***other substances*** can have harmful effects even at low levels of use. For example:

- Cannabis use has been linked to acute psychotic episodes and development of chronic schizophrenia in some people even after its use has stopped.
- Tolerance and dependence to prescription analgesics and benzodiazepines can occur and 40% of benzodiazepine users are likely to experience withdrawal symptoms on cessation.
- Amphetamine use has been linked to psychosis and cardiovascular abnormalities.
- MDMA has been linked to a number of well-publicised deaths after use at dance parties.

Non safe use includes ***hazardous use*** which is defined as repetitive use that presents a risk to the physical or psychological well-being of the person. This includes increased risk of exposure to sexually transmitted infections, increased exposure to disease through sharing needles and increased risk of driving accidents. ***Harmful use*** is indicated when actual physical or psychological harm due to drug or alcohol use (or it's effects) have occurred. Harmful use of alcohol has been determined as a regular daily intake over 60 grams for men and 40 grams for women. ***Abuse*** refers to continuous use despite related problems. These problems often involve the social, legal or interpersonal aspects of the person's life.

Dependence implies a combination of physical and psychological factors. There is impact on the person's ability to control the use of a substance, a craving to take it, a change in behaviour (where the use of the substance takes priority over other activities), tolerance (where higher doses are needed to achieve the desired effect) and withdrawal symptoms. Use is continued despite harmful consequences. ***Intoxication*** is the state of being affected by one or more psychoactive drugs.

It can also refer to the effects caused by the ingestion of poison or by the overconsumption of normally harmless substances.

Conducting a drug and alcohol use history

For many reasons, it can be difficult to discuss personal issues with others. Be aware that talking about drug and alcohol use may be very confronting for the person so avoid being judgemental or threatening.

Here are some points to remember when taking a history:

- Try to make the environment as quiet and private as possible.
- Be mindful of the person's level of physical and emotional comfort.
- Be sensitive to the person's cultural background and language.
- Do not allow personal attitudes to affect the assessment.
- Note any inconsistencies in what the person tells you.
- If a question angers the person, leave it until later. Try to rephrase the question when you ask it for the second time.
- A history of the person's drug and alcohol use can also be elicited from his or her spouse, friends or family.
- Examine hospital medical records and speak to other health workers to gain supporting information for your history.
- Do not assume that the person perceives his or her drug and alcohol use as a problem.

Below you will find information on a screening tool that can be used for assessing alcohol abuse, as well as discussion techniques that can be used to assess both drug and alcohol use.

Screening tool for assessing alcohol abuse

One of the simplest tools for screening for alcohol abuse is the **CAGE** questionnaire:

- Have you ever felt the need to ***C****ut* down on your drinking?
- Have people ***A****nnoyed* you by criticising your drinking?
- Have you ever felt ***G****uilty* about your drinking?
- Have you ever needed a drink first thing in the morning as an ***E****ye* opener or to steady your nerves?

'Yes' answers to two or more of the four questions indicate probable alcohol abuse. If appropriate, offer consultation with a drug and alcohol service or counsellor.

Discussion techniques for assessing drug or alcohol use

The following techniques may help, but be mindful that they may not be suitable for every person. Use discretion and professional judgement when choosing your questions and making comments. The following questions have been phrased to refer to drinking, but the same principles could be applied when asking about other drug use (Adapted from NSW Health, 2008):

- Introduce drinking or drug use as a normal, everyday experience. For example, you could ask: 'What do you like to drink each day?'

- Ask about frequency of drinking with a straightforward question like: 'How often do you have a drink?'
- Use open-ended questions such as: 'How has your drinking changed over time?'
- Try reflective comments such as: 'It sounds like your drinking has been causing you problems lately.'
- Be affirmative by making comments such as: 'It takes a lot of courage to open up and talk about your drug use.'
- Suggest high levels of drug and alcohol use. For example, you could ask: 'How much would you normally drink in a session? Twenty schooners?' This is done because people tend to under-estimate the amount they drink or use because of the awareness of what is socially appropriate. However, when talking with adolescents, be careful that they do not perceive the overestimated amount as an expected figure, thereby encouraging them to exaggerate it further. People who feel disempowered may also agree with overestimations.
- Summarise the person's replies, for example: 'On the one hand you like drinking because it helps you to relax, but on the other hand you're concerned about the effect it will have on the kids.'

