QUEENSLAND MIND ESSENTIALS

Under review

Mental Illness Nursing Documents

Queensland Government

First published by the Hunter Institute of Mental Health in 2008.
Revised by the Mental Health Directorate, Queensland Health in 2010.

Foreword

The nursing workforce is fundamental to our ability to deliver healthcare services across Queensland. Nurses are the backbone of our healthcare system.

Each day Queenslanders present with a variety of health matters, including issues related to mental health and wellbeing.

In Australia, nearly half of the population will experience a mental disorder in their lifetime, and the prevalence of mental disorders is high among people who are accessing our general health and hospital services. Generalist nurses therefore need to have access to reliable and up to date information regarding mental disorders.

In recognition of this the Queensland MIND (Mental Illness Nursing Documents) Essentials resource, as developed by the Hunter Institute of Mental Health, has been adapted for use in the Queensland context for all nursing staff in Queensland.

The Queensland MIND essentials resource provides Queensland nurses with relevant information on different mental disorders, on how they may present in a general nursing setting, practical strategies and guidelines for management, screening tools and links to further information.

The distribution of this resource plays an important role in our ability to deliver a responsive and integrated health service system for all Queenslanders, and represents our on-going commitment to supporting the Queensland nursing workforce.

Paul Lucas MP
Deputy Premier
Minister for Health

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Mental illness nursing documents for nurses and midwives

Queensland MIND Essentials aims to support nurses and midwives working in general health care settings within Queensland Health (QH) hospitals and communities by providing information and strategies on a range of mental health issues.

This project has been adapted for Queensland Health from the MIND Essentials Resource, developed by the Hunter Institute of Mental Health (HIMH) in 2008. MIND Essentials was produced in consultation with nurses and midwives in general acute and community settings, with assistance from clinical experts in mental health and academic staff of the University of Newcastle.

The resource is available online at the Mental Health Directorate homepage by following the links to Queensland MIND Essentials (QHEPS and Internet sites). A printed copy is also available in your facility.

Information on caring for a person experiencing a mental illness

Information in this section and includes:

- A case study providing a real-life example of how a person may present to 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 discussed in this section:

- Anxiety
- Depression
- Eating disorders
- Personality disorders
- Dementia
- Mental illness within the perinatal period
- Schizophrenia.

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 specific issues 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 in this section:

- Suicidal thoughts or behaviour
- Aggressive or violent behaviour
- Intoxication
- Mania
- Hallucinations
- Delusions

Assessment tools

The following information to assist and inform a person's care and management plan:

- What is a mental health assessment?
- Drug and alcohol screening assessment.

Consumers stories

This resource 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 mental disorder.

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

This resource generally uses the term 'nurses' to refer to both nurses and midwives engaged in nursing care. All information in Queensland 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.youthbeyondblue.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 fact sheets 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 Queensland MIND Essentials www.health.qld.au/mentalhealth for the most up-to-date information on this resource.

Under review

Caring for a 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 has shortness of breath, palpitations and dizziness. She is only 24, and when you ask, she says she has been constantly worrying about her work and money. She says that she has experienced this before and the worry is stopping her from going out to do the shopping. You ring her GP and he suggests that she go to hospital for an assessment. Trang has 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. In Australia anxiety disorders are the most common of the psychiatric disorders, with one in four people experiencing an anxiety disorder at some time in their life. Anxiety disorders have the potential to interfere with a persons 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:

- **Generalised anxiety disorder:** feelings of constant apprehension and a general tendency to be worried about many areas of life (for example, health, work, and finances).
- **Specific phobias:** an intense fear of a specific object or situation that leads to avoidance of the fear-inducing trigger, interfering with normal living.
- **Social phobia:** the intense fear of being scrutinised, 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 characterised 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 (for example, an anxious parent may model anxious behaviours and poor coping strategies 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 (for example, 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 okay? 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 have difficulty understanding the person's anxiety. 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 a 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 (for example, 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.

Guidelines for responding to a person experiencing an anxiety disorder

- 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 mental health assessment may be appropriate to undertake — see the MIND Essentials resource 'What is a mental health assessment?'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is essential to take this into account when formulating diagnosis and care plans. Indigenous mental health workers or multicultural mental health coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues.

  For more information please visit www.health.qld.gov.au/pahospital/qtmhc/default.asp
- Learn to identify the signs and symptoms of anxiety and panic, including triggers. 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 is more helpful to provide a reassuring presence.
- Avoid dismissive statements such as 'things can't be that bad' and 'everything will be okay', 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 anxiety 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 etc.). Provide education on possible side effects to any medication (if appropriate) and work with the person to develop appropriate actions to address any issues.
- Be aware of your own feelings when caring for a person with anxiety. Arrange a debriefing for yourself or any colleague who requires support or assistance — this may occur with a clinical supervisor or an employee assistance service counsellor (see below).

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit http://qheps.health.qld.gov.au/eap/home.htm

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, including:

- **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** teach the person control the physical effects of anxiety (for example, breathing and relaxation). 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'. This 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 (for example, 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. If a person changes the unhelpful thinking or behaviour (B), as demonstrated in the example below, a more positive outcome can be expected.

Changing unhelpful thoughts or behaviours

Original but unhelpful thought	*Alternative thought*
A I am invited to go to the movies	**A** 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.	**B** 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.	**C** 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 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 Child Health
- Community Health
- Mental Health Services (infant, child and youth or adult)
- Private service providers

To access the contact number and details for your local services use QFinder (available on QHEPS) or call 13 HEALTH (1343 2584).

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 a 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 one in five Australians over their lifetime. 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 a 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 a person experiencing mania' for more information.

Core symptoms of depression include:

- sleep disturbance
- appetite or weight changes
- dysphoria (a 'bad mood', irritability, or sadness)
- anhedonia (loss of interest in work, hobbies, sex, etc.)
- 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 or 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 being 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 course of a person's life.

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 mental 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 a 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 have difficulty understanding the person's experience. 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 a 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 (for example diet, exercise, not smoking, limit consumption of alcohol and other substances).
- 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.

Guidelines for responding to a person experiencing depression

- 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 mental health assessment may be appropriate to undertake — see the MIND Essentials resource 'What is a mental health assessment?'.
- Assess whether the person's helplessness or hopelessness are indicators of suicidal thinking. Refer to the MIND Essentials resource 'Caring for a person who is suicidal'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is essential to take this into account when formulating diagnosis and care plans. Indigenous mental health workers or multicultural mental health coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues.

  For more information please visit www.health.qld.gov.au/pahospital/qtmhc/default.asp
- 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 okay', 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 (for example, 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 (for example, 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 (for example, arts groups, sports groups).
- Monitor recovery, compliance with medication and general physical health (including nutrition, weight, blood pressure etc.). Provide education on possible side effects to any medication (if appropriate) and work with the person to develop appropriate actions to address any issues.
- Provide family members and carers with information about the illness, if appropriate, as well as reassure and validate experiences with the person. Encourage family members and carers to look after themselves and seek 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 service counsellor.

