Mental Health Nursing
    Is a specialized area of nursing practice
    Employs both the science and art of nursing
        Science
        Art
    Found in nearly every nursing specialty

Evolution of Mental Health Treatment
    Early Christian period (1-100 AD) → exorcisms, removal of bone from the skull
    16th Century Asylums → Inhumane conditions
    18th Century → More humanitarian view
    19th-20th Century Asylums became overcrowded
        Lobotomies, electro-convulsive shock therapy
    1950's → Psychiatric drugs became available (Thorazine & Lithium)
    Institutionalization → negative outcomes
        Social isolation
        Few educated nurses & trained mental health providers

Deinstitutionalism
    1965 → Release of patients confined to mental institutions into the community
        Disorders could be easily treated
        Symptoms would disappear
    The history of the care and treatment of the mentally ill represents an endless journey between two extremes:
        Confinement in a mental hospital
        Living in the community
Results of Deinstitutionalism
    Community Mental Health Centers
        Treatment of drug & alcohol addiction
    By the 1990's deinstitutionalization was considered a failure
    Jails & Prisons
        2 in 5 adults incarcerated in the state and federal prison system have a mental illness
        70% of youth in the juvenile justice system have a diagnosed mental illness
    Homelessness grew dramatically
        21.1% are seriously mentally ill
        45% have any mental illness

Contemporary Mental Health Care
    Recovery from mental illness is realistic and a world-wide goal
    Collaborative health care model
        Partnership in recovery-oriented care
    Client advocacy

Mental Health- Definition
    Successful performance of mental functions, resulting in the ability to
        engage in productive activities
        enjoy fulfilling relationships
        adapt to change

cope with adversity
It is the foundation of:
thinking
communication skills
learning
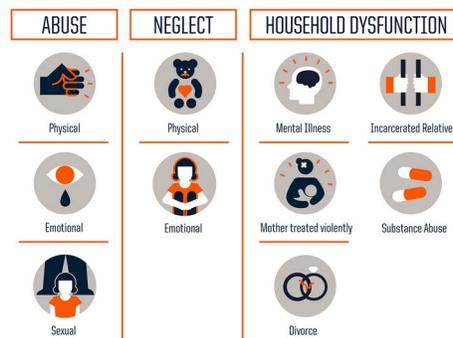emotional growth
resilience
self-esteem

Attributes of Mental Health
Accurate appraisal of reality
Ability to love and experience joy
Think clearly
Problem solve
Use good judgment
Reason logically
Be creative
Ability to control one's own behavior
Capacity to deal with conflicting emotions
Ability to take responsibility for one's own actions

Children and Mental Health
Adverse Childhood Experiences (ACEs)
Traumatic events that occur in childhood
Experiencing violence, Abuse, Neglect
Witnessing violence
Having a family member attempt or complete suicide
The child's environment plays a role
Substance abuse, mental illness, divorce, incarceration
Three Types of ACEs

ABUSE	NEGLECT	HOUSEHOLD DYSFUNCTION	
Physical	Physical	Mental Illness	Incarcerated Relative
Emotional	Emotional	Mother treated violently	Substance Abuse
Sexual		Divorce	

Resilience
The process of adapting well in the face of
adversity
trauma
tragedy
threats
significant sources of stress (family, relationship, health problems, work, and financial)
As much as resilience involves "bouncing back" from these difficult experiences, it can also involve profound personal growth.
How do we increase our resilience?
Build your connections
Prioritize your relationships

Take care of yourself
Avoid negative outlets
Find your purpose: "What's one thing I know I can accomplish today that helps me move in the direction I want to go?"
Accept change
Learn from your past

Trauma Informed Care
Trauma is found in universally in mental health patients and is a contributor to:
Substance Abuse
Chronic Health Conditions
Trauma occurs in many forms
Physical, Sexual, Emotional Abuse
War, Natural Disasters, Global Pandemics
Shift your questioning
"What is wrong with you" → "What has happened to you"
Avoid retraumatizing
Open & collaborative relationship
Patient-centered care

Definition – Mental Illness
▶ "Mental illnesses are health conditions involving changes in emotion, thinking or behavior. Mental illnesses are associated with distress and/or problems functioning in social, work or family activities."
— *American Psychiatric Association*

Diagnostic and statistical manual of mental disorders (DSM-5)
Official guidebook for categorizing and diagnosis psychiatric mental health disorders
Used by: psychiatrists, psychiatric NPs, therapists,
Guide for assessing, diagnosing, and planning care
DSM-5 lists specific diagnostic criteria for each mental health disorder

