Psychiatric – Mental Health Nursing

Orientation Guidebook

Office of Nursing Services Mental Health Field Advisory Committee
Acknowledgements

Veterans Health Administration

Office of Nursing Services

MISSION

The Office of Nursing Services provides leadership, guidance, and strategic direction on all issues relating to nursing practice and nursing workforce across the continuum of care. ONS is committed to aligning nursing strategic goals with field-based operation and organizational priorities.

VISION

VA Nursing is a dynamic, diverse group of honored, respected, and compassionate professionals. VA is the leader in the creation of an organizational culture where excellence in nursing is valued as essential for quality healthcare to those who served America.

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Module One

Safety

Objectives

1. Identify the safety assessment process for the inpatient environment of care.
2. Discuss options for maintaining a safe environment of care.
3. Define "Therapeutic Milieu".
4. Assess practice setting using the questions provided.
5. Assess your personal attitudes related to the therapeutic milieu.

Introduction

The creation and maintenance of a safe environment in the acute inpatient psychiatric setting is the cornerstone of the psychiatric – mental health nurse's (P-MHN) role and responsibility. The role of the P-MHN to assess for environmental and individual safety is active and on-going in order to prevent self-harm or harm to others in the hospital setting. The P-MHN has a responsibility in creating and supporting a therapeutic milieu which incorporates the elements of safety, support, and structure, while creating a social environment that encourages self-understanding and validation of feelings. The acute psychiatric environment of care (EOC), which promotes safety and recovery, is imperative to optimize patient outcomes. This module will review the environmental and clinical assessment process for nurses in the acute psychiatric setting.

Inpatient Mental Health Environment of Care

Suicide attempts and suicide completion continue to occur in the acute inpatient psychiatric setting in hospitals across the U.S. The physical environment is the root cause of the majority
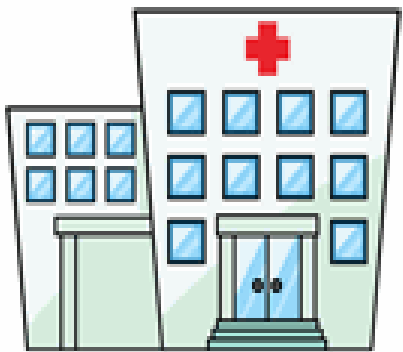
of inpatient suicides. While suicide on VA inpatient mental health units is extremely rare, hanging continues to be the most common method for inpatient suicide.

Nursing staff are responsible to create and maintain a safe environment of care on the acute inpatient unit. Nurses are aware of the potential areas of risk or harm to the Veteran and mitigate that risk through assessment, monitoring, and intervention. During construction of new units or renovation of existing units, nursing staff should be involved in the planning and design process to help anticipate areas of risk and promote a safe and recovery oriented milieu.

Safety and the Mental Health Environment of Care (MHEOC): The physical environment on an acute inpatient unit is important to mental health treatment and must support recovery. The environment must represent hope, healing, and wellness while maintaining safety (Department of Veterans Affairs (VA), 2013). A safe MHEOC is important for the health and wellbeing of Veterans and staff. Safety features can be built into the MHEOC as a preventive measure but ultimately, safety relies on constant staff awareness, action and communication.

Safety relies on the clinical expertise of unit staff who utilize the therapeutic relationship, milieu management, and safety management systems in place to maintain a safe and secure environment.

Nursing staff provides 24/7 care to inpatient Veterans. They are responsible for assessing and maintaining unit safety and promoting a therapeutic milieu. Staff awareness and mindfulness of safety and the MHEOC are paramount. Concerns are promptly communicated to the entire team to be immediately addressed.

Safety Assessment

Suicide prevention on an acute inpatient unit must be an all staff/all shift effort, 24/7. Most inpatient suicides occur on the 2nd and 3rd shift, so all shifts must be actively involved in ongoing risk assessment. Involvement of all staff takes the risk assessment and safety outcomes out of the hands of a few and places it on the shoulders of the entire mental health team.

Creating a safe environment of care requires a clinical assessment by the P-MHN. The MHEOC assessment is an extension of the patient assessment, completed to promote safety and mitigate individual risk for harm. The combination of clinical assessment and environmental assessment maximizes unit risk reduction efforts. **Initial and ongoing clinical assessment remains the single best method for identifying individuals at risk for hurting themselves or others.** This coupled with the MHEOC assessment and promotion of a safe space for healing supports individual and group recovery on the acute inpatient unit.

Part of the MHEOC assessment is identifying which objects are hazardous items, formerly identified as 'contraband', and have the potential to result in harm to the Veteran. Identifying hazardous items (see **Appendix A** for sample list) and reducing access to potential hazards in the environment is crucial for the safety of all on the unit. Checks for hazardous items must be performed at time of admission and as clinically appropriate per facility policy (e.g. when Veterans return from off-unit activities and when Veterans have been with visitors). The process must be respectful and sensitive to Veteran dignity while ensuring that items which may create a safety risk are not brought onto the unit. Such checks must be conducted in a private and secure area. If a bodily search is conducted, such as the use of a wand, the search must be conducted by a staff the same gender as the Veteran. Staff must have documented training in how such searches must be conducted (VA, 2013, p. 11).

Once a safety issue is identified, the P-MHN must take immediate action to provide a safe resolution. The nurse must use sound clinical judgment, critical thinking, systems thinking, and a team approach to resolve the problem to eliminate further threat to environmental safety. When risks are identified and hazardous items are removed, it is important to communicate findings and outcomes to the entire team to promote ongoing unit safety.

Environmental Awareness

Promoting environmental safety and assessing/reassessing the MHEOC is paramount. All staff must be alert to safety issues within the acute MHEOC and communicate frequently with the team. Environmental awareness includes awareness of team members' locations, maintaining access to exits, recognizing environmental safety challenges (e.g. visitors or external staff on the unit - housekeeping, engineering, contractors, etc.), and creating an awareness of potentially hazardous items and spaces.

Maintaining a safe environment starts as soon as the Veteran reaches the unit. Nursing staff complete an initial search and inventory of Veteran belongings (per facility policy) and identify and secure any potentially hazardous items to prevent their presence in the milieu. Potentially hazardous items deemed medically necessary require a monitoring plan to ensure devices are stored properly and securely out of the milieu when not in use. Veterans with medical equipment must be properly monitored. Medical equipment/devices not in active use can be a potential hazard to other Veterans with access to it. Medically necessary items that could be hazardous include but are not limited to Continuous Positive Airway Pressure (C-PAP) equipment, oxygen tanks and tubing, Foley tubing, wheelchairs, hospital beds, splints, canes, etc.

