contents

RECOVERY AND RECOVERY-ORIENTED PRACTICE 4
Recovery 'Star' 5
MENTAL STATE EXAMINATION (MSE) 5
Key areas of assessment 6
SELF-HARM RISK ASSESSMENT 7
Assessing for potential risk of suicide 7
MENTAL ILLNESS: AN OVERVIEW 10
Definitions 12
SIGNS OF MENTAL ILLNESS 13
Symptoms associated with depression, mania and anxiety 14
Possible signs of mental health problems 16
MEDICATIONS USED IN MENTAL HEALTH 17
NEUROLEPTIC MALIGNANT SYNDROME (NMS) 22
Medications associated with NMS 22
Extra pyramidal side effects (EPSE) 24
ASSESSING SPECIFIC MENTAL HEALTH PROBLEMS 25
Pre- and postnatal depression 25
Geriatric depression 28
Assessing risk of self-harm 30
TOPICS FOR PSYCHO-EDUCATION 32
EMERGENCY DEPARTMENT (ED) MENTAL HEALTH TRIAGE 34
Treatment acuity 34
MEDICATION SAFETY 37
Written medication orders 38
Telephone medication orders 39
Medication dosages 39
Medication routes 40
Metric equivalents 41
DRUG SCHEDULING SYSTEM 42
INTOXICATION 43
Standard drinks 43
Features of intoxication 45

Sample pages

CLINICAL HANDOVER TIPS 46
ISBAR 46
CLINICAL DOCUMENTATION 50
The SOAP approach 50
Example of an inpatient clinical audit tool 51
QUICK RELAXATION TECHNIQUES 53
COMMON ABBREVIATIONS 55
USEFUL RESOURCES 57
ENDNOTE CREDITS 59
ADDITIONAL REFERENCES 62

Sample pages

This guide is based on the view that the discipline of mental health nursing occurs within a primary health care framework and in partnership with consumers. Within this worldview, mental illness is seen as only a part of the person, with recovery from mental illness the aim. A *recovery* approach is the hallmark of contemporary models of mental health nursing care.

The guide has been designed as a quick reference for students and beginning practitioner mental health nurses. It is not intended to be a replacement for a more comprehensive mental health text or to override a mental health nurse's accountability or compliance with professional regulatory or organisational policies. Additional generic medication safety information has been included to support the mental health nurse in clinical practice. (ACMHN, <www.acmhn.org>)

While every effort has been made to ensure that the content of this guide is accurate, no responsibility will be taken for inaccuracies, omissions or errors. This is a guide only. The authors do not accept liability to any person for information obtained from this publication or for loss or damage incurred as a result of reliance upon the material contained in this guide.

Sample pages

Recovery and recovery-oriented practice[1]

The concept of *recovery* emerged from the consumer movement in the 1970s and 1980s and continues to be utilised and further developed by people with lived experience.

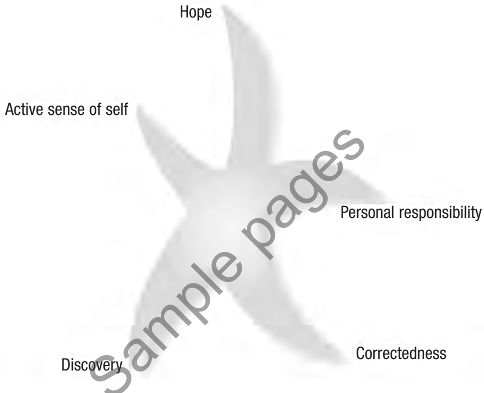
Recovery-oriented practice describes an approach to mental health care that encompasses principles of self-determination and individualised care. A recovery approach emphasises hope, social inclusion, goal-setting and self-management, and includes the following principles:

- self-direction and self-determination
- empowerment of consumers
- individualised and person-centred care
- holistic and integrated care
- non-linear journeys of personal growth and healing
- strengths-based approaches
- peer support.

Sample pages

RECOVERY 'STAR'[2]

The Star symbol was designed to reinforce the five common elements identified as necessary in supporting individual people with their recovery.



Sample pages

Mental state examination (MSE)

The MSE is an important part of the clinical assessment. It is a structured, systematised way of observing and then describing a consumer's current emotional state and physical appearance. Specific domains guide the MSE. These are appearance and behaviour, mood, affect, speech, thought form, thought content perception, insight/judgement and cognition.