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit http://qheps.health.qld.gov.au/eap/home.htm

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 may help them resolve the problem or 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 sort out practical problems and conflicts, and 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), (for example, sertraline, paroxetine)
- serotonin or noradrenalin reuptake inhibitors (SNRIs), (for example, venlafaxine)
- atypical antidepressants (for example, nefazadone and/or mirtazapine)
- tricyclic (for example, amitriptyline, doxepin)
- monoamine oxidase inhibitors (for example, phenelzine, tranylcypromine).

ECT

Electroconvulsive therapy (ECT), is a safe and highly effective treatment for the most severe forms of depression. Many misconceptions remain regarding its use, possibly owing to inaccurate depictions 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 Child Health
- Community Health
- Mental Health Services (infant, child and youth or adult)
- Private service providers

To access the contact numbers and details for your local services use QFinder (available on QHEPS) or call 13HEALTH (13 43 25 84).

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 a 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?

The two most common eating disorders are anorexia nervosa and 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 two and three per cent 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 per cent 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 of all mental disorders. One in five (20 per cent) people with anorexia nervosa will die due to the illness.

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 approximately 70 per cent of cases, onset follows a severe life event or difficulty.

Eating disorders are conditions that develop over time, sometimes taking 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 six to seven years, although some people never fully recover and continue to have abnormal attitudes to food and eating.

Symptoms and physical effects of eating disorders

Typical behaviours associated with eating disorders include difficulties with activities involving food; deceptive behaviours relating to food (for example, 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; 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 nervosa 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 concentrate. Bulimia nervosa is likely to cause erosion of 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 (for example, '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 is it 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 a 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.

Guidelines for responding to a person who has an eating disorder

- Arrange for an initial or follow-up psychiatric assessment if their care plan needs reviewing. A mental health assessment may be appropriate to undertake — see the MIND Essentials resource 'What is a mental health assessment?'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is essential to take this into account when formulating diagnosis and care plans. Indigenous Mental health workers or multicultural mental health coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues.

  For more information please visit www.health.qld.gov.au/pahospital/qtmhc/default.asp
- 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 a 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, 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 their situation. This will enable the person to feel that he or she has control over their 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).
- Provide family members and carers with information about the illness, if appropriate, as well as reassurance and validate experiences with the person. Encourage family members and carers to look after themselves and seek support if required.
- Be aware of your own feelings when caring for a person with an eating disorder. Arrange for debriefing for yourself or 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 service counsellor.

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit http://qheps.health.qld.gov.au/eap/home.htm

Treatment for eating disorders

Changes in eating behaviour might be caused by a number of illnesses other than anorexia nervosa or bulimia nervosa, 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 illness affects 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 (for example, fainting and/or 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 (for example, depression and/or 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 (for example, 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:

- Statewide Eating Disorders Outreach Service. Referral form available from http://hi.bns.health.qld.gov.au/mental_health/eating_disorder/default.htm
- GP
- Community Child Health
- Community Health
- Mental Health Services (infant, child and youth or adult)
- Private service providers

To access the contact numbers and details for your local services use QFinder (available on QHEPS) or call 13HEALTH (13 43 25 84).

Further reading

For more information, see Isis — The Eating Issues Centre at www.isis.org.au and the Eating Disorders Association at www.eda.org.au (internet access required).

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Caring for a 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'.

Kiara is extremely distressed and says that she wants to die and 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 care for 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 wellbeing. 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 10 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); affect (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 six per cent 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, substance use problems 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 edge' waiting for something 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 a 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.

Guidelines for responding to a person with a personality disorder

- Arrange for a review of the person's medication and an initial or follow-up psychiatric assessment if their care plan needs reviewing. A mental health assessment may be appropriate to undertake — see the MIND Essentials resource 'What is a mental health assessment?'.
- Be alert to and regularly monitor suicide risk. Refer to the MIND Essentials resource 'Caring for a person who is suicidal'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is essential to take this into account when formulating diagnosis and care plans. Indigenous mental health workers or multicultural mental health coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues.

  For more information please visit www.health.qld.gov.au/pahospital/qtmhc/default.asp
- 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/or something you like about the person with the personality disorder and focus on this. This can be helpful in lessening the ease with which dislike can develop in response to other 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 can 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.
- 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, which people with personality disorders often have, and treat them separately in the general medical setting. Consultation liaison psychiatry services can be helpful, where available. Provide brief intervention regarding alcohol and drug use and advise psychiatry services of all co-morbid needs. Similarly, it may be useful to give information about Alcohol, Tobacco and Other Drug Services, but remember that people may be pre-contemplative in regards to changing their maladaptive behaviours.
- Provide family members and carers with information about the illness if appropriate, as well as reassure and validate their experiences with the person. Encourage family members and carers to look after themselves and seek 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 colleagues who may need support or assistance — this may occur with a clinical supervisor or an Employee Assistance Service counsellor.

The Employee Assistance Service provides confidential short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit http://qheps.health.qld.gov.au/eap/home.htm

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 (for example, 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 Child Health
- Community Health
- Mental Health Services (infant, child and youth or adult)
- Private service providers

To access the contact numbers and details for your local services use QFinder (available on QHEPS) or call 13HEALTH (13 43 25 84).

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Caring for a 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. This indicates that he has possible cognitive impairment. His dislocated shoulder has been reduced under anaesthesia following two unsuccessful attempts at closed reduction.

Harry 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 per cent 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 per cent of people with dementia have **Alzheimer's disease** and about 20

per cent 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 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 and (the three Ds) requires skilled assessment. The differences and similarities are outlined in Table 1. Be alert to co-morbid substance misuse as complex co-morbidities may mask substance misuse and the impact of co-occurring problems.

***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 a 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.

Guidelines for responding to a person with dementia

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

- Arrange for a review of the person's medication and an initial or follow-up psychiatric assessment if their care plan needs reviewing. A mental health assessment may be appropriate to undertake — see the MIND Essentials resource 'What is a mental health assessment?'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is essential to take this into account when formulating diagnosis and care plans. Indigenous mental health workers or multicultural mental health coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues. For further information please visit www.health.qld.gov.au/pahospital/qtmhc/default.asp

- 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 resistant 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 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 cause 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, etc).
- 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).
- Provide family members and carers with information about the illness if appropriate, as well as reassure and validate their experiences with the person. Encourage family members and carers to look after themselves and seek support if required.
- Be aware of your own feelings when nursing a patient with dementia. Arrange for debriefing for yourself or any colleague who may need support or assistance — this may occur with a clinical supervisor or an Employee Assistance Service counsellor.

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit http://qheps.health.qld.gov.au/eap/home.htm

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 needed, 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 which looks at the:

- activating event
- behaviour
- consequences.

Documenting these can provide clues to patterns and the triggers of behaviour.

Pharmacological strategies

Currently there is no cure for dementia, but drugs such as cholinesterase inhibitors (for example, donepezil, galantamine and/or 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 (for example, temazepam, and/or oxazepam) are preferred to longer-acting agents (for example, diazepam, and/or 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. Some people may present as agitated when suffering a depressive disorder.