Mental Health—Mental Illness Continuum

Mental Health — Mental Illness Continuum
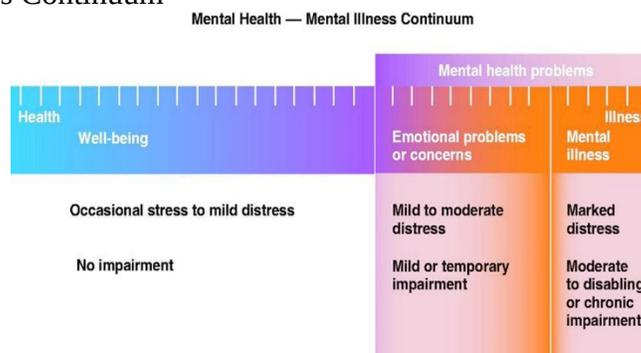
Prevalence rates
The prevalence rate is the proportion of a population with a mental disorder at any given time
1 in 5 adults experience mental health conditions/ year
Dual diagnosis/ co-occurring disorders
Lifetime prevalence= 50%

Who is at risk for developing a mental illness?
Lack of social support

Housing inaccessibility
Adverse childhood experiences and trauma
Unemployment or underemployment
Food insecurity
Lack of access to or poor quality of physical/mental health care
Educational inequities
Income inequities
Unhealthy or unsafe surroundings/neighborhood

What are the barriers for mental health care?
Lack of available treatment options or providers
Inadequate transportation, childcare, or unable to take time off work.
Held belief that mental health treatment "does not work"
High level of mental health stigma in cultural or ethnic group
Racism, bias, and discrimination in treatment settings
Language barriers or lack of providers who speak languages other than English
Lack of adequate health insurance coverage

Stigma
Stigma is a "collection" of:
Negative attitudes, beliefs, thoughts, and behaviors that influence the individual and general public.
Effects of Stigma
Avoiding healthcare
Low self esteem
Feeling Discriminated Against
Nurses should → learn more, be nonjudgmental, have meaningful connections

Mental Health Theories & Therapies:
Sigmund Freud's Psychoanalytic Theory
Id, Ego, Superego

Defense mechanisms
Freud believed that the self, or ego, uses ego defense mechanisms
Method of protecting self
Coping
Operate at an unconscious level

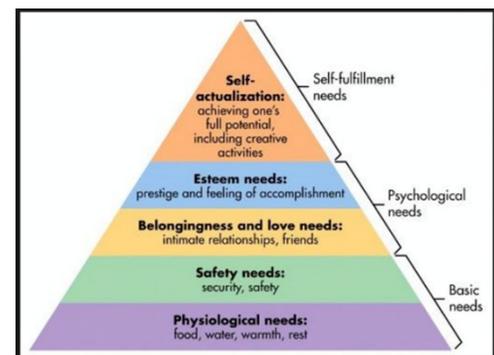Sullivan's Interpersonal Theory
Focuses on interpersonal relationships
People are driven by the need for interaction
Loneliness is very painful
The role of the nurse is very meaningful
Developed the therapeutic milieu

Maslow's Hierarchy of Needs: Humanistic Theory
Pyramid- basic needs on the bottom & self-fulfillment needs at the top.

Basic needs must be met

Behavioral Theory
Observed behaviors
Focus is on child development
Strong factor in shaping a child's behavior
Example: If a child is not shown affection/love, they will not display these attributes to others when growing up

Cognitive Theory
Depressed patients → patterns of negative thinking
Irrational thoughts/ Cognitive distortions
All or nothing thinking
Treatment cognitive → behavioral therapy

Cognitive behavioral therapy
The best approach
Cognitive approach
Behavioral approach
Combining these two therapies allows individuals to see how their thoughts, feelings, and behaviors fit together.

CBT Principles
Emphasizes collaboration and active participation
Goal oriented
Rooted in the here and now
Provides lifelong skills
Emphasized relapse prevention
Time –limited
Variety of techniques

Group Therapy
Interactions within a group can provide support or bring about desired change among individual participants.
Goal- To allow members to share common feelings and experiences and to learn alternative ways to solve problems.
Size of the group matters
Setting is important
Who should not attend group therapy?
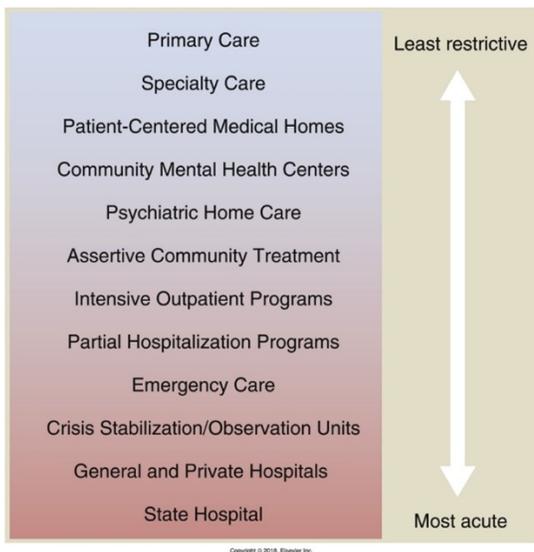Group Therapy
Benefits
More efficient
Cohesiveness
Interpersonal learning
Guidance
Instillation of hope