Once the safe environment is created, it must be maintained by screening other potential avenues for introducing potentially hazardous items to the unit. Nursing staff must be vigilant regarding introducing potentially hazardous items (also referred to as contraband) into the milieu. This can include screening visitors for potentially hazardous items, being mindful of external hospital staff inadvertently leaving supplies in Veteran areas (tourniquets, gloves, housekeeping chemicals, engineering tools, supplies, etc.), monitoring Veterans returning from

off-unit activities, etc. Nearly any item regularly found in a medical hospital can be hazardous in the environment of an acute psychiatric unit. This is a typical Urgent Care or medical patient room; can you find all of the potentially hazardous items in this picture? (Hint - there are 25!)

In addition to preventing potentially hazardous items from entering the unit, it is important to routinely and randomly reassess the environment of care and ensure it is safe. This includes completing room checks (routine and/or focused or random checks), environmental rounds (per facility policy) throughout the shift, and having nursing staff present in the milieu to anticipate safety problems or identify potentially hazardous items or situations.

Tools to Promote Environmental Safety

There are tools offered to support and enhance the application and provision of a safe environment of care on the acute psychiatric unit. Familiarize yourself with these tools and utilize them to support the safe MHEOC:

Mental Health Environment of Care Checklist (MHEOCC)
(http://www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp):
- Identify and eliminate environmental risks for inpatient suicide and suicide attempts.
- Increase the awareness of clinical staff regarding environmental hazards on psychiatric units.
- Focus specific attention on psychiatric unit safety, above and beyond routine facility safety inspections.

The MHEOCC was implemented in 2008 and is designed to identify and address environmental risks for inpatient suicide and suicide attempts in the VA. It is only one part of a comprehensive system to reduce suicide in our veteran population. It is critical that facilities have reliable protocols for
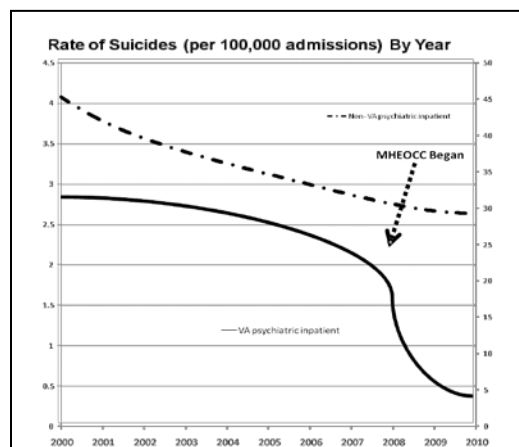
identifying veterans at risk for suicide, assessing the level of suicide risk, and providing appropriate treatment for suicidal Veterans.

Design Guide (http://www.cfm.va.gov/til/dGuide/dgMH.pdf):
- Promotes new building design that is recovery-oriented, patient centered, safe.
- Promotes a sense of calm in Veterans and enhances the connection to their surroundings.

Mental Health Guide
(http://www.patientsafety.va.gov/docs/joe/eps_mental_health_guide.pdf):
- Offers products and solutions to create a safe and therapeutic environment.
- Provide products and ideas to use in the inpatient acute setting, citing positive and cautionary attributes to consider prior to purchase.

Therapeutic Milieu

A therapeutic milieu is a treatment environment in which all aspects have purpose and contribute to recovery. Providing for a therapeutic environment is a core function of a psychiatric-mental health nurse (P-MHN) (American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric Nurses (ANA, APNA & ISPN), 2014). The therapeutic milieu is a purposefully created therapeutic environment that supports mental health recovery. There are five essential processes addressed in constructing and maintaining the therapeutic milieu: safety, support, structure, social involvement, and validation/self-understanding (Gunderson, 1978; LeCuyer, 1992). The new P-MHN must reflect and consider his/her role in each of the processes. The function of each process is described along with sample questions to assist in assessing the dynamic quality of the therapeutic milieu. Please see **Appendix B** "Evaluation of the Therapeutic Milieu" to apply concepts to your acute setting.

Safety

Safety is provided in the therapeutic milieu through individual safety and physical security. External safeguards include regulation informed policies, quality indicators such as the Mental Health Environment of Care Checklist (MHEOCC), and structural requirements of accrediting bodies such as The Joint Commission (TJC). Unit policies for trauma informed use of restraint and staff training in de-escalation and therapeutic holding are expressions of safety in the acute setting.

Setting assessment:
- Is a sensory room available to assist clients to self-regulate?
- Are cameras restricted to protect Veteran privacy?
- Are select hazardous items available with staff supervision (razors, nail clippers, scissors, etc.)?
- Does clinical staff practice verbal and physical behavior management techniques in a classroom setting?

Self-assessment:
- How can my tone of voice, body language, and facial expressions contribute to Veteran safety?
- Are there resources to assist me if I am uncomfortable around a particular Veteran?
- Am I confident in my own and my team's disruptive behavior management skills?

A Veteran was frightened of her impulses and isolated herself in a corner near the phone booth right before shift change; other Veterans were worried about her. The nurse sat with her and reflected that the Veteran looked frightened. The Veteran said she was afraid she would cut herself and she had a plastic knife from lunch. The nurse helped the Veteran relinquish the knife and spent time walking with her until the anxiety dissipated. The nurse met with all Veterans to discuss how to increase safety on the unit and cope with feelings of fear.

Support

Support consists of efforts to provide Veterans with comfort and security by offering assistance and assurance. Support includes concrete provisions such as an aesthetically pleasing physical environment, nourishing food, availability of clothing, access to medical and social services, and assisting the Veteran toward independence. Support is balanced with safety through a non-threatening and non-punitive environment.

Setting assessment:
- Are Veterans encouraged to wear their own clothing? Is there a washing machine available so they can wash their clothing?
- Is the environment aesthetically pleasing?
- Is the milieu noise level managed? Are spaces with limited stimulation available for patient use (quiet rooms, meditation spaces, sensory rooms, etc.)?

Self-assessment:
- Am I comfortable providing a silent presence to a Veteran who is not willing to talk?
- Can I promote independent nursing interventions?

The evening nurse spends time teaching the Veteran sleep hygiene and the effects of caffeine on sleep.
The medication nurse assists the Veteran with proper placement of the nicotine patch.