Discharge planning

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

- GP
- Aged Care Assessment Teams (ACAT): http://qheps.health.qld.gov.au/acat/home.htm
- Older Persons Mental Health Services
- Private service providers

To access the contact numbers and details of your local services use QFinder (available on QHEPS) or call 13HEALTH (13 43 25 84).

Further reading

For more information, contact:

- Dementia Behavioural Management Advisory Service — 1800 699 799
- Carers Queensland — 1800 242 636
- Commonwealth Carer Respite Centre — 1800 059 059
- Alzheimer's Australia: www.alzheimers.org.au

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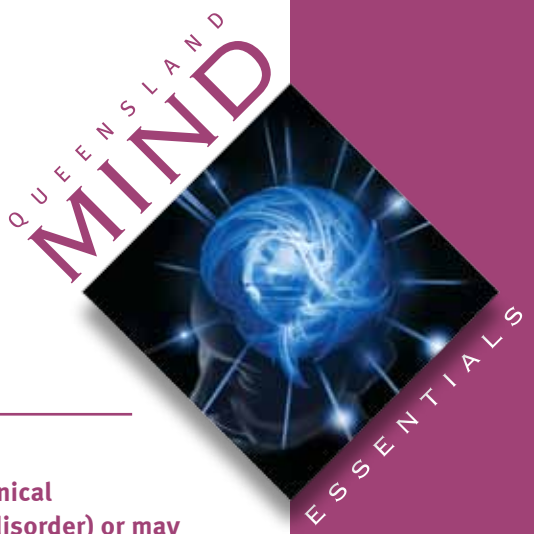
Caring for a person experiencing mental illness in the

Perinatal period



A woman in the perinatal period may have a pre-existing clinical diagnosis of mental illness (for example, bipolar affective disorder) or may develop a mental illness specific to this period (for example, 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 and infant mental health (PIMH) refers to the emotional wellbeing 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 experiencing mental health disorder. 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. Additionally, there is a change in the risk-to-benefit ratio that affects decisions around psychotropic medication use, and there is potential for greatly increased detrimental impact on the family unit, particularly the infant.

In addition, women who have already experienced mental health disorders 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 and infant mental health disorders is higher for women who have a history of depression, experienced recent life stresses, a low level of partner support, experienced abuse or neglect, a tendency to worry, low self-esteem or an unwanted pregnancy.

Relevance of perinatal mental illness for wellbeing of infants

Parental responsiveness and sensitivity are significant predictors for secure infant attachment. Maternal mental illness can directly affect a mother's responsiveness and sensitivity during interactions with her baby. Internal preoccupations and symptoms will interfere with parental capacity to respond appropriately to an infant's needs, which can result in an insecure attachment relationship between mother and infant.

The effects of maternal mental illness on infants occurs early, so it is important to identify and treat those at risk as early as possible in order to ensure the wellbeing of the mother, infant and other family members. If left untreated the effects of parental mental illness can impact on the lifelong physical development and social, emotional wellbeing of infants.

What is the normal response to birth?

Between three and 10 days after giving birth, almost 80 per cent 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 one in 10 Australian women; postnatal depression can develop from one month to one year after birth and affects almost one in six 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 one 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 in the perinatal period due to a range of factors the partner is at an increased risk of developing depression; and the infant is at an increased risk of developing an attachment disorder. Factors such as increased and changed role demands, and vulnerabilities or depression of the new mother may adversely impact on the partner's and infant'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 (for example, DSM IV, ICD 10 etc.). However, specific caution is recommended around symptoms that may be influenced by context (for example, sleep disturbance, loss of libido and/or anxiety about difficulties bonding with 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 a person experiencing depression' may be relevant.

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

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 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.

- Promote effective strategies to help bonding and attachment between the mother and her infant.
- 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.
- Be alert to and regularly monitor suicide risk. Refer to the MIND Essentials resource 'Caring for a person who is suicidal'.

Guidelines for responding to a 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 essential to take this into account when formulating diagnosis and care plans. Indigenous Mental Health Workers or Multicultural Mental Health Coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues. For further information please visit www.health.qld.gov.au/pahospital/qtmhc/default.asp
- 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.
- Provide information about the attachment needs of the infant and the importance of the parental role meeting these needs.
- 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 (for example, attending to the infant's physical, intellectual, social and emotional needs)
  - the impact of the mental illness on the woman's functioning
  - the capacity of both parents (if relevant) to support the family
  - the style of partnership between the parents (if relevant)
  - the child's needs and 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, and that you may reconnect with your own feelings and parenting experiences. 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 Service counsellor.

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit http://qheps.health.qld.gov.au/eap/home.htm

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 physical and emotional 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 mental disorder can also have serious consequences for later life outcomes for both mother and infant.

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 13HEALTH (13 43 25 84).

Discharge planning

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

- GP
- Community Child Health
- Community Health
- Mental Health Services (infant, child and youth or adult)
- Private service providers

To access the contact numbers and details for your local services use QFinder (available on QHEPS) or call 13HEALTH (13 43 25 84).

Further reading

For more information, see the following:

Clinicians Knowledge Network at https://sp.cknservices.dotsec.com/ckn/

PIMH Print Books are listed in the Queensland Health Libraries catalogue 'HealthCat' http://healthcat.slq.qld.gov.au/cgi-bin/Pwebrecon.cgi?DB=local&PAGE=First

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Zero to Three at www.zero03.org.au

beyondblue at www.beyondblue.org

Mental Health First Aid Manual at www.mhfa.com.au (internet access required)

Children of Parent with a Mental Illness (COPMI) at www.copmi.net.au/

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Fact sheet:
Schizophrenia

For more information also see the following MIND Essentials resources — 'Caring for the person experiencing hallucinations' and 'Caring for a 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 psychosis.

Schizophrenia usually first appears in people aged between 15 and 25 years, although it can appear later in life. It affects approximately one per cent of the population. About 25 per cent of people who have schizophrenia experience a complete recovery, 40 per cent experience recurrent episodes of acute illness and 35 per cent 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 wellbeing 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 one per cent of people develop the illness. However, if one parent suffers from schizophrenia, the children of the family have a 10 per cent chance of developing the condition (and a 90 per cent 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 significant stigma associated with, and a great deal of 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 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 and 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 per cent 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 review progress regularly 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 two to three weeks to work. Psychological strategies may assist in addressing negative symptoms. 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 a person experiencing delusions' or 'Caring for a person experiencing hallucinations'.

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Caring for a 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, Yousef 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 they perceive they have been obstructed.
- **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**. The person 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 friends 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 influence
- bipolar affective disorder (BPAD).

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 one per cent.

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 (for example, corticosteroids) and are not included in this diagnostic category. Be aware co-occurring substance use disorders are common and engage in routine screening and assessment.

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 a 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 (for example, diet, exercise, not smoking etc.).
- 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.