Where to next?

Once you have conducted the assessment, carefully document the findings. It may also be appropriate to speak with someone about the assessment. The drug and alcohol assessment should help inform care planning – see the MIND Essentials resource 'Caring for the person who is intoxicated'.

Further reading

For information sheets on related topics (such as making changes, harm minimisation, short-term health consequences and safe use of illicit drugs) and for detailed information on managing intoxication, overdose and withdrawal, see the NSW Health resource 'Nursing and midwifery clinical guidelines – Identifying and responding to drug and alcohol issues' at
http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_001.pdf

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Consumer Stories

When some people with a mental illness attend a general hospital for reasons other than their psychiatric problems, they sometimes feel that they are treated differently than they otherwise might be, or that the help they get is not very useful. While not all experiences are negative, these are some of the stories we have been told.

Story 1

Mine was a planned admission to have a hysterectomy. I went to the pre op clinic and spoke with them about the concerns I had with regards to my mental health - I suffer from depression and anxiety and was on antidepressants that would need to be maintained while I was in hospital. I was particularly concerned about the effect of the hysterectomy on my depression. I also told them I was very anxious about undergoing a major operation because my father had died on the operating table. Because of my anxiety attacks, I requested a pre-med so I would feel calmer before the procedure. It was agreed that my antidepressant medication would be maintained throughout my hospital stay and that I would be given a pre-med before the operation.

However, so many things went wrong - the whole experience was horrendous. I arrived early on the morning of the procedure, and had followed the directions of nil by mouth - which meant that I had been unable to take medication that day. I waited for ages for my pre-med and asked the nurse about it a second time. I was told that it hadn't been charted and by then it was too late so they couldn't give it to me. This did not help my feelings of increasing distress. I then had to walk to theatre and was escorted by a very tall man - but he walked quickly and I had to run to keep up with him. By the time I got to theatre, I was quite distressed and really needed some reassurance that my care plan would be followed.

When I came out of the anaesthetic I was very unwell, vomiting, and haemorrhaging which couldn't be stopped. I was moved to intensive care and spent four days there, still haemorrhaging. I was on a morphine drip, and was a mess. My wound became badly infected. I wasn't eating. I hadn't been given any mental health medication as it was thought that I was self medicating.

Five days after my operation, I was pacing the ward at two and three in the morning. I yelled at my husband and kids just because his shorts were dirty, I'd yelled at mum on the phone and was acting irrationally. I became suicidal. I felt so unwell. It felt like no one seemed to notice - or care - that I was upset.

I rang my husband and asked him to come and get me. I tried to keep calm, thinking that he'd come soon. But he didn't turn up for what seemed like a long time and I figured he wasn't coming - so I left the ward because I didn't feel I could handle it any more. Luckily my husband turned up and stopped me and took me back to the ward.

I told the staff I wanted to be discharged. I left the hospital, staples still in, still haemorrhaging.

When I got home, I became delusional. My husband called a doctor who immediately sent me to emergency at a different hospital. Because of my blood loss I needed a blood transfusion but was unable to have this because of the infection. The staples were removed and the whole wound opened up. I was too unwell to go to theatre for it to be cleaned and restitched. I stayed for another four or five days until they got it cleaned up a bit. I came home with a wound about 20cm wide and a hole in my stomach that was still bleeding. I still have a very nasty scar.

Some of the things that would have helped:

- Ensuring that it was noted that I had a mental health issue. My mental health as well as my physical health needed care while I was in hospital - and I was too sick to advocate for either.
- Ensuring the care plan was documented and followed - from pre-op through to recovery.
- Checking in with me to see how I was feeling - especially in the context of my mental health problems and the meaning of having a hysterectomy. I really needed someone to ask me "are you OK?" and to help me identify what supports I could call on.
- Intervention when I was showing obvious signs of distress e.g. pacing the floor, screaming at my family, and help to de-escalate my distress.