Structure

Structure is unique to each unit and is driven by clinical staff. All aspects of the environment that provide predictability such as schedules, assignments, and consistency represent the function of structure. While guidelines and consequences are safety measures, clarity of these guidelines and consequences is structure. Therapeutic groups involve planning for staff and space and cannot occur without structure. The community meeting is an excellent vehicle for reinforcing structure. Physical design is also part of structure for inpatient units. A unit

guideline consent is available in **Appendix C**, a community meeting template in **Appendix D**, and a sample treatment program schedule and progress log in **Appendix E**.

Setting assessment:
- Is there a daily schedule of therapy groups, activities, recreation, and creative expression opportunities available to Veterans? How and where is the schedule posted?
- How is the Veteran informed of unit guidelines?
- Is there adequate space for socializing, group meetings, receiving visitors, and privacy?
- How does the Veteran learn about program updates or changes?
- Does the Veteran have an opportunity to participate in program governance via a community meeting?

Self-assessment:
- Do I keep my commitments with Veterans within a reasonable time frame and let them know if I will be late?
- Do I make sure that supplies are available and program activities begin on time?
- Am I able to set reasonable limits (boundaries, time, behavior, etc.)?
- Do I have the knowledge, competence, and confidence to facilitate groups?

Social Involvement

Social involvement promotes interpersonal interaction by individual sessions, therapeutic groups, and social activities. It pertains to the Veteran's participation in his or her treatment plan and his/her ability to participate in unit planning.

Setting assessment:
- Is there at least one group meeting where all staff and Veterans participate?
- Are there socialization groups appropriate to the functional level (e.g. social bingo)?
- Are there opportunities for socialization on the weekends?

Self-assessment:
- Do I encourage Veterans to explore and understand challenging social interactions to adapt to the milieu?
- Do I integrate evidence-based clinical practices (CBT, motivational interviewing, recovery, etc.) to establish and maintain therapeutic relationships with Veterans, families, and the multidisciplinary team?
- Do I assist Veterans to identify and mobilize sources of interpersonal support?
- Do I reflect on my social interaction skills and their impact on the milieu, emphasizing constructive interactions?
- Do I assist Veterans to develop a greater level of self-awareness through the process of interacting with others and encourage development of socialization techniques?

A Veteran was exhibiting socially inappropriate behaviors such as cutting in line, making lewd comments, and invading peer Veteran's personal space. The nurse approached the Veteran

about the behaviors and discussed the concerns in the milieu setting. The Veteran requested help in meeting appropriate behavior goals. The nurse encouraged a role play with the Veteran to act out appropriate behaviors in a public setting, while addressing verbal and non-verbal feedback from others regarding behavior. The nurse provided direct feedback to the Veteran and helped practice socially appropriate skills to participate in the group setting.

Validation/Self-Understanding

Validation or self-understanding is any intervention that affirms the uniqueness of the individual. It is a core principle of the Recovery Model discussed further in **Module 2**. Veterans are not labeled or dehumanized in any way; all contributions are acknowledged. Treatment plans are individualized, strengths and competencies are identified, and opportunities for individual expression are made available.

Setting assessment:
- Are there provisions for functionally appropriate activities?
- How are cultural considerations incorporated into the program? Is there a plan to provide for the needs of transgendered individuals, those with Military Sexual Trauma (MST), female Veterans, etc.?

Self-assessment:
- Do I use self-reflection to inventory my personal feelings about Veterans in the milieu to develop an understanding of how my feelings affect the care provided?

Nurses collaborate with the Veteran to develop a "Wellness Recovery Action Plan (WRAP)", an evidence based system for monitoring, reducing, and eliminating uncomfortable or dangerous physical and emotional difficulties. The steps include (Copeland, 2011):
- ➢ Developing a wellness toolbox, daily maintenance plan and crisis planning
- ➢ Identifying triggers and early warning signs
- ➢ Recognize when things are breaking down
- ➢ Establishing a post crisis plan

Development of a therapeutic milieu is a clinical skill that requires practice and ongoing feedback. The P-MHN can develop and expand his/her ability to create and maintain the therapeutic milieu through ongoing learning including:
- Gaining knowledge and skills on the therapeutic use of self.
- The guiding principles of the Recovery Model (further information in **Module 3**).

Summary

It is an expected, active, and on-going process to assess for and maintain safety for all persons in the acute, inpatient environment. Incorporation of both environmental safety and personal safety starts prior to admission and continues throughout the inpatient stay. Being aware of potential items of harm and what actions to take if safety is compromised is the responsibility

of every P-MHN. Safety is enhanced by utilization of tools such as the MHEOCC, personal reflection and assessment, and understanding of facility and unit level policies created to promote and maintain safety in the acute psychiatric setting. The overarching goal is the reduction or elimination of suicide in the inpatient setting, and safety or no-harm for all persons working and recovering in that environment.

✓	Knowledge Check
	I can explain the 5 processes of the therapeutic milieu.
	I can describe the role of the P-MHN in safety assessment and environmental awareness.
	I am familiar with the MHEOCC and how to access it.
	I can identify the single best method of identification of individuals at risk of self-harm or harm to others.

Resources

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Module Two

<u>Communication</u>

Objectives

1. List the components of SBAR hand-off communication.
2. Give examples of at least two types of therapeutic communication techniques.
3. Compare recovery oriented language and non-recovery oriented language.
4. Describe the impact of defense mechanisms on relationships.
5. Describe the importance and legality of documentation in the patient chart.

Introduction

Communication is an essential element of human interaction and is crucial in the provision of patient care within healthcare settings. Providing safe care depends upon accurate and effective communication from the interdisciplinary team, including the P-MHN. "The P-MHN communicates effectively in a variety of formats in all areas of practice" (ANA, APNA & ISPN, 2014, p. 75). Communication in nursing practice incorporates verbal, non-verbal, and written approaches. A variety of communication tools including computers, forms, phones, etc. are available when sharing information with others. Nurses use handoff reports, verbal/written shift reports, treatment team meetings, and medical record documentation to share information about patient progress while documenting changes in Veteran status. These methods of communication are essential when delivering care to the Veteran. Clear, consistent, and concise documentation in the medical record serves as an ongoing communication tool to healthcare providers and is a part of the permanent legal record of care provided to the Veteran. It is imperative for the P-MHN to understand the professional and organizational roles and responsibilities related to communication to ensure accountable

practice. No matter what aspect or tool is used to communicate, the P-MHN consistently demonstrates respectful, professional, and effective communication to establish a therapeutic relationship in all stages of care delivery.