Treatment settings

Primary Care	Least restrictive
Specialty Care	
Patient-Centered Medical Homes	
Community Mental Health Centers	
Psychiatric Home Care	
Assertive Community Treatment	
Intensive Outpatient Programs	
Partial Hospitalization Programs	
Emergency Care	
Crisis Stabilization/Observation Units	
General and Private Hospitals	
State Hospital	Most acute

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Emergency Care
- Primary goal → triage & stabilize
- Issues → long wait times
- Peer Recovery Support Specialist (PEER)

Inpatient care settings
- General/ Private Hospitals
- State Hospitals
- Goals:
  - Develop short-term therapeutic relationship
  - Develop comprehensive plan of care
  - Administer medication
  - Monitor nutrition and self care
  - Provide health assessment and interventions
  - Offer structured socialization activities
  - Plan for discharge

Therapeutic Milieu
- A healthy environment
- Rights and responsibilities
- Safe to test new behaviors and interact adaptively with others
- The psychiatric-mental health nurse provides structures and maintains a safe and therapeutic environment in collaboration with patients, families, and other healthcare clinicians.
- Within the therapeutic community setting, the client is expected to learn adaptive coping and interaction and relationship skills that can be generalized to other aspects of his or her life.
- Goals
  - Increase client's self esteem
  - Decrease social isolation
  - Encourage appropriate social behaviors
    - Peer pressure
    - Inappropriate behaviors are dealt with as they occur
- Democratic form of self government
- Every interaction is an opportunity for a therapeutic intervention

Safety
- Essential component of any inpatient setting
- Protecting the patient, staff, and other patients

Safety needs on admission
- Checking all personal property on admission
- Monitor patients every 15 minutes
- Monitoring visitation
- Paper trash bags
- Special door handles
- Locked units

Suicide Precautions
- Sitter within arms reach
- Remove all ligature risks
- Place patient in paper scrubs
- Remove belongings
- Patient must be visible at all times

Outpatient Care settings
- Primary Health Providers
- Specialized Psychiatric Care Providers
- Goals:
  - Establish long-term therapeutic relationships
  - Develop a comprehensive plan of care
  - Encourage medication compliance
  - Involve support system

Psychiatric Disorders & Psychopharmacology

Psychopharmacology
- Psychopharmacology is the primary biological treatment for mental disorders.
- Administer medication safely
- Make decisions about prn medication
- Evaluate for therapeutic and adverse responses to medication

Overview: Medication categories

Antidepressants
- SSRI
- Tricyclic Antidepressants
- SNRI
- MAOIs
- Atypical Antidepressants

Mood Stabilizers
- Lithium
- Antiseizure
- Atypical Antipsychotics

Antipsychotics
- Conventional
- Atypical

Anxiolytics
- Benzodiazepines
- Atypical anxiolytics

Depression

Emotional disorder characterized by a sad or despondent mood.
Symptoms:
        Lack of energy
        Sleep disturbances
        Abnormal eating pattern
        Feelings of despair, guilt, hopelessness

Pharmacology- Depression

Selective serotonin reuptake inhibitors (SSRIs)	Fluoxetine (Prozac)
Serotonin-norepinephrine reuptake inhibitors (SNRIs)	Duloxetine (Cymbalta)
Atypical antidepressants	Bupropion (Wellbutrin)
Tricyclic antidepressants (TCAs)	Amitriptyline (Elavil)
Monoamine oxidase inhibitors (MAOIs)	Phenelzine (Nardil)

SSRI Side Effects:
        Serotonin Syndrome:
                Caused by over-activation of serotonin receptors
                Too high a dose OR drug interaction
                Greatest risk = SSRI + MAOI
                Symptoms: confusion, fever, tachycardia, HTN, seizure
                Treatment: antihypertensives, antipyretic, cooling blanket, benzodiazepines

MNEMONIC

SSRIs Side Effects
BAD SSRI

B ody weight increase
A norexia
D izziness
S uicidal thoughts
S erotonin syndrome
R eproductive -sexual dysfunction
I nsomnia

Special Considerations for MAOIs
        Tyramine combined with a MAOI can lead to:
        Hypertensive Crisis: anxiety, sweating, fever, seizure, severe HTN
        Tyramine can be in certain foods & medications (pseudoephedrine)
        Treatment: Treat the symptoms
        Foods with Tyramine:
                Aged cheese
                Cured, smoked, or processed meats
                Pickled or fermented foods
                Soybeans
                Snow peas, fava beans
                Dried fruits (raisins, prunes), overripe bananas or avocados
                Alcoholic beverages: especially beer