Guidelines for responding to a 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 mental health assessment may be appropriate to undertake — see the MIND Essentials resource 'What is a mental health assessment?'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is essential to take this into account when formulating diagnosis and care plans. Indigenous mental health workers or multicultural mental health coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues.

For more information visit www.health.qld.gov.au/pahospital/qtmhc/default.asp

- 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 healthcare 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 and suicide.
- 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 (for example, 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 etc). 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 (for example, vomiting, diarrhoea, tremors, drowsiness, muscle weakness and/or 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.
- Provide family members and carers with information about mania if appropriate, as well as reassure and validate their experiences with the person. Encourage family members and carers to look after themselves and seek 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 Service counsellor.

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit http://qheps.health.qld.gov.au/eap/home.htm

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 experiencing acute mania.

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 two 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 referral to the following:

- GP
- Community Child Health
- Community Health
- Mental Health Services (infant, child and youth or adult)
- Private service providers

To access the contact numbers and details for your local services use QFinder (available on QHEPS) or call 13HEALTH (13 43 25 84).

Further reading

For information on antipsychotic medication, see the MIND Essentials resources ‘Caring for a person experiencing delusions’ or ‘Caring for a 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 a person experiencing Hallucinations

For more information see also the following MIND Essentials resources — 'Caring for a person experiencing delusions' and 'Schizophrenia fact sheet'.

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 three 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 per cent and 12.5 per cent 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 is it 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 experiencing hallucinations

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 experiencing hallucinations

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 hallucinations.
- Promote positive health behaviours, including medication compliance and healthy lifestyle choices (for example, diet, exercise, and/or 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.

Guidelines for responding to a person who is experiencing hallucinations

- 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 mental health assessment may be appropriate to undertake – see the MIND Essentials resource 'What is a mental health assessment?'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is essential to take this into account when formulating diagnosis and care plans. Indigenous mental health workers or multicultural mental health coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues.

  For more information visit www.health.qld.gov.au/pahospital/qtmhc/default.asp

  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 experiencing hallucinations. 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 experiencing hallucinations. 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 experiencing hallucinations 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 undertake 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 etc.). Provide education on possible side effects to any medication and work with the person to develop appropriate actions to address any issues.
- Provide family members and carers with information about hallucinations if appropriate, as well as reassure and validate their experiences with the person. Encourage family members and carers to look after themselves and seek support if required.
- Be aware of your own feelings when caring for a person experiencing hallucinations. Arrange for debriefing for yourself or any colleague who may need support or assistance — this may occur with a clinical supervisor or an Employee Assistance Service counsellor.

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit http://ceps.health.qld.gov.au/eap/home.htm

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 and/or shuffling gait) and akathisia (restlessness and/or inability to sit still)
- orthostatic hypotension (fall in blood pressure when standing)
- tardive dyskinesia (repetitive involuntary movements, which are usually irreversible)
- agranulocytosis

- photosensitivity
- lowered seizure threshold
- Neuroleptic Malignant Syndrome (NMS) — a life-threatening condition that can occur in up to one per cent 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
- Community Child Health
- Community Health
- Mental Health Services (infant, child and youth or adult)
- Private service providers

To access the contact numbers and details for your local service use QFinder (available on QHEPS) or call 13HEALTH (13 43 25 84).

Further reading

See also the Mental Health First Aid Manual at www.mhfa.com.au (internet access required).

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Caring for a person experiencing
Delusions

For mor information also see the following MIND Essentials resources — 'Caring for a person experiencing hallucinations' and 'Schizophrenia fact sheet'.

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 that are out of touch 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 three 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. Knowing how to respond appropriately can be challenging and confusing.

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 the difficulties in engaging with the person.

Goals for nursing a 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 (for example, diet, exercise, not smoking and/or limit consumption of alcohol and other substances).
- 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.

Guidelines for responding to a person experiencing delusions

- Arrange for a review of the person's medication for delusions and an initial or follow-up mental health assessment if their care plan needs reviewing. A mental health assessment may be appropriate to undertake — see the MIND Essentials resource 'What is a mental health assessment'.
- A person's cultural background can influence the way symptoms of mental illness are expressed or understood. It is essential to take this into account when formulating diagnosis and care plans. Indigenous mental health workers or multicultural mental health coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues. For more information visit www.health.qld.gov.au/pahospital/qtmhc/default.asp
- 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.
- Provide family members and carers with information about delusions if appropriate, as well as reassure and validate 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 Service counsellor.

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit http://qheps.health.qld.gov.au/eap/home.htm

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 dystonia (painful muscle contractions or jerking movements that may cause airway obstruction), Parkinsonism (tremors, shuffling gait) and akathisia (restlessness and/or inability to sit still)
- orthostatic hypotension (fall in blood pressure when standing)
- tardive dyskinesia (repetitive involuntary movements, which are usually irreversible)
- agranulocytosis
- photosensitivity
- lowered seizure threshold
- Neuroleptic Malignant Syndrome (NMS) — a life-threatening condition that can occur in up to one per cent of people taking antipsychotics. Symptoms including fever, extreme muscle rigidity and altered consciousness can occur hours to months after commencing or increasing drug therapy.

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.

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.

Discharge planning

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

- GP
- Community Child Health
- Community Health
- Mental Health Services (infant, child and youth or adult)
- Private service providers

To access the contact numbers and details for your local services use QFinder (available on QHEPS) or call 13HEALTH (13 43 25 48).

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 a person who is Suicidal

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 the behaviour presents in the context of mental illness or not.

It is important that you:

- Know the indicators of suicide risk.
- Know how to interact with a patient who is at risk of suicide.
- Know who to talk to if you are concerned that a patient might be at risk of suicide.

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.

Sarah 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?

People of all ages and from all walks of life take their own life, and suicidal thoughts and behaviours are most likely to occur when the person feels helpless or hopeless, and they consider suicide to be their only option. The causes of suicide often appear to be a complex mix of adverse life events, social and geographical isolation, cultural and family background, socio-economic disadvantage, genetic makeup, mental and physical health, the extent of support of family and friends; and the ability of a person to manage life events and bounce back from adversity.

A person's perspective on what is it 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.'

Who is at risk of suicide?

Research has identified a range of factors that can make a person more or less vulnerable to suicide.

- Risk factors make a person more vulnerable and therefore increase the likelihood of suicide.
- Protective factors improve a person's ability to cope with challenging circumstances and therefore decrease the likelihood of suicide (see Table 1). It is important, however, to note that the presence of protective factors does not necessarily mean that an individual is not at risk of suicide.

Suicide risk and protective factors relate to the individual, their family, their environment and the broader community. Research into risk factors has enabled the identification of subpopulations or groups that are at risk of suicide, however there is no way of predicting if or when an individual will suicide. Population groups that are at increased risk of suicide include Indigenous people, people with a mental illness and those under psychiatric care, people in custody and people from minority groups such as those from culturally and linguistically diverse backgrounds and the gay and lesbian population.

