NUR5006 – Mental Health Nursing

NUR5006 – MENTAL HEALTH NURSING 1

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Intro Content
Background, Legislation/Policy

DEFINITIONS
Mental Health = a state of mental well-being that enables people to cope with stresses of life, realise their abilities, learn well and work well, and contribute to their community - Mental health is a continuum and we can think of every one as walking on this continuum and being capable of being in different states at different points rather than thinking of people as mentally well or ill. Mental Illness = a wide range of mental health conditions that affect a person's thinking, feeling, mood, and behaviour which can significantly impact daily function and quality of life. - WHO – a mental disorder that has a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour. Usually associated with distress or impairment in important areas of functioning. - Diagnostic Statistical Manual 5 (DMS5) – a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or development processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above - **Mental Health and Wellbeing Act 2022 (VIC)** = mental illness is a medical condition that is characterised by a significant disturbance of thought mood, perception, or memory ○ **CRITIQUE of this definition:** note that it specifically states a 'medical condition' but that could be very limiting and also introduces stigmatization Protective Factors = conditions or attributes that help individuals cope with stress and reduce the likelihood of developing mental health issues Statistic Risk Factors = age, gender, family history, are unchangeable and provide a baseline level of risk for an individual developing a mental illness

Dynamic Risk Factors = Current mental health status, substance use, and social support are modifiable risk factors for developing mental illness that fluctuate over time

DETERMINANTS OF MENTAL HEALTH WELLBEING

Emotional Well-Being	The ability to manage emotions and express them appropriately - E.g. experiencing a range of emotions, and being able to handle them in a healthy way
Psychological Well-Being	Having positive outlook on life, feeling good about oneself, and having a sense of purpose and meaning. - E.g. being able to think clearly, make decisions, or solve problems
Social Well-Being	Building and maintaining healthy relationships with others. - E.g. effective communication, empathy, and ability to form and sustain meaningful connections
Resilience	Capacity to bounce back from adversity, stress, and challenges. Resilient individuals can adapt to difficult situations and maintain a positive attitude
Self-Care	Engaging in activities that promote physical, emotional, and mental health. - E.g. regular exercise, balanced diet, adequate sleep, relaxation techniques
Balance	Maintaining healthy balance between work, leisure, and relationships. Helps to prevent burnout and ensures all aspects of life are given attention

MENTAL HEALTH AND WELLBEING PERSPECTIVES

Biomedical	Overview: Uses a medical framework to make sense of the problem and employs a medical solution to treat the problem. Predominant Australian healthcare perspective Treatment: Designed to target and alleviate symptoms by addressing underlying biological cause. E.g. use medications or electroconvulsive therapy Criticisms: reduces the human experience to biological components. E.g. Medicating a person experiencing depression during a serious overwhelming life event may pathologize normal variations in human behaviour and emotion. Generates feelings of hopelessness, promoting dependence, and fostering stigma.
Psychological	Overview: Focuses on how cognitive, emotional, motivational, attitudinal and behavioural processes lead to mental health problems Treatment: Psychotherapy and counselling e.g. cognitive behavioural therapy (CBT), psychodynamic psychotherapy, motivational interviewing Criticisms: Mental health problems may be determined by other factors external to person e.g. social or economic circumstances. Approach to treatment may not go beyond individual level
Socioecological	Overview: Perspective recognises that although individual characteristics (biological and psychological) may contribute to distress and illness, cause is not simply located w/I individual. Experiences are result of interactions between individuals and environment. Societal factors therefore increase persons rick for poor mental health Treatment: Community-based programs, social support networks, addressing systemic issues that contribute to mental health disparities

	Criticisms: Perspective would be less relevant for disorders that have been found to be mostly caused by genetic variants
Recovery	Overview: Focus is not on reduction of symptoms (or disease-diagnosis-deficit), instead it is on person's overall wellbeing and quality of life. Idea of who has the professional expertise and knowledge is flipped, the person with the lived experience is privileged not the healthcare professional Treatment: Approaches to treatment are approached from holistic view of wellbeing and a collaborative approach e.g. goal-setting, peer support Criticisms: Criticised for not having true practical implications

THE BIOPSYCHOSOCIAL MODEL

A model of mental health that is a comprehensive approach that considers **biological**, **psychological** and **social factors** in understanding and treating mental health conditions. Looks at the interplay between factors.