Bipolar

Characterized by episodes of depression alternating with episodes of mania

        Depression- lacking energy, inability to concentrate, difficulty sleeping, feelings of despair, lack of interest

        Mania- grandiosity, decreased need for sleep, pressured speech, flight of ideas, distractibility

Pharmacology- Bipolar
- Mood stabilizers: Lithium
  - Narrow therapeutic window (0.8-1.4 mEq/L)
  - S/E weight gain & fine hand tremor
- Antiseizure drugs
  - valproic acid- S/E thrombocytopenia
  - Lamotrigine- S/E Steven Johnson Syndrome (SJS)
  - Carbamazepine- S/E agranulocytosis
- Atypical antipsychotics: aripiprazole, quetiapine, risperidone

Schizophrenia
- A type of psychosis characterized by abnormal thoughts and thought processes
- Positive Symptoms
  - Add on to normal behavior
- Negative Symptoms
  - Take away from normal behavior

Pharmacology- Schizophrenia

Conventional (1st generation) antipsychotics
- Chlorpromazine
- Haloperidol
- Thioridazine

S/E: Extrapyramidal: Acute Dystonia/ Pseudoparkinsons

Atypical (2nd generation) antipsychotics
- Aripiprazole (Abilify)
- Clozapine (Clozaril)
- Risperidone (Risperdal)

S/E Metabolic: Weight gain/ hyperglycemia/ dyslipidemia

Anxiety
- Anxiety disorders include:
  - Generalized anxiety disorder
  - Panic disorder
  - Obsessive-compulsive disorder
  - Social anxiety disorder
  - Post-traumatic stress disorder
- Over 19 million Americans are diagnosed with anxiety every year
- Illnesses that commonly coexist with anxiety are depression, eating disorders, and substance abuse
- Physical manifestations: palpitations, tachycardia, SOB

Pharmacology- Anxiety
- Benzodiazepines
  - Lorazepam (Ativan)
  - Alprazolam (Xanax)
  - Diazepam (Valium)
- Atypical Anxiolytic
  - Buspirone

Substance Use Disorder
 Alcohol withdrawal syndrome
 Peaks after 24 to 48 hours
 Symptoms continue for 5-7 days
 Treatment
 Lorazepam
 Multivitamin/ B12/ Folic Acid
 Thiamine
 Seizure Precautions
 The clinical institute assessment from alcohol scale (CIWA)

Substance Use Disorder
 Opiates (heroin & oxycodone)
 Overdose → Naloxone (Narcan)
 Withdrawal → Irritability, agitation, insomnia, yawning, runny nose, hot/cold sweats , severe
 muscle aches, abdominal cramping
 1-12 hours after use
 Peaks 3-5 days
 Lasts 1-4 weeks
 Clinical Opiate Withdrawal Scale (COWS)
 Treatment → Methadone

The Nursing Process
 Uses a problem-solving approach
 Quality client care
 Foundation of the standards of practice
 Psychiatric-Mental Health: Scope and Standards of Practice
 Continuous & Ongoing process

Nursing Assessment
 Holistic Approach to Care
 Patient Centered Care
 Primary vs. Secondary Source

Psychiatric Nursing Assessment: Goals
 Establish rapport
 Identify current problem
 Physical assessment
 Risk factors
 Mental status
 Psychosocial status
 Goals for treatment
 Plan of care
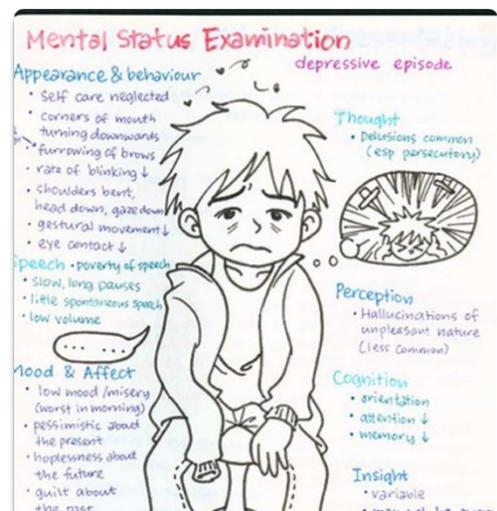 Documentation

Mental Status Examination
 Personal information
 Age
 Gender
 Marital status
 Religious preference
 Race & ethnicity