It is imperative the P-MHN is knowledgeable and utilizes principals of recovery in all aspects of communication and patient care throughout the therapeutic relationship. One important characteristic of recovery oriented care is using 'person first language', which emphasizes that people be placed first, and that patients are not defined by their illness (i.e. a person living with schizophrenia vs. a schizophrenic patient). Recovery oriented language and communication is consistently utilized when speaking with or about the Veteran.

Therapeutic Communication

Effective interpersonal communication skills are at the core of the mental health nursing role. These skills help build a therapeutic alliance with the Veteran and communicate relevant information to the interdisciplinary team. Essentially, *therapeutic communication skills form the basis of every intervention provided*. Knowledge of therapeutic communication skills is key to helping the Veteran experiencing emotional distress, as well as developing a positive nurse-patient relationship. The recovery model provides a context to which the therapeutic communication takes place in the acute inpatient setting.

Communication with the Team

Communication Hand-off SBAR is a standardized approach to "hand-off" communication that includes the opportunity for staff to ask and answer questions. It establishes an effective and improved communication technique that can enhance patient safety using a succinct and efficient format:
- <u>Situation</u> – briefly state the problem
- <u>Background</u> – provide pertinent background information; add direct quotes if relevant
- <u>Assessment</u> – what is your own assessment of the situation
- <u>Recommendation</u> – what is it that you want, or what does the provider want

Shift report is unit specific; please follow the policy of your facility. Shift report can include but is not limited to:
- Patient diagnosis
- Commitment/legal status and timeline (duty to warn status)
- Observation and/or precaution levels
- Risk assessment (self-harm, falls, BRADEN, etc.)
- Mental status
- Mobility or ADL needs
- Pertinent medical issues, Allergies
- Medication issues, changes, PRNs given during shift
- Notable events from shift
- Disposition plan

Interdisciplinary team reports are frequently discussed during team meetings:
- This is unit or facility specific, but the interdisciplinary team may include: nurses, psychiatrist, chaplain, peer support specialist, social workers, students, pharmacy, unlicensed staff, Nursing Assistants, and/or others.
- Discussion amongst team members includes review of patient goals, patient progress, response to treatment, proposed treatment changes, new recommendations, and discharge planning, .
- The team meeting could also include having the Veteran meet with the team to discuss his/her goals, feelings and thoughts about treatment, and progress. Consideration should be given to limiting the number of people involved in this meeting to those directly treating or providing care to the Veteran.

Communication with the Veteran

Recovery oriented language focuses on the Veteran and includes an emphasis on Veteran abilities, strengths, interests, and individuality, while using language that helps drive hope and a positive outlook. The P-MHN asks the Veteran how they would like to be addressed. Recovery oriented language is not condescending, does not place labels, does not focus on limitations, and never assumes. We are often unaware of the impact that our words can have on those around us. Language must be respectful and non-judgmental.

> Words are important. The language we use and the stories we tell have great significance to all involved. They carry a sense of hope and possibility or can be associated with a sense of pessimism and low expectations, both of which can influence personal outcomes. (Devon Partnership Trust & Torbay Care Trust, 2008, p. 2)

A recovery-oriented environment includes positive portrayals of mental illness, while fighting stigma and discrimination (Substance Abuse and Mental Health Services Administration (SAMSHA), 2009). Recovery language conveys hope and possibility.

Recovery language honors the Veteran's culture, which includes beliefs and values and affects all aspects of life including health and interactions with the healthcare system. Culture needs to be considered by the P-MHN including where the person was raised, heritage, what conflict the Veteran fought in, religion, sexual orientation, gender expression, etc. The P-MHN can assess further by asking questions in an open, honest, and sensitive way to get to know the Veteran better. Culturally competent care based on trust, respect, and relationship is a starting point to assess and treat each Veteran as an individual. Communication can lead to misunderstanding if assumptions are made regarding verbal or nonverbal cues. Remember that some nonverbal communication techniques such as use of eye contact, touch, humor, and silence can impact feelings of respect and acceptance. The P-MHN has to be self-aware and realize his/her own paradigms and culture. Consider the cultural norms regarding health when engaging each Veteran in discussion (for more information on culture, see **Module 3**).

Non-recovery Language = referring to people as...	Recovery Language = The Veteran *lives with / has* ...
Schizophrenic	been diagnosed with schizophrenia
Alcoholic	an alcohol abuse disorder
Bipolar	bipolar disorder
Unmotivated / Not motivated	Veteran does not seem sure that he/she wants to change his/her behavior Veteran has not yet found anything that makes changing worthwhile Veteran has thoughts that seem to contribute to him/her being 'stuck'
Manic	Veteran has not slept in several days/seems to be internally stimulated to keep moving
Frequent flyer	Veteran has not been able to establish and maintain stability or support yet Veteran seems to need frequent support or resources
Paranoid	Veteran seems to be more fearful of his/her surroundings than what is warranted
Noncompliant/resistant to treatment	Veteran is choosing not to.../would rather.../is frequently looking for other options
Manipulative Grandiose In denial Passive aggressive Self-deprecating Oppositional	Veteran is trying to get a need met on his/her own terms, OR has a perception that is different from the staff, OR has a self-opinion of not shared by others. These efforts are not effectively getting the result the Veteran seeks. (Issue is about control)

Therapeutic Communication Techniques

Non-Verbal Communication is an important part of communication and includes (Epstein, R., et. al, 2000):

Proxemics – The relationship of space to communication; may vary with culture or environment. Four zones exist in American communication. These zones can be increased or decreased for those with psychiatric illness, or in particular psychotic states.

- *Intimate distance* (6 inches to 18 inches): for close contact, embracing, whispering.
- *Personal distance* (18 inches to 4 feet): for interactions among friends and family
- *Social distance* (4 feet to 12 feet): for interactions among acquaintances
- *Public distance* (12 feet or more): used for public speaking

Kinesics – Includes facial expressions, posture, gestures, and body movements and can be positive or negative.