KEY AREAS OF ASSESSMENT

DOMAINS	ISSUES TO EXPLORE
Appearance and behaviour	What does the consumer's grooming, posture, clothing, height and weight, psychomotor activity, mannerisms and gait look like?
Mood	What the consumer actually describes about how they are feeling—e.g. I feel depressed, I am really elated (subjective).
Affect	What you (the nurse) observe—e.g. the consumer appears perplexed, their affect is blunted (objective).
Speech	What is the consumer's speech like? Assess the rate, volume and flow—e.g. is it pressured speech, loud, quiet?
Thought form	Are the consumer's thoughts coherent—e.g. continuity of ideas, tangential, disturbance in language or meaning?
Thought content	What is the consumer actually thinking about—e.g. delusions, suicidal thoughts, obsessions, phobias?
Perception	Is the consumer admitting to or demonstrating signs of hallucinating or having illusions?

Sample pages

DOMAINS	ISSUES TO EXPLORE
Insight/ judgement	Does the consumer have an awareness and understanding of their illness? Can the person describe the early warning signs that they are becoming unwell? What illness does the consumer think they have? What triggers their illness? What does the consumer think is wrong? What brought them to seek help?
Cognition	Is the consumer oriented to time, place and person? What is their short-term and long-term memory like? Can they concentrate? For how long? Can they think in an abstract manner?
Risk	Is the consumer at risk of self-harm? Is anyone else at risk of harm from the consumer? Is there a risk of dependence or institutionalisation?

Sample pages

Self-harm risk assessment

ASSESSING FOR POTENTIAL RISK OF SUICIDE

- Is there a history of suicide attempts or self-mutilation?
- Is there a family history of suicide attempts or completion?
- Is there presence or a history of a mood disorder, or drug or alcohol misuse?
- Does the consumer have a mental illness (depression, schizophrenia, bipolar disorder)?

- Does the consumer have a history of chronic physical illness, chronic pain or recent surgery?
- Does the consumer have thoughts about harming self?
- To what extent does the consumer feel hopeless?

Example of how an MSE might be documented in nursing notes

Appearance and behaviour

Farid is a 31-year-old Lebanese/Australian man of average height and weight. At the time of the interview, he was well groomed and dressed neatly and casually in clean jeans and polo shirt. During the interview, Farid displayed no signs of tremor or abnormal movements. Farid was cooperative and pleasant, answering all questions without hesitation. Eye contact was maintained throughout the interview and posture was upright. He smiled appropriately during the interview. Farid's behaviour changed when he started talking about his brother. He became agitated and moved about in his seat. He also started to fiddle with his hands. He said that speaking about his brother, who had died from cancer, made him really sad. Farid said that it was the anniversary of his brother's death in one week.

Sample pages

Mood: When Farid was asked how he felt, he said that he was 'depressed'. He stated he 'wanted to die' and that he 'did not see what there was to look forward to'. He said, 'I would be better off dead.'

Affect: For the most part, Farid displayed a poor range of emotions during the interview. He did not look

depressed. His affect changed when speaking of his brother. He became physically agitated, wringing his hands and was unable to sit still.

Speech: Farid articulated himself clearly. He answered questions spontaneously at a normal rate and rhythm. He spoke evenly throughout the conversation, except when he started to speak about his brother. At this time he spoke more loudly and more quickly.

Thought form: Farid did not exhibit any formal thought disorders. He was able to answer questions spontaneously and directly. He did not use any new or created words. Farid did experience thought block when exploring sensitivities in his past, particularly related to the death of his brother. No negative thought disorder was apparent.

Thought content: Farid was anxious about his physical health. He was obsessed with knowing his blood results and was constantly asking to see them. Thoughts that the tiredness was related to cancer were causing Farid to lack motivation and feel depressed. Other than appearing obsessed regarding blood results, Farid has no other positive symptoms, such as delusions, phobias or compulsions.

Perception: Perceptual disturbances were not noted during the MSE. Symptoms, such as illusions, misinterpretations, depersonalisation, passivity phenomena, were not elicited. There was also no indication of alterations to sensory perception. Farid denied any symptoms related to auditory, gustatory, olfactory, tactile or visual hallucinations.

Sample pages

Insight and judgement: When questioned about his condition, Farid accepted the fact that he is ill and that he requires treatment. He did not feel as though anything would work as he was 'too depressed' but was cooperative and was compliant with management.

Cognition: Farid was alert and orientated to person, time and place. He was able to answer questions and recall his past without difficulties.

Risk: Suicidal ideation was not detected, and his risk of self-harm was assessed as being low. Farid was asked if he wanted to harm himself and or others—he said no.

Sample pages

Mental illness: An overview[3]

The following lists give a quick overview of issues related to mental illness and mental health.

Statistics from the 2007 National Survey of Mental Health and Wellbeing[a]

- Almost half the total population (45.5%) experience a mental health disorder at some point in their lifetime.
- One in five, or 20% of the Australian population aged 16–85 years, experienced mental disorders in the previous 12 months [of their survey]. This is equivalent to 3.2 million Australians.
- One in 16 (6.2%) had affective (mood) disorders; one in seven (14.4%) had anxiety disorders; and one in 20 (5.1%) had substance abuse disorders.