Employment
Living arraignments
Screening Tools
Appearance
Grooming and dress
Level of hygiene
Pupil dilation or constriction
Facial expression
Height, weight, nutritional status, presence of body piercings, tattoos, scars
Relationship between appearance and age
Behavior
Excessive or reduced body movements
Peculiar body movements
Abnormal movements
Level of eye contact
Speech
Rate: slow, rapid, normal
Volume: loud, soft, normal
Disturbances
Mood
Affect
Mood
Disorders of the Form of Thought
Thought process
Thought content
Perceptual disturbances
Hallucinations
Illusions
Cognition
Orientation
Level of consciousness
Memory
Attention
Abstraction
Insight
Judgment
Ideas of Harming self or others
Suicidal or homicidal history and current thoughts
Presence of a plan
Means to carry out the plan

Screening Tools
CAGE
AUDIT
Hamilton
SAD PERSONS
SAFE-T
SBIRT

Diagnosis
Data from the assessment is analyzed
Diagnoses and potential problem statements are formulated and prioritized

Nursing Diagnoses → the problem or unmet need

Patient Outcomes
     Maximum level of patient health
     Realistic
     Evaluates Nursing Interventions
     For clinical use short term outcomes
     Patient-centered

Interventions
     Evidence-based interventions for achieving the outcome criteria are selected
     Must be in priority order
     Top priorities in Mental Health: Establish Trust/ Rapport & Safety
     Realistic and Individualized

Implement
     Coordination of Care
     Health Teaching and Health Promotion
     Milieu Therapy

Evaulate
     Measures progress toward attainment of expected outcomes.
     Often neglected
     Ongoing
     Revisions to the nursing process may occur

Nursing Process Case Study
     Sam is presented through the emergency department to the psychiatric unit of a major medical center. He was taken to the hospital by police, who were called by department store security personnel when Sam frightened shoppers by yelling loudly to "imaginary" people and threatening to harm anyone who came close to him.
     On the psychiatric unit, Sam keeps to himself and walks away when anyone approaches him. He talks and laughs to himself and tilts his head to the side, as if he were listening to something. When the nurse attempts to talk to him, he shouts, "Get away from me! I know you are one of them!" He picks up a chair, as if to use it for protection.
     Sam's appearance is unkempt. His clothes are dirty and wrinkled, his hair is oily and uncombed, and there is an obvious body odor about him. The physician admits Sam with a diagnosis of schizophrenia and orders Thorazine and Cogentin on both a scheduled and prn basis.
Nursing Process Case Study
- Highlight 4 pieces of information from the assessment data that would be significant to nursing.
- List appropriate nursing diagnoses from analysis of the data identified in question 1.

- Provide outcome criteria for the four nursing diagnoses.

- Describe appropriate nursing interventions to achieve the outcome criteria.

Therapeutic communication

Effective Communication Skills for Nurses
   The goals of the nurse in the mental health setting are to help the patient:
      Feel understood and comfortable.
      Identify and explore problems relating to others.
      Discover healthy ways of meeting emotional needs.
      Experience satisfying interpersonal relationships.

nurse–patient relationship
   The first connections between the nurse and patient are to establish an understanding that the nursing relationship is:
      Safe, confidential, reliable, and consistent.
      Conducted within appropriate and clear boundaries.

Therapeutic communication
   The nurse-client relationship is the foundation on which psychiatric nursing is established.
   Benefits
      Feeling safer
      Higher satisfaction
      Increased recovery rates
      Improved compliance

Therapeutic communication
   Saying the wrong thing
   Will this be harmful to the patient?
   Factors that affect communication
      Personal Factors
         Depression → slowed thinking and speech
         Anxiety → decreased concentration
         Mania → inability to concentrate
      Environment Factors
         Physical factors
      Relationship Factors
         Level of equality

The Therapeutic Nurse-Client Relationship
   Goals and the problem-solving model
      Weigh benefits and consequences of each alternative.
      Help client select an alternative.
      Encourage client to implement the change.
      Provide positive feedback for client's attempts to
      create change.
      Help client evaluate outcomes of the change and make modifications as required.

Therapeutic & nontherapeutic aspects
   Therapeutic Relationship
      Facilitating (therapeutic communication)
      Assisting patient in:
         Alternative problem solving

Developing new coping skills
Helping
Promoting independence
Focusing on patient's problems
Encouraging behavioral changes
Nontherapeutic Relationship
Blocking
Does not assist patient in:
Alternative problem solving
Developing new coping skills
Controlling
Promoting dependence
Focusing on nurse's needs
Enabling negative behaviors

Nonverbal Communication
90% of all communication
Components of nonverbal communication
Physical appearance and dress
Body movement and posture
Touch
Facial expressions
Eye behavior

nurse–patient relationship
Empathy
Is "temporarily living in the other's life."
Empathy vs. sympathy
In empathy, we understand the feelings of others.
In sympathy, we feel the feelings of others; objectivity is lost.
Genuineness
Self-awareness of one's feelings occurs; develops the ability to communicate when appropriate.
Positive regard
Displays respect; has the ability to view another person as worthy.

transference and countertransference
Role and boundary blurring are often a result of unrecognized:
Transference
Person unconsciously and inappropriately displaces (transfers) those emotional reactions that originated from significant figures in childhood onto another individual. The patient may say, "You remind me of _____."
Countertransference
Tendency of the nurse to displace feelings related to people in his or her past onto a patient.
Frequently, the patient's transference to the nurse evokes countertransference feelings in the nurse.