- *Positive*: leaning forward, nodding head, open hands, eye contact
- *Negative*: hands on hips, arms crossed, drumming fingers, looking at watch

Paralanguage – Includes vocal sounds that are not actually words and characteristics of spoken languages.
- *Vocal sounds*: taking a breath, making sounds with the tongue, and whistling
- *Spoken language characteristics*: volume, tone, cadence (speed)

Therapeutic Communication is a nursing skill that requires practice and ongoing feedback. Different therapeutic communication techniques are appropriate to utilize in different situations. The nurse must be flexible in recognizing which form of therapeutic communication is best suited to each individual Veteran and may utilize multiple forms of therapeutic communication to develop a positive rapport in the milieu and with each Veteran.

Therapeutic Communication Technique	Example
Using Silence: allows the Veteran to control parts of the discussion, or time to collect his/her thoughts	Waiting for the Veteran to answer or encouraging them to continue the conversation by waiting (silence).
Restating: helps the Veteran know that what they said was understood	Veteran: "I forget to eat because I'm never hungry anymore." Nurse: "You're not thinking about eating because you never really feel hungry."
Reflecting: helps direct any questions or feelings back to the Veteran	Veteran: "I feel nervous about moving, what do you think I should do?" Nurse: "You are not sure about moving and that is causing you to feel nervous."
Exploring: helps the discussion dive further into a subject or area	"Please tell me more about that." "Tell me how that accident happened."
Seeking Clarification: helps explain vague statements and maximizes a mutual understanding	"I had trouble following what you said; could you tell me more specifically what you were trying to say?" "Give me an example of when you felt that way."
Making Observations: verbalizes what is observed or perceived, draws attention to Veteran's behavior	"You seem upset." "I noticed you stayed in bed all day and didn't eat lunch."
Giving Broad Openings: allows the Veteran to select the topic of discussion or take the lead	"I am wondering what you are thinking about." "What topic do you think we should discuss today?"

Giving Recognition: acknowledges what the Veteran has said or done, indicating awareness of effort	"I see that you combed your hair today." "You ate your whole breakfast this morning."
Accepting: helps convey a positive regard or that the Veteran has been understood	"Yes, I hear what you are saying." "Some patients mention they are worried about becoming addicted to their medications. What are your worries about taking medications?"
Presenting Reality: helps to clarify any misconceptions and describe facts or indicate what is real	Veteran: "Are you a ghost?" Nurse: "I am Karin, your nurse today." Veteran: "Was that gunfire?" Nurse: "That sound was from a door closing."

Nurse - Veteran Relationship

Building a therapeutic relationship is the heart and essence of the P-MHN role. The performance of nursing tasks in the absence of a relationship is not nursing, it is simply performing tasks. The therapeutic relationship can be influenced by individual nursing characteristics and organizational factors (Parzargadi, et al., 2015). It is important to understand the historical, individual, and organizational contexts influencing therapeutic relationships. Initial interactions help establish a sense of trust and understanding (LaRowe, 2004).

The therapeutic relationship is unique to each nurse, who utilizes a therapeutic use of self to creatively and individually form a positive bond with the Veteran. Peplau's Model of the Nurse-Patient Relationship, developed in the late 1950's, recognized the "shared experience as an important part of the person's recovery" (Clarke, 2012, p. 840). The therapeutic relationship utilizes communication to focus on the Veteran's needs. The P-MHN works within this relationship with clearly defined boundaries to encourage change. This is different from communication in a social relationship, where the primary focus is often friendship, enjoyment, or mutual needs are being met. A therapeutic relationship between a nurse and Veteran includes specific goals (Varcarolis & Halter, 2010):

- Facilitate the Veteran's ability to communicate upsetting thoughts, feelings, or distress
- Support the Veteran to identify self-defeating behaviors, thoughts, and examine alternatives
- Promote positive self-care and further independence

Boundaries

The P-MHN maintains therapeutic and professional interpersonal relationships with appropriate role boundaries. When in the professional role, the P-MHN advocates for the

Veteran and assists in development of skills for self-advocacy. The nurse recognizes and avoids using the power inherent in the therapeutic relationship to influence the Veteran in ways that are not related to treatment goals. Boundaries can include physical emotional space (in communication) which may be different from person to person, culture to culture, and within the same person during a different phase of life. For example, Veterans with anxiety or a history of trauma may need quieter communication and more space.

There are times when the P-MHN may have a pre-existing personal relationship with a patient admitted to the unit. This must be immediately brought to the attention of the unit supervisor and the treatment team by the nurse. Strategies must be discussed to immediately address staff presence and/or involvement on the unit with consideration given to patient confidentiality, recovery, staff dual roles/relationships, and unit interventions required to preserve the therapeutic rapport and environment for the patient.

The P-MHN must be mindful of transference and countertransference. Transference and countertransference are normal occurrences that can take place within the therapeutic relationship. The nurse-patient relationship is the primary focus of mental health nursing care and is vulnerable to transference and countertransference. Facilitating staff awareness of this phenomenon is important as clinical staff may not always be aware that it is occurring.

Transference occurs when a Veteran unconsciously transfers feelings, conflicts and attitudes related to people/figures in the Veteran's past or current life (e.g. "you remind me of my mother") to the nurse. The potential for nurses to become the object of transference is significant as the nurse is a constant presence in the provision of care. It can result in positive or negative feelings toward the nurse, groups of nurses, or other providers.

Countertransference involves the same principles as transference but is reversed. Countertransference occurs when the nurse unconsciously displaces or transfers feelings and behaviors related to people/figures in the nurse's past or current life to the Veteran. For example, a Veteran displaying childlike dependency on the nurse may engender a parental attitude in the nurse or the opposite if the nurse begins to resent the Veteran due to dependency on the nurse. It can result in positive or negative feelings toward the Veteran.

Transference or countertransference may not be related to any readily identifiable patient or nurse behaviors. When transference or countertransference inhibits the therapeutic process or poses a serious barrier to therapy or patient safety, the relationship needs to be terminated and care reassigned.

Defense Mechanisms

People use conscious and unconscious coping strategies in an attempt to explain or change the meaning of a life situation in their mind. Defense mechanisms are behaviors usually learned in childhood that serve as a coping strategy. When used temporarily for tension reduction or to protect oneself from intolerable anxiety, defense mechanisms can be healthy. However, their

value is limited and unhealthy when they serve as a form of self-deception and/or when they distort reality. As an adult, we can make choices to learn new, healthier behaviors and reduce the use of the more primitive defense mechanisms such as acting out (physically or verbally) or regression (physically or emotionally).