Table 1. Risk and Protective factors for suicide (LIFE Framework)

	Risk factors for suicide	Protective factors for suicide
Individual	• gender (male)	• gender (female)
	• mental illness or disorder	• mental health and wellbeing
	• chronic pain or illness	• good physical health
	• immobility	• physical ability to move about freely
	• alcohol and other drug problems	• no alcohol or other drug problems
	• low self-esteem	• positive sense of self
	• little sense of control over life circumstances	• sense of control over life circumstances
	• lack of meaning and purpose in life	• sense of meaning and purpose in life
	• poor coping skills	• good coping skills
	• hopelessness	• positive outlook and attitude to life
	• guilt and shame	• absence of guilt and shame
	Risk factors for suicide	**Protective factors for suicide**

Social	• abuse and violence	• physical and emotional security
	• family dispute, conflict and dysfunction	• family harmony
	• separation and loss	• supportive and caring parents/family
	• peer rejection	• supportive social relationships
	• social isolation	• sense of social connection
	• imprisonment	• sense of self-determination
	• poor communication skills	• good communication skills
	• family history of suicide or mental illness	• no family history of suicide or mental illness
Contextual	• neighbourhood violence and crime	• safe and secure living environment
	• poverty	• financial security
	• unemployment, economic insecurity	• employment
	• homelessness	• safe and affordable housing
	• school failure	• positive educational experience
	• social or cultural discrimination	• fair and tolerant community
	• exposure to environmental stressors	• little exposure to environmental stressors
	• lack of support services	• access to support services

What do I need to know about suicide risk?

It is important to be aware of the following things when thinking about suicide risk in your patients:

- It can be difficult to identify which individuals are at risk of suicide, and when individuals are at high risk of suicide.
- The level of an individual's suicide risk can change quickly due to external and internal factors, which is why regular monitoring of a person's level of risk is so important.
- Suicidal ideation, when a person is having thoughts about ending their own life, is temporary. Most people who consider or attempt suicide can be assisted by health professionals to a point that they are no longer at high risk of taking their own life.
- Suicide can be an impulsive act that occurs without warning; however it can also be carefully planned. In many cases, a person's suicidal thoughts and intents are communicated to others. It is therefore important to take all threats, communications and suggestions regarding suicide seriously.
- People who consider or attempt suicide require support and care from family, friends, the community and health professionals. All people who interact with persons who consider or attempt suicide can assist by way of emotional support and encouragement.

What are the signs that a patient might be at risk of suicide?

A suicide warning sign indicates that someone might be at a heightened risk of suicide. The following behaviours may be considered as warning signs and are more common among people who are considering taking their own life:

- threatening to hurt or kill themselves
- looking for ways to kill or hurt themselves, or talking about their suicide plan
- talking or writing about death, dying or suicide, especially when this is out of character or unusual for the person (this may include statements such as 'I wish I were dead', 'They won't have to bother with me any more'; 'I think dead people must be happier than when they were alive'; 'I'd like to go to sleep and never wake up')

- expressing feelings of hopelessness, or saying they have no reason for living or have no purpose in life
- engaging in reckless or risky behaviours
- expressing feelings of being trapped, or that they feel there's 'no way out'
- increased use of alcohol or other drugs
- withdrawing from friends, family or the community; giving away possessions or saying goodbye to family and/or friends
- abnormal anxiety or agitation
- abnormal sleep patterns (for example, not sleeping or sleeping all the time)
- dramatic changes in mood, such as sudden feelings of happiness after a long period of sadness or depression.

What are the Do's and Don'ts when you are nursing a person who is at risk of suicide?

DO:

- Act immediately if there is a risk to someone's life or safety.
- Provide opportunities for your patient to talk openly.
- Demonstrate empathy and willingness to listen.
- Ensure a safe environment for you, the patient and other staff.
- Record details of your interactions with the patient in accordance with record keeping protocols.
- Be aware of your own reactions and feelings (see *How will nursing a suicidal patient impact on me?*). Having supervision and opportunities to debrief with colleagues is critical.
- Keep within your role — to support and nurse the patient. It is not your role to provide counselling or suicide risk assessments.
- Be mindful of the possible impact of the patient's cultural background, and seek advice from relevant people (Indigenous mental health workers, and Multicultural Mental Health Coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre, are available for advice and assistance in understanding these issues. For more information visit www.health.qld.gov.au/pahospital/qtmhc/default.asp).

DON'T:

- Dismiss threats or suggestions of suicide or self-harm. These should always be taken seriously.
- Agree to keep a patient's suicide ideation or self-harm a secret. When someone's life or safety may be at risk, you are obliged to break confidentiality and share information with the relevant people.
- Feel pressured to have the 'right answer' — there usually isn't one. It is more important for you to be there for the person and allow them space to talk and feel listened to.
- Be judgmental or dismissive towards the patient.
- Be afraid to ask about a patient whether they are thinking about suicide or self-harm. Asking a person about suicide does not increase their risk of suicide or prompt them to act on their thoughts. Instead, asking a person about suicide can make a person feel understood and listened to, and can prompt the person to access the help that they need. Some suggested questions are: 'Just how bad have things become for you?', 'Have things been so bad for you that you don't want to be around anymore?', or 'It sounds like you are feeling really sad and hopeless. Have you been thinking about hurting yourself or taking your own life?'.

What should I do if I am concerned that a patient might be at risk of suicide?

The first thing you should do if you are concerned about the suicide risk of a patient is discuss the situation with your line manager (Nurse Unit Manager, supervisor or clinical director).

It is also important to be aware of the procedures in your workplace for accessing specialist mental health assessments for your patients. Many hospital settings have access to a consultation-liaison service or mental health clinicians, who can complete a mental health assessment. For further information on specialist mental health assessments, see the MIND Essentials 'What is a mental health assessment?' resource.

How will nursing a suicidal patient impact on me?

Working with someone who is suicidal can be extremely challenging and confronting. Engaging in supervision and debriefing is essential. Common reactions can include:

Anxiety particularly in regards to managing the risk of suicide in a patient, knowing how to respond and 'saying the wrong thing'.

Avoidance particularly when a nurse is inexperienced, has had limited exposure to relevant training and is lacking in confidence.

Anger some nurses may feel angry towards the person, and may see them as undeserving of the resources being used to manage their physical/ medical condition.

Distress particularly when the nurse has had personal experience with suicide or self-harm.

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.

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.

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit http://qheps.health.qld.gov.au/eap/home.htm

Discharge planning

Following consultations with the relevant line manager you may need to discuss referral options with the person and consider referrals to the following:

- GP
- Community Child Health
- Community Health
- Mental Health Services (infant, child and youth, adult or older persons)
- Private service providers

To access the contact numbers and details for your local services use QFinder (available on QHEPS) or call 13 HEALTH (13 43 25 84).

Further reading

For more information, see the following:

Mental Health First Aid Manual at www.mhfa.com.au (internet access required).

The Living is for Everyone initiative at www.livingisforeveryone.com.au/ (internet access required).

QHEPS for direct links to your local Health Service District for policy and procedures.

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Caring for a 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 (for example, 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 the context of 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 medical staff due to many previous visits, usually because of injuries he has suffered as a result of his heavy drinking. Sean has often presented as a very aggressive man, and one occasion hit a staff member 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 (for example, 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 mental 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 per cent 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 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.