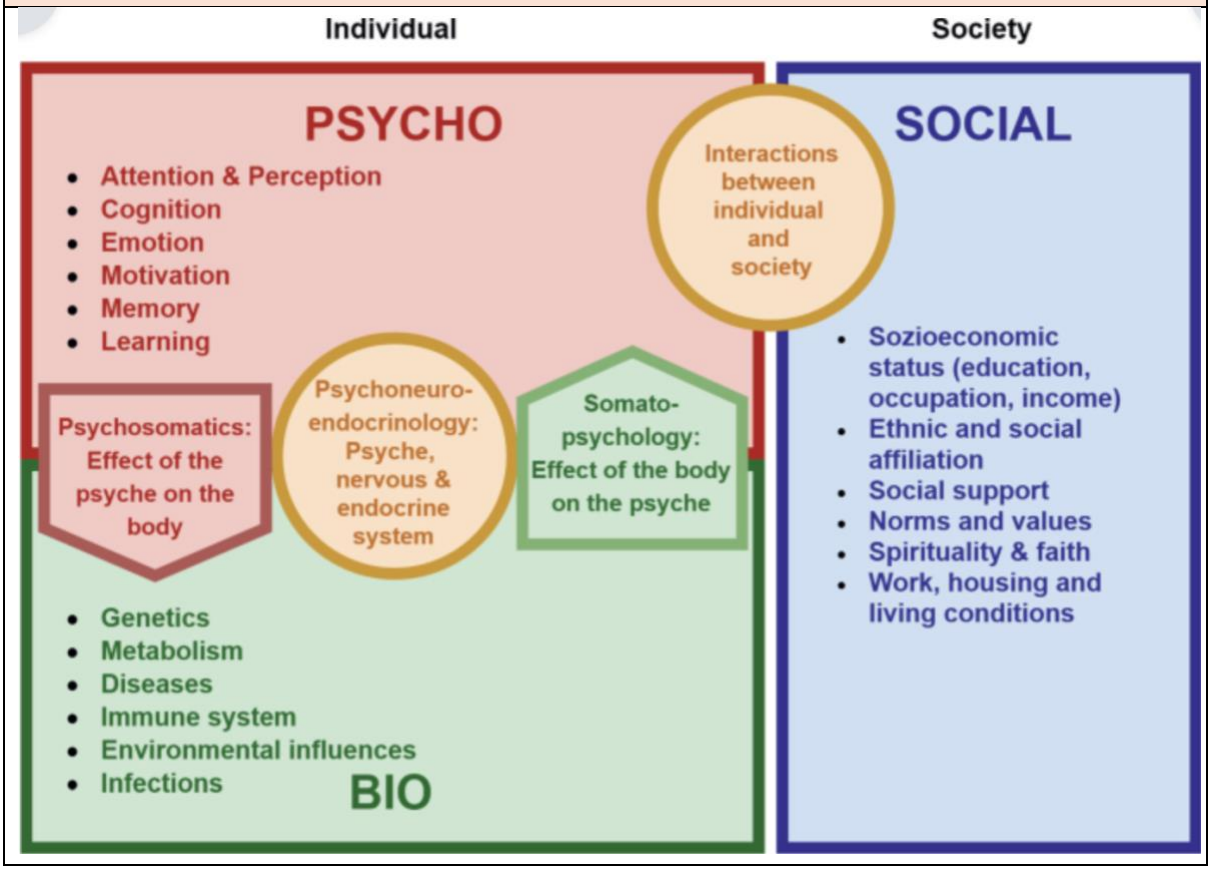
Risk Factors increase the likelihood of developing mental illness while **Protective Factors** reduce.