Defense Mechanism	Definition	Example
Projection	Attributing unacceptable thoughts/feelings, facts or behaviors, or attitudes onto another person who does not have those thoughts or feelings. Projection may be the result of a lack of insight or knowledge of one's own motivations and feelings. This is often expressed as blame.	Gloria is married and has engaged in multiple one night stands with business acquaintances over the past several years. She tells her friends that she thinks her husband is having an affair with his secretary and blames him for the problems in their marriage.
Denial	Refusing to accept reality by saying that it does not exist.	Larry lacks insight into a diagnosis of alcohol use disorder and instead insists that he rarely drinks alcohol and never drinks to excess.
Rationalization	Offering a plausible or believable explanation for unacceptable behavior, e.g. offering a different explanation for one's perceptions or behaviors when things do not turn out as the person had anticipated.	Jeff is fired due to his poor work performance and absenteeism; he tells his wife that he was fired because he would not have an affair with his female boss.
Compensation	A process of counter-balancing perceived weaknesses by emphasizing strength in other areas. When used selectively and not to overcompensate, compensation may help reinforce self-confidence and self-image.	Unlike his brother who is tall, handsome, and great at sports, Ralph is short and overweight. When being compared to his brother, Ralph states, "I may not be good at sports, but I am a great chess player and gourmet cook."
Repression	Unconscious blocking of unacceptable thoughts, feelings or impulses, after an experience.	A Veteran cannot remember a traumatic event involving the death of fellow Marines.

Documentation

Clinical care, assessment, and patient discharge plan information is documented in individual Veteran chart by the clinical team. Nurses document most frequently in the chart as they provide 24 hour care for the Veteran and monitor the duration of the inpatient stay. Nurses provide documentation in the clinical chart from admission to discharge including: the initial nursing assessment, daily shift assessment, treatment planning, group information, discharge notes, and other relevant information to patient treatment and goals. Documentation of objective and subjective data collected by the nurse illustrates the presentation of the patient and is completed utilizing clinical terminology in a professional, objective manner. Documentation is the legal record of information specific to the Veteran during his/her engagement in VA care. Legally, if it is not documented, it did not happen.

Admission Assessment Documentation

Documentation of the initial nursing assessment is integral to compiling a comprehensive overview of the Veteran to be reviewed by the interdisciplinary team. Data is collected through examination of the physical, psychological, intellectual, social, and spiritual aspects of the Veteran by utilizing the nursing process to assess, diagnose, identify outcomes, and develop a plan of care. The P-MHN synthesizes information obtained from interviews, behavioral observations, and other available sources to compile information that is documented in the initial nursing assessment. This serves as the foundation for the nursing care of the Veteran. The initial nursing assessment must include the following information per TJC standards:

- The chief complaint – Veteran's reason for admission (may be different from the family or nurse's reason for admission)
- Psychiatric history
- Assessment for tobacco, alcohol, and substance use and history
- Medical history with physical examination
- Family history and involvement
- Cultural and spiritual assessment
- Screening and assessment of risk to self or others
- Allergy assessment
- Advance directives (AD) (physical and mental health AD)
- Vital signs with pain assessment
- Nutritional status screen

- Assessment of trauma, abuse, neglect, or exploitation
- Assessment for educational status, legal issues, vocational status
- Assessment of patient goals, strengths, and preferences

Timelines and requirements for documenting the initial nursing assessment are established at the facility level. Please refer to your local policy regarding the initial nursing assessment for documentation requirements, timeframe, and expectations. It is important for the P-MHN to be aware of his/her facility survey standards and other accrediting body requirements.

Shift Assessment Documentation

The daily shift assessment reflects any modifications to expected outcomes based on goal achievement and intervention response. The P-MHN uses appropriate evidence based assessment techniques, instruments, and tools to collect data and perform on-going assessments. Assessment of the interaction between the Veteran and his/her response to the environment promotes a safe and therapeutic milieu. The P-MHN demonstrates quality by documenting the application of the nursing process in a responsible, accountable, and ethical manner. Documentation includes all relevant data in a retrievable format inclusive of communications, rationales for changes, and any collaborative discussions to improve outcomes (ANA, APNA & ISPN, 2014, p. 159). The purpose of assessment is to determine the care, treatment, and services needed to meet the Veteran's initial and on-going needs. Veteran needs must be reassessed throughout the course of care. Documentation of the daily nursing assessment is determined by facility policy. The P-MHN conducts on-going, systematic, and criterion-based evaluation of Veteran outcomes and goals in relation to treatment plan interventions and timelines. The P-MHN documents using standard and recognized medical/psychiatric terminology and approved abbreviations which are descriptive and familiar to all disciplines. Please see **Appendix F** to document an assessment of an example case scenario.

The P-MHN is responsible for completing a review of systems as part of the nursing assessment, documenting any findings outside of normal expectations. This demonstrates advocacy for the patient and protection for licensure. In addition to a physical assessment, the daily psychiatric nursing assessment focuses on these components:

- Appearance and dress
- Psychomotor activity
- Eye Contact (with consideration of culture)
- Thought Process
- Affect
- Perceptions
- Mood

- Insight and judgment
- Behavior
- Speech
- Cognition (orientation, alertness memory)
- Commitment/Guardianship status
- Suicidal/Homicidal ideation

**It is important for the P-MHN to include a descriptive narrative with objective and subjective supporting evidence, including direct quotes, relevant to the patient assessment and progress toward the patient's goals.

Psychoeducation Group Documentation

The psychoeducation (PE) group led by the P-MHN illustrates the vital role the P-MHN plays in providing health teaching in a group setting that promotes the Veteran's mental health recovery (ANA, APNA & ISPN, 2014). The PE group focus is mental health education and wellness for effective living, problem management, and mental health recovery. Two overarching objectives relevant to any PE group include gaining a basic understanding of the topic, and/or exploring how the topic will the Veteran in terms of his/her mental health recovery. Topics covered in PE groups led by the P-MHN can include illness management, education of mental health disorders, coping strategies to manage symptoms, prevention of symptom relapse, medication education, principles or components of mental health recovery, lifestyle management (dealing with conflict, problem-solving, crisis management, wellness promotion, self-care, and stress reduction), etc. PE groups require documentation including but not limited to (VA Office of Nursing Services (ONS), 2014):

- The specific topic covered.
- The number of group members present.
- The stated objectives for the group.
- Resources used (written information, handouts used during the session)
- Training method /process (lecture, interactive exercises, case examples, DVD/webinar, etc.)
- Themes identified during the group discussion
- The role played in the group session (group process)
- The Veteran's response (attentive, non-attentive, distracted, disruptive, difficulty tracking topic, etc.)
- Level of involvement (active participant, no verbal participation, etc.)
- Individual Assessment (affect, behavior, thought content, etc.)
- Evaluation/Plan for mental health recovery

Tips for Documenting a Psychoeducation Group: Check with your facility to see if a PE group note template can be developed for ease of documentation. Documentation of the group session can be more overwhelming than conducting the group itself. A sample group note is included in **Appendix G and a group note template in **Appendix H** to more fully illustrate the documentation process.