Effective Communication Skills
Use of Silence
Active Listening
Observing the patient's nonverbal behaviors & verbal message
Providing feedback

Clarifying Techniques
    Paraphrasing: "in other words you are saying…" or "was I correct in saying…"
    Restating
    Reflecting: "you sound as if you have had a really hard time lately"
    Exploring: "tell me more" or "give me an example of…"
The "What if" question
    Helps the patient imagine thoughts, feelings, and behaviors they may have in a certain situation
    "What if you could go back and change…. What would you do differently"
    "If you had 3 wishes, what would you wish for?"
The "Miracle question"
    If you woke up one morning (a miracle happened) and your problem went away, what would be different & how would your life change?

Nontherapeutic Techniques
    Asking excessive questions
        Conveys a lack of respect
    Giving approval or disapproval
    Advising
    Asking "why" questions
    Using "you" statements

Positive or negative?
    Consistency
    Pacing
    Rewarding positive behavior
    Listening
    Comfort
    Balancing control
    Inconsistency
    Unavailability
    Mutual avoidance
    Lack of self-awareness
    Addressing negative behavior

The Clinical Interview
    Nurse uses communication skills and active listening to better understand a patient's situation & to plan care.
    Nurse provides the opportunity for the patient to reach specific goals and to:
        Feel understood and comfortable.
        Identify and explore problems relating to others.
        Discuss healthy ways of meeting emotional needs.
        Experience a satisfying interpersonal relationship.
    Preparing for the Interview
        Permit the patient to set the pace.
        Setting
            Enhance feelings of security.
        Seating
            Ensure ease of communication.
    SOLAR
        • **S** – Sit squarely facing the client (unless ethnic/cultural background of client discourages direct eye contact)
        • **O** – Observe an open posture

- **L** – Lean forward toward the client
- **E** – Establish eye contact (unless ethnic/cultural background of client discourages direct eye contact).
- **R** – Relax

Introductions
Making introductions
    Address confidentiality
Initiating the interview
    Open-ended questions
        "Where should we start?"
        "Tell me what's been going on with you"
    Offering general leads
        "go on"
    Making statements of acceptance
        "I understand"

What to Avoid
    Do Not:
        Argue
        Give false reassurance
        Probe about sensitive areas
        Try to sell the patient on accepting treatment
    Try to:
        Focus on the patient's perspective
        Make observations of the patient's behavior
        Focus on nonverbal communication
        Help the patient come up with pros & cons
        Helpful Guidelines
        Speak briefly.
        When you do not know what to say, say nothing.
        When in doubt, focus on feelings.
        Avoid giving advice.
        Avoid relying on questions.
        Note nonverbal cues.
        Keep the focus on the patient.

Therapy Example
    What did the therapist do well?
    Did the therapist say anything that was not therapeutic?
    What therapeutic techniques were used?
    What non-therapeutic techniques were used?

Interactions with Selected Behaviors
    Violent Behavior
        Stay out of striking distance
        Change the topic if a patient's behavior is escalating
        Call for assistance if patient is losing control
        Move the patient to a quiet area and observe
        Offer a physical outlet
        Offer PRN medication

Interactions with Selected Behaviors
- Hallucinations (hearing voices that others do not)
  - Initially try to understand what the voices are saying or telling the person to do.
  - Assessment of the hallucination
  - Thereafter, do not focus on the hallucination
- Interactions with Selected Behaviors
- Delusions (a distortion in thought content)
  - Clarify reality of the patient's experience and feelings of fear
  - Avoid being drawn into the conversation regarding content of the delusion
  - Never argue or reason with the patient
  - Careful monitoring

De-Escalation Techniques
- Respond early to aggressive behaviors
- Ensure the patient knows they are in a safe place
- Assess personal safety & pay attention to the environment
  - Leave the door open
  - Ensure you have a quick exit if needed
  - Never turn your back when a patient is angry
  - Leave the room if the behavior is out of control
- Appear calm and in control
- Speak softly
- Display genuineness and concern
- Set clear and consistent limits
- Sit next to the patient
- Listen carefully and clarify when needed
- Avoid overreacting

Crisis Intervention

Definition of Crisis
- A sudden event in one's life that disturbs homeostasis, during which usual coping mechanisms cannot resolve the problem.
- Acute
- Time-limited phenomenon

Crisis Intervention
- What nurses and other health professionals do to assist those in crisis to cope
- Interventions need to be broad, creative, and flexible