Guidelines for responding to a 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.

Queensland Health (2008) recommends protection strategies when violence occurs or seems imminent. Whilst the prevention of occupational violence is not always possible, should a violent event be imminent the following protection strategies may be considered:

- Presence, disengagement, negotiation, de-escalation, escape, defense and control techniques such as code black response teams (if appropriate) for the management of occupational violence.
- Appropriate solutions proportional to the event to be considered in accordance with legislative and organisational requirements.
- Selection of appropriate protection strategies and techniques must balance clinical, safety and security requirements.

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.

Following 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 other times 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.
- Ensure compliance with home visiting policies and procedures 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 essential to take this into account when formulating diagnosis and care plans. Indigenous mental health workers or multicultural mental health coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues.

  For more information please visit www.health.qld.gov.au/pahospital/qtmhc/default.asp

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.

- If a person is violent/aggressive, the nurse should immediately contact security and ensure the safety of all people in the vicinity.
- 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.
- Reflecting a person's feelings can be very effective, if it is done in a genuine and appropriate way. 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 the current issues. 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 usual manner of 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.
- Encourage the person to speak with a mental health worker or social worker and to accept medication voluntarily, if appropriate. 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.'
- Help them to identify triggers and any management strategies, if appropriate. It is important to do this when the person is calm and open to discuss the issues. If the person has a mental illness it may be important to consider to what degree the symptoms 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.
- Provide family members and carers with information about aggression and violence, if appropriate, as well as reassure and validate their experiences with the person. Encourage family members and carers to look after themselves and seek 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 service counsellor.

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. For more information visit: http://qheps.health.qld.gov.au/eap/home.htm

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit http://qheps.health.qld.gov.au/eap/home.htm

Further action: Build up your confidence with training

The Queensland Health approved training course is the Aggressive Behaviour Management (ABM) for Healthcare Workers course. The ABM course is available to all staff, it is based on sound risk management principles, designed to support the delivery of health care and improve patient safety through prevention, protection from and treatment control of aggressive behaviour incidents.

For more information see the Occupational Violence site http://qheps.health.qld.gov.au/safety/occup_violence/home.htm

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Under review

Caring for a person who is *Intoxicated*

For more information also see the following MIND Essentials resource — 'Drug and alcohol screening assessment'.

Intoxication and substance use are not unique to mental illness, nor are they necessarily common features or symptoms of mental illness. 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 the behaviour presents in the context of mental illness or not.

Case study

Colin has been in hospital several times in the last six 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 misuse and intoxication?

Use of substances can be viewed across a spectrum ranging from non-use to experimental, recreational, regular use and dependence. There are risks associated with all levels of use. **Dependence** indicates that the 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. See the MIND Essentials Resource 'Drug and alcohol screening assessment' for more information. 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). The interactive effects of substance use on prescribed medication should be considered in all phases of treatment.

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 'Drug and alcohol screening assessment' for more information.

'**Dual diagnosis**' is a term used when a person presents with both a substance use problem and mental illness. Although 'dual' refers to two disorders it is common for consumers to present with multiple problems. There is a range of explanations for the development of dual diagnoses. 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 stimulant abuse. There may also be factors that are common to both the alcohol and drug use and mental illness, increasing the likelihood that they will co-occur. It can be difficult to distinguish between the two disorders, but it is important that both conditions and the interactive effects of these problems 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 three years have been identified as potential indicators for future substance use problems. In adolescence, increased risk taking and sensation-seeking behaviour can include drug and alcohol use. There are also significant rates of co-occurring mental illness in those with substance use problems. 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 per cent of men and 75 per cent of women drink **alcohol**; 20 per cent of men and 10 per cent 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 per cent of all deaths and four per cent of hospital bed days.
- About seven per cent of Australians take a daily dose of **sedatives** or **hypnotics** such as the benzodiazepines. Many people taking a benzodiazepine for more than two 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 the ages of 18 and 30 have tried it. In Western countries, three per cent of people aged 18-40 use cannabis every day.
- **Opiates** have a lifetime prevalence of one per cent in Western countries, but in Australia, the USA and southern Europe there is a prevalence of four to six per cent. 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 nine per cent of those surveyed admitted to using amphetamines, four per cent cocaine and five per cent ecstasy.
- **Hallucinogens** like LSD or psylocibin (magic mushrooms) have been used by approximately 10 per cent of Australians.
- **Inhalants** (for example, 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 is it 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 a person who is intoxicated

- Ensure intoxication is the accurate diagnosis for the person's condition establishing the type and quantity of the substance(s) consumed and when they last consumed these substances. Assess for potential withdrawal symptoms and manage these withdrawal symptoms (if applicable) following established local and state protocols.
- 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.
- Once the person is no longer intoxicated, promote healthy lifestyle behaviours and establish interest in addressing any issues, thoughts or situations that may cause drug and/or alcohol use. Ensure the goals for addressing substance use are included on care plans and other relevant service providers are involved.
- 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 access to relevant information, support and self-care activities for families and carers of the person who is intoxicated.

Guidelines for responding to a person who is intoxicated

It is important for a drug and alcohol assessment to be conducted — refer to the MIND Essentials resource 'Drug and alcohol screening 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 QHEPS for direct links to your local Health Service District for policy and procedures.

The Management of Psychostimulant Toxicity Guidelines for Emergency Departments (Queensland Health 2008). These guidelines provide information on sedation, medical management, behavioural management post – sedative management and follow up care. These guidelines are accessible on QHEPS at http://www.health.qld.gov.au/atod/documents/psychostimulant_toxic.pdf

The following considerations 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.)
- Ensure collateral information regarding substance use is obtained from carers/family/ significant others and laboratory tests.
- Look for risk factors for withdrawal. These include frequent and regular use, duration of use and time and date of last dose. Use validated tools for assessing withdrawal as outlined in the local and state protocols.
- 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 a person with dementia' for more information). Regardless, the person requires close observation, appropriate care and reduced stimulation.

Guidelines for responding to a person reporting drug or alcohol use

For those presenting with concerning levels of drug or alcohol use, the following are relevant:

- Be accepting and non-judgmental. This will provide the first step to engage 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 intoxicated.
- 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.

  The factors maintaining substance use in those with mental disorders are complex. People may self-medicate for lots of reasons, including past abuse or trauma and major mental disorders (such as psychosis or depression). Substance abuse should be considered a comorbid issue for some people with a mental illness and appropriate assessment and integrated treatment for both problems should be obtained.
- 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 and ensure the consumer is linked into the appropriate service. Consider child protection issues and report or refer these as indicated.
- Provide family members and carers with information about intoxication, substance use problems and dual diagnosis, if appropriate, as well as reassure and validate their experiences with the person. Encourage family members and carers to look after themselves and seek support if required.
- A person's cultural background is important in understanding the context of their drug or alcohol use. It is essential to take this into account when formulating diagnosis and care plans. Indigenous mental health workers or multicultural mental health coordinators and the Transcultural Clinical Consultation Service from Queensland Transcultural Mental Health Centre are available for advice and assistance in understanding these issues. For more information visit www.health.qld.gov.au/pahospital/qtmhc/default.asp
- 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 Employee Assistance Service counsellor.