Treatment Plan Documentation

Treatment Plans are a way of communicating the needs and goals of the Veteran to other members of the interdisciplinary healthcare team. It outlines observations, actions, and instruction based on the Veteran's current condition and desired outcome. Interventions help the patient achieve long and short term goals. The treatment plan is patient-centered, recovery based, and focuses on individually identified Veteran goals. Treatment planning must meet accrediting body requirements (see **Appendix I** for a treatment plan process crosswalk of APA Scope and Standards of nursing practice to TJC requirements).

> **The P-MHN develops an individualized plan in partnership with the healthcare consumer, family and others considering the healthcare consumer's characteristics or situation; this plan can include, but is not limited to, values, beliefs, spiritual and health practices, preferences, choices, developmental level, coping style, culture and environment, available technology, and individual recovery goals** (ANA, APNA & ISPN, 2014, p. 50).

Treatment plan timeline and documentation requirements are established at the facility level. The P-MHN must be familiar with his/her local facility policy and work as a member of the interdisciplinary team to develop a recovery oriented treatment plan for the patient upon admission and routinely during the acute, inpatient stay. Treatment goals, objectives, and interventions are updated consistently over the course of the admission. Documentation of the treatment plan includes but is not limited to:

- Interdisciplinary team members present for the meeting
- A list of Veteran strengths
- Veteran stated goal(s)
- Problems related to Veteran diagnosis / behaviors
- Measurable goals specific to each problem
- Interventions with measurable evaluation criteria

Summary

Communication is an integral skill and responsibility of the P-MHN. The various forms of communication are utilized to report information to team members, develop rapport with each Veteran and promote a therapeutic relationship with Veterans and a professional working relationship with the interdisciplinary team. As you continue to learn more about Psychiatric-Mental Health Nursing, you will find that some methods of communication are more effective in specific situations. You will also learn which methods of communication you are most comfortable with. Practicing new communication skills with peers can help you learn how they fit into your nursing practice.

✓	Knowledge Check
	I can identify SBAR report requirements.
	I can identify two types of therapeutic communication techniques.
	I can explain the difference between Recovery and non-recovery oriented language.
	I can describe when defense mechanisms are helpful and when they are harmful.
	I understand the importance of documentation in the legal medical record.

Resources

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Module Three

Patient Centered Care

Objectives:

1. Identify three cultural structures.
2. Discuss the relevance of military culture for Veteran patients.
3. Identify the purpose of completion of the Mental Health Advance Directive.
4. Discuss the role of the Peer Support Specialist.
5. Recognize appropriate group modalities for the generalist P-MHN.
6. Identify different types of trauma and how to coordinate trauma informed care.

Introduction

Patient centered care is defined by "providing care that is respectful of, and responsive to, individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions" (Institute of Medicine (IOM), 2001, p. 3). Patient centered care promotes recovery in Veterans with mental illness and establishes a cooperative partnership between clinical staff and the Veteran in defining care goals and inpatient stay expectations. "It shifts the balance of authority and responsibility of the doctor-patient relationship and incorporates shared decision making (SDM) between the clinician and the patient, particularly when it comes to treatment" (Dixon & Lieberman, 2014, para. 2). The patient-centered approach allows the entire Veteran to be cared for and seen as a whole person. Patient centered care starts by recognizing the whole Veteran and his/her experience and contribution to their own health and wellness. The P-MHN creates a patient centered approach by engaging in open dialogue with

the Veteran about him/herself. Conversations and assessment regarding individual culture, military history, and perspective of health issues can help get the clinical team and the Veteran on the same page to start setting goals for the inpatient stay. The P-MHN acts as an advocate for the patient and promotes self-advocacy when appropriate. Part of advocating for Veteran autonomy, independence, and safety is being aware of and monitoring for potential ethical issues inherent in providing care to the Veteran in mental health crisis. Providing teaching and access to health care interventions such as recovery-oriented care, advance directives (AD), peer support services, psychoeducational groups on relevant topics, and trauma informed care supports the Veteran in setting his/her own goals and working towards Recovery.

Recovery

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. (SAMHSA, 2012c)

Recovery-oriented care is a newer model of care integrated into all VA mental health services over recent years, including the acute inpatient setting. During the 1970's and 80's de-institutionalization and cuts in funding of state and private psychiatric facilities resulted in a huge movement to return 'psychiatric patients' to their communities and re-integrate them into society. This changed how mental health care was offered and created the possibility of independent living for many individuals with mental illness, while resulting in homelessness and limited access to care for many others. For the past 15 years, various agencies (World Health Organization (WHO), SAMHSA, U. S. Government) have promoted a culture shift in mental health care from a medical model of care to a recovery-oriented model of care (Moller & McLoughlin, 2013). The President's New Freedom Commission on Mental Health (United States Department of Health and Human Services (USDHHS), 2003) identified recovery as the chosen model of care for mental health and substance use treatment in the United States.

Traditionally, mental health treatment was paternalistic and built around staff convenience with rigid rules and highly structured activities, meals, medication, curfew, and bedtime. Patients were required to follow rules without question; noncompliance resulted in power struggles between staff and patients, patient loss of privilege, or threats. Staff were expected to retain strict control of their patients and patient privileges were earned, instead of being a routine expectation of clinical care (e.g. snacks after bedtime on medical units, wearing personal clothes, access to activities, etc.). The punitive, paternalistic and control-based approach created mistrust between staff and patients and resulted in control/coercion to force compliance.