Characteristics of a Crisis
- Occurs in all individuals
- Precipitated by specific identifiable events
- Crises are personal in nature
- Acute and will be resolved
- Potential for psychological growth or deterioration

Prevalence and Comorbidity
Factors that limit the ability to problem solve or cope include the presence of stressful life events such as:
- Mental illness
- Substance abuse
- History of poor coping skills
- Diminished cognitive abilities

Preexisting physical health problems
Limited social support network
Developmental and physical challenges
Resiliency

Roberts's Seven-stage Model of Crisis Intervention

Types of Crises
Three types of Crisis
Developmental Crisis
Situational Crisis
Adventitious Crisis
Pre-existing mental health problems
Individual is more prone to crisis
Individual is more vulnerable

Developmental Crisis
A process of maturation through each stage of life
New coping mechanisms are formed for each stage of life
Transition leads to increased anxiety until the person establishes new equilibrium

Situational Crisis
Arises from external rather than internal source
Unanticipated
Examples
Loss of job
Death of a loved one
Divorce
Common & most individuals will experience during their lifetime
Resolutions depends on:
Support system
Resiliency
Emotional health

Adventitious
Crisis of Disaster
Appearing accidentally or unexpectedly and tend to catastrophic
Examples:
Natural disasters
Terrorist attacks
School shootings
Global pandemics- COVID-19

Phases of Crisis
Individuals experiencing a crisis will naturally use their normal coping skills.
If this is unsuccessful, different skills will be used.
Leads to frustration, anxiety, & disorganization

4 Distinct Phases of Crisis
Phases of Crisis
Phase 1
The individual is exposed to a precipitating stressor

Phase 2
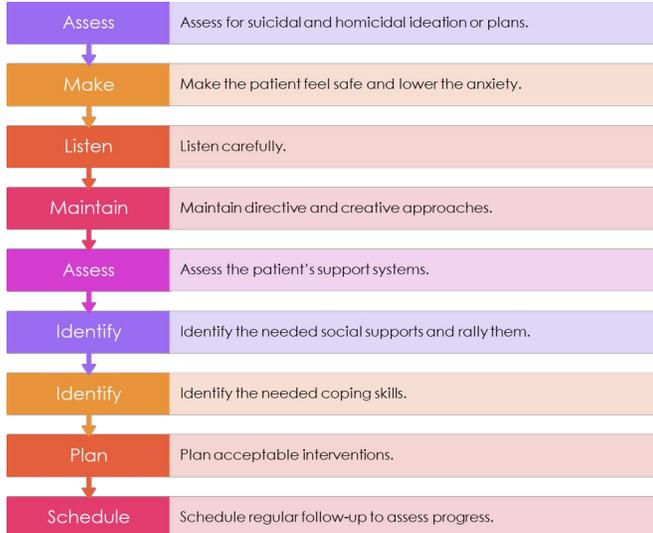 Usual defense mechanisms fail; attempts at solving the problem begin
Phase 3
  Problem solving attempts fail, anxiety increases to severe/ panic, fight or flight
Phase 4
  Coping skills are exhausted, anxiety overwhelms the individual, suicidal behaviors may develop

Assessment and Interventions: Crisis

Assess	Assess for suicidal and homicidal ideation or plans.
Make	Make the patient feel safe and lower the anxiety.
Listen	Listen carefully.
Maintain	Maintain directive and creative approaches.
Assess	Assess the patient's support systems.
Identify	Identify the needed social supports and rally them.
Identify	Identify the needed coping skills.
Plan	Plan acceptable interventions.
Schedule	Schedule regular follow-up to assess progress.

Assessing Patient's perception
  Determining whether an event is a crisis
  See the event through the eyes of the patient
  Assess the individual/family's perception of the problem
  The more clearly the problem can be defined, the better the chance that an effective solution will be found.

Assessing Situational Supports
  Assess the individual's support system
    Determines available resources
    Does the crisis involve important people
  Questions to ask:
    To whom do you talk when you feel overwhelmed?
    Whom can you trust?
    Who is available to help you?

Assessing Coping Skills
  Evaluate the individual's level of anxiety
  What are their usual coping mechanisms?
    Healthy vs. unhealthy
  Questions to ask:
    What do you usually do to feel better?
    Did you try it this time? If so, what was different?
    What helped you through difficult times in the past?

Assessment Guidelines
  Psychiatric treatment/ hospitalization?
  Can the patient identify the precipitating event?

Does the patient understand situation supports?
Identify the patient's usual coping skills.
Determine the religious and cultural beliefs.