The Employee Assistance Service provides confidential, short-term counselling free-of-charge to Queensland Health staff to assist them to resolve personal and work related problems. For more information visit http://qheps.health.qld.gov.au/eap/home.htm

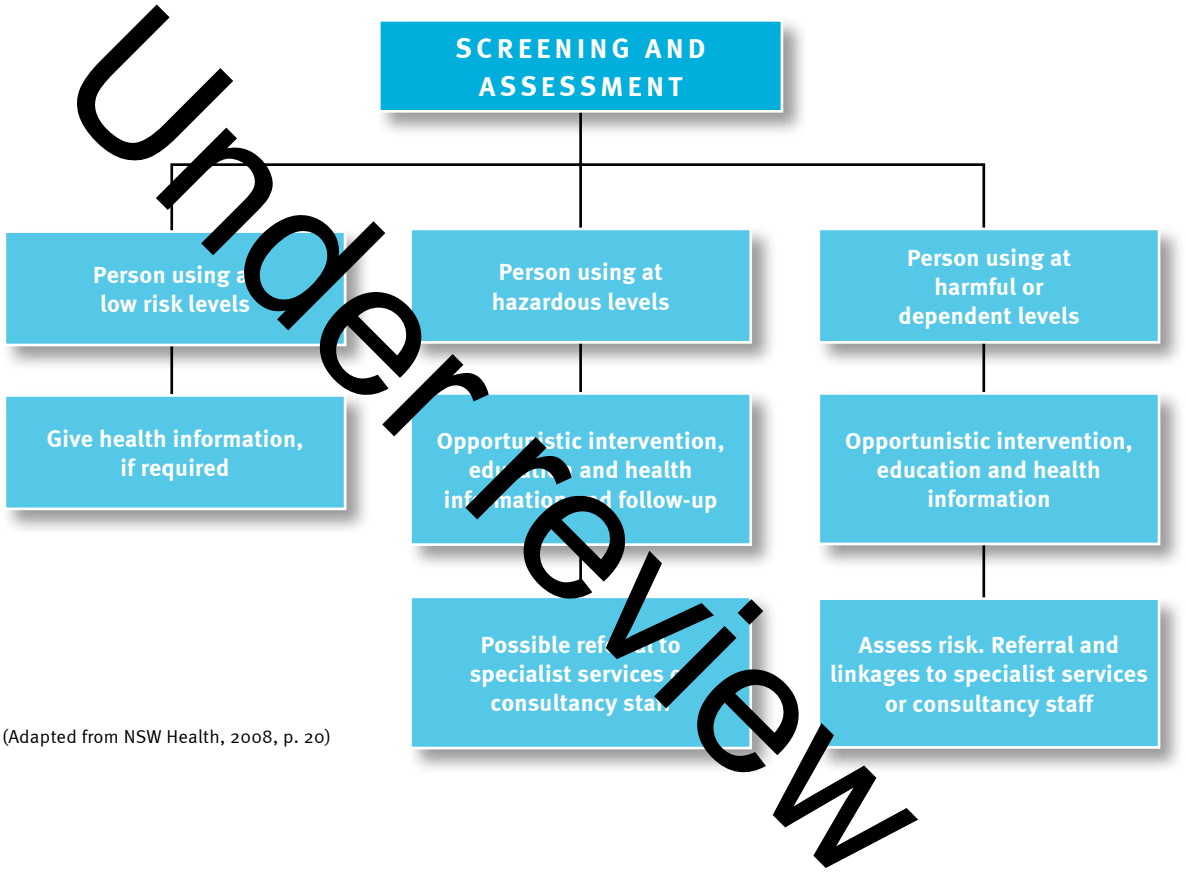
Treatment of intoxication and drug or substance use

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 'Drug and alcohol screening assessment' for details on drug and alcohol assessment.

The drug and alcohol screening 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 screening 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 (for example, 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
- For information regarding the location of your nearest Alcohol, Tobacco and Other Drug Service, please call the 24 hour Alcohol and Drug Information Service on 1800 177 833 or visit www.health.qld.gov.au/atod
- Mental Health Services (infant, child and youth or adult)
- Private service providers

To access the contact numbers and details for your local services use QFinder (available on QHEPS) or call 13HEALTH (13 43 25 48).

Further information

For guidelines regarding immediate management of intoxication and substance use, please refer to the Queensland Health Resource 'Emergency Department Mental Health Management Protocols' which can be assessed at:
http://qheps.health.qld.gov.au/mentalhealth/docs/ed_guidelines.pdf

Sources

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Under review

What is a Mental health assessment?

It is important to be aware of the procedures in your workplace for accessing specialist mental health assessments for your patients. Many hospital settings have access to a consultation-liaison service or mental health clinicians who can complete a mental health assessment.

In Queensland Health, a mental health assessment can be completed by a psychiatrist, psychiatric registrar or clinician (psychologist, social worker, occupational therapist, mental health nurse) within the mental health service. A comprehensive mental health assessment will involve clinical assessment and information gathering in the following areas:

- Presenting problems
- History of presenting problems (onset, duration, course, severity)
- Current functioning (across domains for example, employment/education, family, social)
- Relevant cultural issues (personal and family)
- Previous assessments and interventions*
- Psychiatric history (personal and family history)
- Current medications
- Medical history
- Family history
- Developmental history**
- Substance use
- Forensic and legal history
- Risk screen (for example, suicide, self-harm, aggression, vulnerability; absconding risk+, risks to dependent children++, and risk of disrupted attachment+++)
- Goals for treatment
- Mental Status Examination

* Standardised assessments may also form part of a comprehensive mental health assessment. This may include cognitive and psychometric assessments.

** Included in assessment of children and young people.

+ For inpatient consumers.

++ For consumers who have care/custody responsibilities for children (full-time or periodic).

+++ For children and young people

A core part of a comprehensive mental health assessment is the clinical formulation. This is a clinical summary of the assessment using a bio-psycho-social approach. The clinical formulation broadly aims to answer the questions 'why this person?', 'why this problem?', 'why at this time?'. The formulation will include information regarding the predisposing, precipitating, perpetuating and protective factors that are relevant to the person's clinical presentation, the diagnosis, the prognosis and current risks.

Following the completion of the comprehensive mental health assessment, a treatment plan is developed. A standard treatment plan includes recommended actions to reduce and/or manage risk, recommendations regarding the need for follow up assessment/treatment and an outline of treatment objectives.

Drug and alcohol screening assessment

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

Drug and alcohol assessment helps inform a comprehensive care and management plan that meets all of the needs of the individual. 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.