Factors are important for understanding prevention and intervention strategies.

Biological Factors	- Genetics: FHx and genetic predisposition (risk) - Neurochemistry: imbalances in neurotransmitters (e.g. serotonin and dopamine) (risk) - Brain Structure: Abnormalities in brain structure and function (risk) - Physical Health: Chronic illnesses, hormonal imbalances, other physical health issues (risk)
Psychological Factors	- Cognitive Processes: Patterns of thinking, perception, interpretation of events (risk or protective)

	- Emotional Regulation: Ability to manage and express emotions effectively plays a crucial role in mental well-being (protective) - Personality Traits: Resilience and optimism and treats that affect ability to cope with stress and adversity (protective) - Trauma and Stress: Past experiences of trauma and ongoing stress (risk)
Social Factors	- Social Support: Strong relationships and supportive social network (protective) - Cultural Influences: Cultural beliefs, values and practices that shape one's attitude towards mental health and influence coping strategies (risk or protective) - Socioeconomic Status: Economic stability, access to education, and employment opportunities (risk or protective) - Environmental Factors: Living conditions, community safety, access to healthcare services (risk or protective)

INTEGRATION OF FACTORS



MENTAL HEALTH NURSES' ROLE

Holistic approach to ensure pts receive comprehensive support tailored to unique needs

Assessment and Diagnosis	- Conduct comprehensive assessments of patients' mental health status - Collaborating with other healthcare professionals to diagnose mental health conditions
Treatment and Care	- Developing and implementing individualized care plans - Administering medications and monitoring effects - Providing therapeutic interventions, such as counselling and psychotherapy - Supporting patients in managing their symptoms and improving their quality of life
Patient Education and Support	- Educating patients and their families about mental health conditions and treatment options - Offering support and guidance to help patients cope with their conditions
Crisis Intervention	- Responding to mental health crises and providing immediate care and support - Working with emergency services to ensure patient safety
Advocacy	- Advocating for patients' rights and ensuring they receive appropriate care - Promoting mental health awareness and reducing stigma
Collaboration	- Working as part of a multidisciplinary team, including psychiatrists, psychologists, social workers, and other healthcare professionals - Coordinating care and ensuring continuity of treatment
Community Engagement	- Engaging with community resources and support networks to provide holistic care - Facilitating access to social services and community programs

Stigma and Discrimination

Types of Stigma	
Public Stigma	Negative attitudes and beliefs held by general public towards people with mental health conditions - Leads to discrimination, social exclusion, reduced opportunities in employment and education
Self-Stigma	Internalized negative beliefs and feelings that people with mental health conditions may hold about themselves - Can result in feelings of shame, guilt, and low self-esteem
Institutional Stigma	Policies and practices within institutions (e.g. healthcare, education, workplace) that systematically disadvantage people with mental health conditions

Consequences of Stigma	
Reduced Help-Seeking	Prevent people from seeking help and accessing mental health services due to fear of judgment and discrimination
Social Isolation	Experiences of social isolation and exclusion from social activities and relationships due to stigmatization
Worsening Symptoms	Stress and anxiety caused by stigma can exacerbate mental health symptoms and hinder recovery
Economic Impact	Lead to unemployment or underemployment, resulting in financial instability and reduced quality of life

Importance of Language

- Clear, compassionate, and respectful communication can significantly impact well-being and recovery of persons with mental health conditions
- See: https://mhcc.org.au/wp-content/uploads/2022/10/Recovery-Oriented-Language-Guide-3rd-edition.pdf

LEGISLATION AND POLICY

Legislation shapes mental health care and is designed to ensure rights and well-being of people with mental health conditions. They provide guidelines for: (i) treatment, (ii) care, (iii) protections for people experiencing mental health issues, (iv) aim to promote access to services, (v) protect the rights of patients, (vi) ensure mental health care is humane and respectful