Planning & implementing
Patient-centered care
As anxiety reduces the patient becomes more active in planning
Caring attitude, flexibility, active listening
Social support & building resilience
Patients may experience
Cognitive impairment
Behavioral changes
Emotional issues

Key Concepts of Crisis Intervention
1. A crisis is self-limiting and is usually resolved within 4 – 6 weeks
2. Resolution results in one of three levels:
Higher level of functioning
The same level
A Lower lever of functioning
3. The goal is to return the person to pre-crisis level of functioning
4. During a crisis, people are more open to outside intervention than they are at times of stable functioning
5. Deals with the person's present problem and resolution
6. Nurse takes an active, direct role
7. Early intervention increases chances for a good outcome

Ethical and Legal Considerations

Mental health laws
State specific
Review your state's code- search "mental + health + statutes + (your state)"
Ethics- right or wrong
Bioethics- ethical questions in health care
Admission & Discharge procedures
Voluntary Admission
Sought by the patient
Client has the right to request release
Admission & Discharge procedures
Involuntary Admission
Without the patient's consent
Mentally ill
Posing a danger to self or others
Gravely disabled
A legal hold
72 hours

Admission & Discharge procedures
Discharge Procedures: Depends on the patient's admission status
Conditional Release
Unconditional Release/ Discharge
Release Against Medial Advice (AMA)

Patient's rights under the law
- All clients have the following rights:
  - The right to treatment
  - The right to refuse treatment
  - Exception to this right:
    1. Serious mental illness
    2. Ability to function is deteriorating/ exhibiting threatening behavior
    3. Benefits of treatment outweigh the harm
    4. Lacks capacity to make decisions
    5. Less restrictive treatments have been unsuccessful
  - Right to informed consent
    - Patient has been provided with basic understanding of risks, benefits, and alternatives

Rights: restraint and seclusion
- Restraints have a long history of abuse
- Legislation & accreditation now maintain strict guidelines
- Agitation, confusion, and combative behaviors
- Least restrictive interventions/ environment must be used 1st:
  - Verbally intervene
  - Reduce stimuli
  - Active listening
  - Provide diversion
  - Offer PRN medications
- Restraints can be physical or chemical
  - Chemical interventions are usually less restrictive than physical restraints
  - Haloperidol
- Seclusion
  - Confining a patient alone
  - Preventing the patient from leaving
- Quiet Room

Least restrictive environment
- The "least restrictive restraint" is defined as the restraint that permits the most freedom of movement to meet the needs of the client.
- Physical Restraints
  - Seclusion
  - 4 Side Rails
  - Geri Chair with Tray Locked
  - 2-point Restraints
  - 4-point Restraints
- Chemical Restraints
  - Lowest dose

Restraint use protocols
- In an emergency, RN can apply restraints
- Provider order within 1 hour
- No more than 24 hours in restraints
- Documentation every 15 minutes
- Close monitoring
- D/C at the earliest possible time

Rights and confidentiality
    Confidentiality
        Health Insurance Portability and Accountability Act
    Exception to the rule
        A duty to warn
        Suspected child or elder abuse

The nurse is discussing client privacy and confidentiality with a new patient. Part of the discussion involves protecting the patient's confidentiality of records and communications. The nurse informs that in certain circumstances certain medical information may be released without consent. Which information can be released without the patient's consent? For each teaching point, place an "X" in the column to specify whether it is appropriate or not appropriate.

Teaching Points	Column A: Appropriate Information	Column B: Not Appropriate Information
1. Pertinent medical information can be shared in a life-threatening situation.		
2. Medical information can be released to a family member.		
3. In some states, the nurse can be called on to testify in cases in which the medical record is used as evidence.		
4. The medical record can be provided to an employer for support of a work-related absence.		
5. In most states, information can be released in situations for which the patient is at risk for harm of self or others.		
6. Medical information can be shared if the nurse suspects that the patient's spouse is abusive.		

Laws
    Nurses in the psychiatric setting should understand:
        Unintentional torts
   Intentional torts
         Assault
        Battery
           False imprisonment

Laws on reporting child, disabled, elder abuse
    Required to report suspected abuse
    Child Abuse
        Maltreatment of a child or teen
        Resulting in risk of serious injury or death
        Emotional, sexual, physical
    Child neglect
        Failure to provide basic needs for the child (physical, medical, educational)
        Poor nutrition, inadequate clothing, poor access to education
    Elder abuse
        Physical or emotional
        Overmedicating or withholding medications

Sexual Assault
- Any sexual act where the victim does not give consent
- Many assaults go unreported
- Nursing Actions:
  - Evaluation by a Sexual Assault Nurse Examiner (SANE)
    - Obtains samples for evidence
    - Ensure patient safety, comfort, & preserve evidence
    - Offer emotional support

Documentation
- Accurate & complete information
- Medical records used for Quality Improvement
- Specific & Objective
- Risk Management
- Legal
- Remember "if it wasn't charted, it wasn't done"