Story 2

I went to the hospital with severe pain in the right side of my stomach and I told the nurses that it was very painful and I could hardly stand up. I needed someone to look at me. They asked me some questions and then wanted to know when I was last at James Fletcher Hospital. I said I didn't think that was important as I was in severe pain. They asked more questions about my mental illness and I kept saying I was in a lot of pain. The nurses seemed to think that my mental illness was far more important. Eventually I was seen by a doctor who actually was interested in the amount of pain that I was in, not the fact that I had a mental illness. It turned out I had a cyst on my ovary.

Story 3

On a day 2 years ago at about 3pm, I began to experience symptoms that were quite foreign to me - trembling pain, pins and needles in my arms and hands, chest pains, severe stomach cramps and breathing difficulties. I thought I was going to die. I was lucky that a friend called over in time and she paged my psychiatrist for me. I was so weak and out of breath that I couldn't speak to him. He told my friend to take me to the hospital just to be on the safe side. (I had recently stopped taking an antidepressant because it had given me dangerously high blood pressure).
We arrived at the hospital at about 5pm. The nurse got the run down on why I was there. I had an ECG 3 hours later. Then I had to wait for a doctor to see me and tell me the results. At 9pm the doctor came in. By this time I was exhausted and

emotional and very confused. I didn't understand what had happened to me. Until that afternoon I thought my life and my health was just starting to pick up. I asked the doctor to explain what he thought was wrong. He said, "Your ECG was normal, you've most likely had an anxiety attack." I was shocked. I asked him if these attacks would be a recurring thing or if I'd be right from them on. He replied "If it happens again just lie down in a dark room." Then he just left.

Story 4

A consumer was admitted to the hospital recently. She was having hallucinations and did not trust the staff with her medications. The consumer called me (the consumer project officer) to go to the hospital to try to ease some of her thoughts and ideas. When I got there the staff said to me: "She's from James Fletcher Hospital, what do you expect from her?" I said to the staff that regardless of where the patient has been before, she needs to be shown respect. The main problem occurred when it came time for the medication. The consumer refused to take it from the nurse unless she had been shown that it had come out of the correct box. The nurse said "Don't be stupid, just take it." I suggested that it wouldn't take long to show the consumer that the tablets had come out of the different boxes. The nurse finally agreed to do it but I don't think she was very happy.

Story 5

I was referred by an orthopaedic surgeon for a procedure on my big toe that involved a cortisone injection to treat osteoarthritis. I had undergone this procedure once before so had some idea what to expect. I have Bipolar disorder and was recently diagnosed with an anxiety disorder as well. I was quite anxious and can become quite obsessed with health problems.

There was the doctor and two staff who were observing (I think they were students). I was able to see the placement of the needle on a monitor. One of the students was being very reassuring and taking her cue from the doctor and informing me what was happening. The doctor was very focused and not answering my questions. To me it looked liked the injection was going into the bone. I could also see some bleeding. When I mentioned this he denied it which made me more anxious. He would just say "I'm a senior doctor and it's fine." The student however was being very reassuring, using a measured tone of voice and acknowledging my anxiety. At the end of the procedure the doctor said it was very successful but then my toe went stiff. I had not experienced this before and the student was no longer present. Others were less patient with their reassurances and seemed not to value my need for information. It felt like they wanted to get it over with quickly.

It would have helped if the doctor had acknowledged when questions were asked and explained that things were proceeding as expected. I had to wait half an hour or so after the procedure and during this time the student reappeared and showed interest and concern and offered me a cup of tea and a sandwich. She also asked me if there were any other questions. The student validated my concerns and made me feel looked after. I think if she had not been there I would have been much more anxious. I would have felt alone and that no one was listening.