KEY ASPECTS OF MENTAL HEALTH LEGISLATION AND POLICY	
Protection of Rights	Ensure treatment is done with dignity and respect, and rights are protected
Access to Care	Facilitating access to mental health services and support for individuals, regardless of background or circumstances
Involuntary Treatment	Providing clear guidelines for when and how people can be treated involuntarily, typically in cases where they pose a risk to themselves or others
Family and Carer Involvement	Recognising important role of families and carers in treatment and support of people with mental health conditions
Human Rights Considerations	Aligning mental health care with international human rights standards to ensure faire and equitable treatment

The Mental Health and Wellbeing Act (2022) (VIC)

(MHWB) Act

The act provides a framework for the treatment of those receiving mental health care such as: (i) emphasising autonomy and dignity, (ii) involvement in decision making and treatment, (ii) recognises the role of families and caregivers

The Act also provides a framework for the detention and treating of people in designated mental health services.

There is criticism that the current 2022 act still allows for the violation of mental health patient's human rights

Note: pts can be under the Act while receiving treatment elsewhere, i.e. on an oncology ward you work on. So, you still need to know the legislation even if you are not working in a mental health dedicated atmosphere.

13 Mental Health and Wellbeing Principles

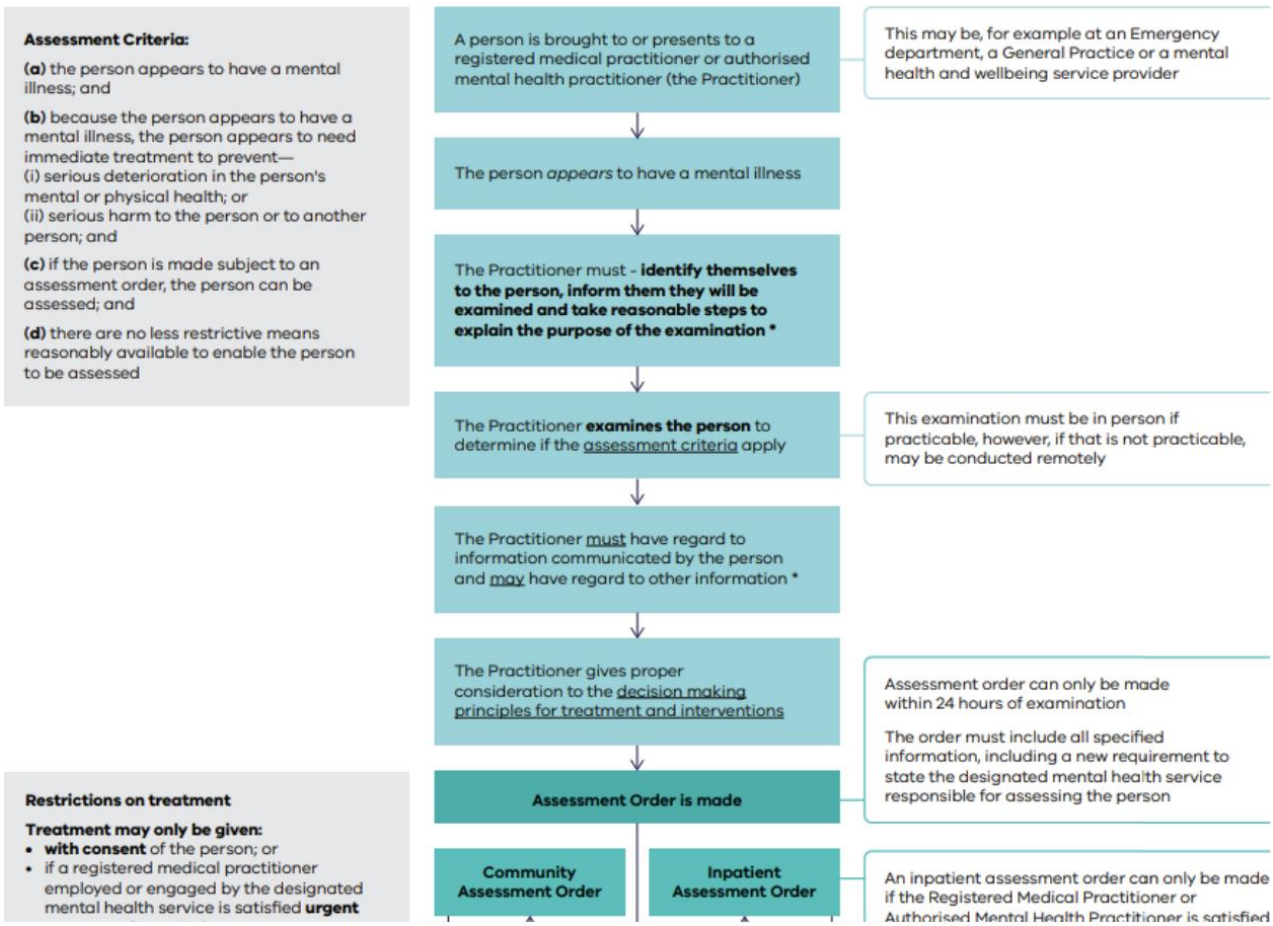
https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/context-of-the-act/mental-health-and-wellbeing-principles