There is increasing evidence of the high prevalence of co-occurring mental health and alcohol and other drug problems (dual diagnosis). Dual diagnosis is often associated with poor treatment outcomes, severe illness and high service use, presenting a significant challenge for service providers across both service sectors. Relapse of one disorder often triggers a relapse in the other disorder among people with psychotic disorders (Mueser et al. 1990). The increased incidence of poor clinical outcomes including a significant number of fatal sentinel events in mental health consumer populations highlights the need for increased detection and management of co-occurring problems.

Screening is a component of an assessment. A screen is an initial brief method of determining whether a particular condition is present. A positive screen should trigger a detailed assessment that will confirm whether the condition or disorder is indeed present (Croton, 2007) and whether a detailed assessment of co-occurring disorders is warranted. The outcome of the assessment will inform and develop integrated treatment planning for all detected disorders.

Given the high prevalence of co-occurring problems, the detection of either a mental health problem or alcohol and/or other drug problem should prompt screening and assessment for the other problem. Increasing detection of co-occurring problems will inform treatment planning and ensure that the broad scope of consumers health needs are addressed. Effective, holistic and safe care relies upon detection and management of all health concerns particularly when these health concerns may contribute to an interactive effect and trigger negative clinical outcomes for the management of consumers if one of these problems is left untreated.

The need for screening and assessment of these problems has evolved because:

- often co-occurring disorders are not recognised, even by experienced clinicians
- under-recognised, under-treated co-occurring disorders reduce the effectiveness of the treatment of 'target' disorders

- there is potential for large-scale human and financial savings in increasing our recognition of and developing our response to co-occurring disorders
- there is a need to improve the effectiveness of responses to high-prevalence disorders (anxiety, depression, and hazardous rather than dependent substance abuse).

(Croton 2007)

Why assess for Alcohol and Other Drug use (AOD)

The alcohol and drug screening assessment will help establish the level of alcohol and drug use and whether a person is consuming substances at a risky or hazardous level. This will help establish the level of use and risk associated with the person's drug and alcohol use, identify potential interactions between alcohol and/or other drug use and mental health problems and inform treatment.

There is no level of safe use of substances. Low levels of use are often associated with consumption levels that are 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. Other potential negative impacts of alcohol and drug use are outlined below.

- 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 per cent 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.
- Psychostimulant toxicity represents a medical emergency.

There is no amount of alcohol that can be said to be safe for everyone (NHMRC, 2009). Screening for alcohol use is important due to the high personal, economic and social cost of alcohol related harm. To assist in the detection of risky levels of alcohol consumption, the following has been identified by the National Health and Medical Research Council (NHMRC) as representing low risk drinking levels (NHMRC 2009):

- For healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol related disease or injury.
- For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.
- Children under 15 years of age are at the greatest risk of harm from drinking and that for this age group, not drinking alcohol is especially important.
- For young people aged 15-17 years, the safest option is to delay the initiation of drinking as long as possible.
- For women who are pregnant or planning a pregnancy, not drinking is the safest option.
- For women who are breastfeeding, not drinking is the safest option.

Specific populations can be at increased risk if they drink alcohol. These include:

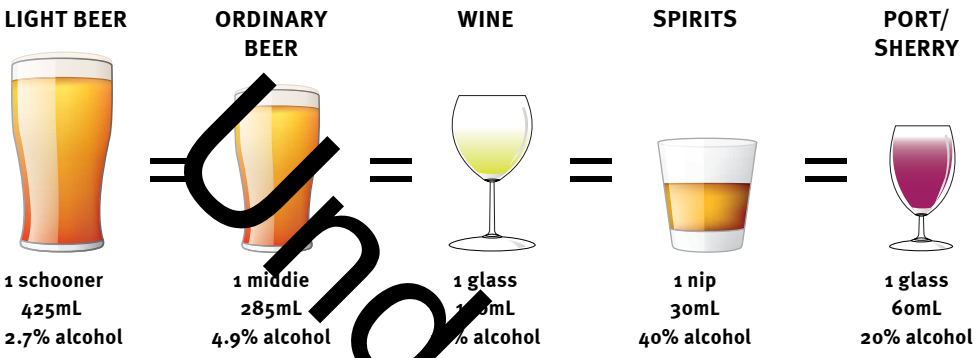
- Young adults aged 18-25 years.
- Older people aged over 60 years.
- People with a family history of alcohol dependence.
- People who use drugs illicitly.

A range of people may need to seek professional advice about drinking because of the possibility of interactions and harmful effects. This include:

- Anyone taking medication, either over the counter or prescription.
- People with alcohol-related or other physical conditions that can be made worse or affected by alcohol.
- People with mental disorders.

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:



One of the simplest tools for screening for alcohol abuse is the AUDIT tool:
www.smartrecoveryaustralia.com.au/HealthProviderAUDIT.pdf
Clinicians are encouraged to utilise this screening tool as a routine part of patient care.

The detection of alcohol and drug use even at these low consumption levels will inform treatment formulation and a person's care. Initial screening is paramount to ensure that a person is receiving appropriate and safe treatment.

Where to next?

Once you have conducted the initial screen consideration of whether a more detailed assessment is required. If a screening tool indicates a positive response to either a potential alcohol or other drug problem or mental disorders, more detailed assessment is warranted. Mental Health Service and Alcohol, Tobacco and Other Drugs Services Consultation Liaison Officers are available in many health service districts to assist with the provision of a comprehensive Mental Health and AOD assessment.

Refer to your local Health Service District protocols to involve a specialist Mental Health clinician or Alcohol, Tobacco and Other Drug Service clinician to provide a comprehensive assessment of these issues.

Further reading

Croton 2007, Screening for and assessment of co-occurring substance use and mental health disorders by Alcohol and Other Drug and Mental Health Services, Victorian Dual Diagnosis Initiative Advisory Group, Victoria.

For more information and resources on related topics, see the resources provided by Alcohol and Drug Information Service (ADIS) Metro North Health Service District Alcohol and Drug Service, freecall 1800 177 833 24 hours a day 7 days per week.

DrugInfo Clearinghouse (http://druginfo.adf.org.au/) is a service provided by the Australian Drug Foundation (ADF) and functions as a drug prevention network, providing easy access to information about alcohol and other drugs, and drug prevention.

For information on the management of withdrawal please refer to the Queensland Health Clinical Protocols for Detoxification in Hospitals and Detoxification Facilities 2002 please visit www.health.qld.gov.au/atods/documents/24904.pdf

Information regarding the Management of patients with Psychostimulant toxicity Protocols for Emergency Departments Mar 2008 please visit www.health.qld.gov.au/atod/documents/psychostimulant_toxic.pdf

For more information on the assessment, management and care of people with co-occurring mental health and alcohol and other drug problems please refer to Queensland Health Dual Diagnosis Clinical Guidelines (in draft due for release mid-late 2010).

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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, 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.

So many things went wrong — the whole experience was horrendous. I arrived early on the morning of the procedure, and had followed the direction 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 okay?' and to help me identify what supports I could call on.
- Intervention when I was showing obvious signs of distress (for example, pacing the floor and 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 two 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 three 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.

Acknowledgments

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Advocart

Consumer voices

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