Involuntary Assessment and Treatment

Treatment for those who do not recognise they are unwell, considered a 'lack of insight'. Important to always consider how those individuals must feel when they believe they have essentially been abducted, locked away, and forced to take meds with side effects that affect their everyday life such as sexual function

COMPULSORY TREATMENT AND RESTRICTIVE INTERVENTIONS	
Assessment Orders	The first step in initiating compulsory mental health treatment – authorises compulsory examination to discern if someone needs compulsory treatment - Authorised by: registered mental health practitioner or authorised mental health practitioner Criteria for assessment: (i) person appears to have mental illness, (ii) personal appears to need immediate treatment to prevent with serious deterioration in mental or physical health AND/OR serious harm to person or to another person, (iii) if the person is made subject to an assessment order, person can be assessment, (iv) there are no less restrictive means reasonable available to enable the person to be assessed - If the assessment order deems that someone requires treatment, they may then be subject to a temporary treatment order after assessment by a psychiatrist

Temporary Treatment Orders (up to 28 days)	Authorises person being detained and taken into mental health facility to be subject to treatment as an inpatient. Compulsory Temporary Treatment Order Criteria: (i) person has a mental illness, and (ii) because of the mental illness, the person needs treatment to prevent deterioration in their mental or physical health; AND/OR to prevent serious harm to the person or another person, (iii) if person is made subject to treatment order or a treatment order the immediate treatment will be provided to the person, and (iv) there are no less restrictive means reasonably available to enable the person to receive the immediate treatment
Treatment Orders (3 months if under 18. 6 months over 18)	When a temporary treatment order is coming to an end but it appears someone requires further treatment. A tribunal reviews the case and can make a Treatment Order - Only difference from the above temporary treatment order is that it is for a longer duration
Questions to run through	1) Does the person appear to have a mental illness? 2) Do they appear to need IMMEDIATE treatment to prevent: (a) serious deterioration in the person's mental or physical health, (b) serious harm to the person or to another person 3) If the person is made subject to assessment order, can the person be assessed? 4) Are there NO LESS RESTRICTIVE means REASONABLY available to enable assessing the person? If the answer to any of those questions were no, an assessment order could not be made



Statement of Rights

A Statement of Rights provides information relevant to a person's circumstances. Must be provided to everyone receiving mental health treatment at a designated mental health service. That includes those admitted under the MHWB Act and those admitted voluntary. Statement of Rights must be provided every time a patients legal status changes.

INFORMATION INCLUDED IN A STATEMENT OF RIGHTS They have a right to:
Information, support and help making decisions
Communicate
Feeling safe and respected
Make an advance statement of preference
Choose a nominated support person
Apply to the Mental Health Tribunal for a revocation of a compulsory treatment order
Seek a second psychiatric opinion

Code Grey

Code greys occur when a client loses verbal or behavioural control. It is a hospital-wide coordinated clinical and security response to actual or potential aggression or violence and

- Students are not expected to restrain a client as they have no had appropriate training but we may be instructed to hold the door open or be directed to stay with co-clients

Restraints

- Common chemical restraints = Diazepam, Olanzapine, and Risperidone
- Vital to use least restrictive method of administration
    - Start with tablets and syrup. Only resorting to intramuscular last
- Minimise the type and range of medications administered to minimize incidences Neuroplastic Malignant Syndrome (NMS) and other side effects
- Close attention to vitals after the administration of chemical restraint medications is essential – esp if client has not taken before as the meds can cause respiratory depression.

Psychosis and Psychotic Disorders

DEFINITIONS
Delusions = False beliefs that are not based in reality
Hallucinations = Seeing, hearing, or feeling things that are not there
Disorganised Thinking = Incoherent or nonsensical speech
Disorganised Behaviour = Unpredictable or inappropriate actions
Negative Symptoms = Reduced ability to function normally, such as lack of emotion or motivation
Hallucinations = - Auditory = perceiving sounds (voices or noises) - Visual = seeing things that aren't there - Tactile = involve the feeling of touch or movement in your body - Olfactory = smelling something that isn't there - Gustatory = tasting things that aren't there
Emotional Blunting = not displaying any emotion whether positive or negative

PSYCHOSIS

Psychosis or a psychotic episode is a group of symptoms that may include hallucinations, delusions or disorganised speech and behaviour. Psychosis is a symptom of psychotic disorders which can be caused by medications, substances, or other cognitive disorders like Parkinson's. Note that symptoms such as hallucinations can occur in more circumstances than those experiencing schizophrenia.

PSYCHOTIC DISORDERS

Severe mental illnesses that cause abnormal thinking and perceptions. Can cause a disconnect from reality and the person can experience several episodes of psychosis

<table>
<tr><th colspan="3">PATHOPHYSIOLOGY</th></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><th colspan="3">BIOPSYCHOSOCIAL FACTORS</th></tr>
<tr><td colspan="2">Genetic Factors: family history of psychotic disorders = a higher risk of developing the condition</td><td>Environmental Factors: stressful life events, trauma</td></tr>
<tr><td colspan="2">Brain Chemistry: imbalances in neurotransmitters</td><td>Medical Conditions: diseases like Parkinson's, Alzheimer's, or brain tumours</td></tr>
<tr><th colspan="3">CLINICAL MANIFESTATIONS</th></tr>
<tr><td>Delusions</td><td>Hallucinations</td><td>Disorganised Thinking</td></tr>
<tr><td>Disorganised Behaviour</td><td>Negative Symptoms</td><td></td></tr>
<tr><th colspan="3">COMMON PSYCHOTIC DISORDERS</th></tr>
<tr><td>Schizophrenia
Characterised by delusions, hallucinations, disorganised thinking, and impaired functioning</td><td>Schizoaffective Disorder
Features symptoms of both schizophrenia and mood disorders, such as depression or bipolar disorder</td><td>Delusional Disorder
Involves persistent delusions w/o other major symptoms of psychosis</td></tr>
<tr><td>Brief Psychotic Disorder
A short-term condition with sudden onset of psychotic symptoms,</td><td>Substance/Medication-Induced Psychotic Disorder:</td><td>Psychotic Disorder due to Another Medical Conditions:
Caused by medical conditions like brain</td></tr>
</table>

lasting less than one month	Triggered by the use of certain drugs or medications	injuries or neurological disorders

SCHIZOPHRENIA

Characterised by thoughts or experiences that seem out of touch with reality, disorganised speech or behaviour and decreased participation in daily activities.

Tends to develop in late adolescence to early adulthood. 5 cases per 1000 experience psychosis, almost half of these were diagnosed with schizophrenia. Generally, develops late adolescent to early adulthood

Note that those with schizophrenia have poor health outcomes.

PHASES OF SCHIZOPHRENIA		
1) Prodromal	**2) Psychotic**	**3) Residual**
Decline in functioning. Early signs and symptoms. E.g. begins social isolating, doesn't partake in old activities, possibly more irritable	Symptoms such as perceptual disturbances, delusions and thought disorder. Generally, the positive symptoms of schizophrenia.	Between episodes of psychosis, flat affect, social withdrawal, odd thinking & behaviours
POSITIVE SYMPTOMS		
Symptoms that are in excess or distortions of common/ordinary experiences		
Hallucinations	**Delusions**	**Disorganised Behaviour**
False sensory perception concerning one or more senses: Auditory, visual, tactile, gustatory, olfactory	e.g. Fixed false beliefs, that are inconsistent with a person's normal social, cultural, religious beliefs. E.g. Somatic, grandiose	e.g. incongruent affect, abnormal motor behaviour, act childlike, poor ADL attention, inappropriately dressed
NEGATIVE SYMPTOMS		
Symptoms that take away from or suggest a deficit in relation to a common experience		
Social Withdrawal	**Apathy (disinterest in activities)**	**Lack of Motivation and Drive**

Emotional Blunting	**Having Few Words or Expressions**	**Attention Impairment**
NURSING CONSIDERATIONS AND CARE		
Establish trust and rapport	**Maximise level of functioning**	**Promote social skills**
Ensure adequate nutrition	**Keep it real**	**Deal with hallucinations**
Promote adherence to treatment and monitor pharmacotherapy	**Create caring, safe, compassionate environment**	**Approach with empathy, patience, and understanding**

Communicating with Someone Experiencing Psychosis

GENERAL APPROACHES		
Acknowledge and Validate their Experience Do not ignore what they've said, they can be experiencing a lot of distress	**Explore what They are Experiencing**	**Acknowledge your Understanding**
Avoid Arguing with the Person	**Be Aware of Non-verbal Communication**	**Slow paced speech and short sentences with simple vocab**
Repeat when necessary	**Maintain calm, quiet tone**	

Nursing Considerations

ESTABLISH THERAPEUTIC RAPPORT	Build trust and be honest
PERSON CENTRED	Be responsive to the person's immediate needs using active listening skills, being supportive and providing reassurance

ENCOURAGE CONSUMER TO DISCUSS FEELING AND THOUGHTS	Acknowledge, validate, clarify and empathise with their experience Encourage them to come to you when they are experiences hallucinations Ask clients with regular hallucinations if they've experienced any today Tell them thank you when they share what they're experiencing and that its brave of them if they came to you on their own to discuss what they are experiencing.
SAFETY TO SELF AND OTHERS	People experiencing psychotic episodes may be agitated, irritable, or aggressive. Don't keep pushing questions that are agitating someone Keep yourself safe Assess if they feel safe on the ward but do not ask them something like "do you think there are cult members on the ward" you can end up making them paranoid of the people around them. So leave it minimal with simple questions like "do you safe on the ward" Remain calm in verbal and nonverbal communication Suicide precautions (note that while increasing visual obs is helpful, it's also good to make it varied. Some people will time how often you're coming around so they can self-harm or attempt to end their life when they know your schedule)
SENSORY MODULATION	Targeted sensory input can produce calmer states in people with mental health conditions or distress and reduce sensory disturbances Quiet, low stimulus room to support person in managing symptoms Headphones and music can also aid in distraction and disturbances
SUPPORT WITH BEHAVIOURAL AND SOCIAL SKILLS	Consumer may require support with ADLs, behavioural skills like prioritising tasks, problem solving and support with social skills Required to increase functioning and reduce the likelihood of relapse