The inpatient unit focuses on crisis stabilization and treatment of acute symptoms through pharmacological, psychoeducational, and psychological interventions and safety. The goal of each hospitalization is to return the

Veteran to their baseline functional status and discharge them to a lower level of care. The P-MHN plays an active role in supporting Veteran navigation through the recovery process starting at admission and extending through discharge. Recovery starts with trust and is an ongoing journey. VHA recovery includes principles of privacy, security, honor and support for VA patient rights in addition to the 10 guiding principles of recovery established by SAMHSA (2012c):

- **Hope** - Hope is crucial for recovery, to establish goals, and define a better future. The Veteran finds his/her own hope as he/she believes the information, encouragement, and support given by his/her support system. The P-MHN supports the Veteran to look forward, celebrate small gains, and cultivate optimism. People **can** and **do** overcome mental illness.

- **Person-Driven** - Recovery is Veteran led and oriented through self-determination and self-direction, which defines the recovery path for each Veteran as he/she leads, controls, and chooses his/her own goals and recovery path. The P-MHN facilitates this by encouraging autonomy, independence, and offering choices. This empowers the Veteran to make informed decisions, build on their strengths, and gain or regain control over their lives.

- **Culture** - Recovery is not a 'one-size-fits-all' approach to wellness; it is individualized and builds on unique strengths and resiliencies, needs, preferences, experiences, and cultural values, traditions, and beliefs. The P-MHN delivers culturally competent care in effort to negotiate, make decisions, and support the Veteran's recovery. This requires the Veteran to be an active participant and guide their clinical care and goals. There are multiple paths to recovery.

- **Holistic** - Recovery is holistic and recognizes the whole Veteran; mind, body, spirit, and community. Clinical and interpersonal interventions are not directed only at distressing symptoms, but are focused on collaboration with the Veteran.

- **Many Pathways** - Recovery is non-linear; it is continuous and individual with constant movement forward and backward toward identified goals. Change can move slowly or quickly. Each Veteran is unique with distinct needs, strengths, preferences, goals, culture, and backgrounds – including traumatic experiences – that affect and determine their pathway in recovery. Setbacks are a natural part of the recovery process and foster resilience for each Veteran and family.

- **Strengths/Responsibility** - Recovery builds on the strengths and qualities of each individual Veteran. The P-MHN focuses the Veteran on valuing and building on his/her capacities, resiliencies, talents, coping abilities, and worth. Recovery *always* comes back to the individual Veteran. The Veteran has a personal responsibility for self-care and his/her own recovery journey. The Veteran has obligations and is accountable for his/her choices and decisions. The P-MHN encourages the Veteran to be courageous and be willing to take risks, speak in their own voice, and step outside of safe routines.

- **Peer Support** – Peers and allies offer shared experiences, social normalization, a sense of belonging, supportive relationships, valued roles, and community. In the inpatient setting, peer support encourages the Veteran to connect with others, provides a sense of belonging, and encourages a multi-faceted support system of peers, family, friends, and mental health professionals. Further information on the formal VA Peer Support program is included later in this module.
- **Relational** – Recovery is supported through relationship and social networks. The presence and involvement of a support system that believes in the person's ability to recover are important. The positive support system creates a safe space for a person to engage in new, healthy life roles leading to an improved sense of belonging, identity, empowerment, autonomy, social acceptance, and community participation.
- **Respect** – Human dignity and respect are a basic right and a provision of every kind of nursing care. In mental health nursing, dignity and respect are core concepts of the recovery model and are achieved by eliminating discrimination, reducing stigma, and offering acceptance and appreciation for each Veteran. The Veteran speaks for his/her own needs, wants, desires, and dreams.
- **Addresses Trauma** – Trauma experiences (combat, physical/sexual abuse, domestic violence, war, disaster, etc.) are often associated with substance use and mental health problems. The P-MHN provides trauma-informed care by ensuring an emotionally and physically safe environment, building trust, and promoting choice, empowerment, and collaboration. More information on trauma-informed care is included later in this module.

Recognition of the history of mental health care allows us to move forward and consciously change our practice to be recovery-oriented, particularly in the inpatient setting. Implementation of recovery principles can be challenging as it disrupts the status quo. Increased need for consistency, vigilance, and accountability is staff intensive. The P-MHN strives to implement recovery-oriented principles in his/her clinical care, therapeutic relationships, unit milieu, activities, and environment. The P-MHN creates trust and empowerment through transparency, patient education, and support for the Veteran to make his/her own choices. The Veteran makes personal choices from available options and participates in *all* decisions that affect his/her life. The Veteran is able to take increasingly more responsibility for him/herself (developing goals, participating in treatment, reaching goals, engaging in self-care, etc.) and learns through the consequences of his/her choices.

Recovery-oriented care focuses on individual Veteran needs, not staff needs. It asserts that Veterans are capable and responsible for guiding their own care; it decreases staff power and control over Veterans. The focus moves from a paternalistic caring *for* the Veteran to a focus on respect, dignity, and hope *with* the Veteran. Recovery-oriented care can be cultivated in the inpatient setting through various interventions including but not limited to:
- Decreasing rules (safety rules are exempt)
- Encouraging flexibility in meeting Veteran requests
- Adjusting to individual situations and needs

- Eliminating coercive actions or mandating Veteran compliance
- Providing activities without expectation or requirement of Veteran reciprocation (i.e. birthday parties, pizza/movie nights, special treats, etc.)
- Implementing Veteran discussion groups on recovery concepts/ideas
- Empowering staff to suspend rules to prevent conflict, allowing the treatment team to discuss and deal with the issue the next day

The P-MHN recognizes the necessary transition from inpatient to outpatient and prepares the Veteran for discharge. Recovery continues after hospitalization and is supported through health, home, purpose, and community (SAMHSA, 2012b). Health includes overcoming or managing disease or symptoms by making informed, healthy choices to support physical and emotional wellbeing. Home offers a stable and safe place to live. Purpose includes meaningful daily activity (job, school, volunteering, hobbies, etc.) and the independence, income, and resources to participate in society. Community is built through relationships and social networks that provide support, friendship, love, and hope.

Further information and training on recovery in the acute setting for the P-MHN is available through the American Psychiatric Nurses Association (2017) at http://www.apna.org/i4a/pages/index.cfm?pageID=5296

Culture

Culture is defined as integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups (TJC, 2010a). It is fluid and shaped by various factors such as race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation. Personal views regarding health and wellness are colored by culture and individual values, beliefs, and behavior (Georgetown University, 2004). Culture is important and relevant in healthcare as it can account for how Veterans communicate symptoms and which symptoms they report. Culture can have a significant impact on whether people seek help for mental health issues, what types of help they seek, what coping tools and social support system they have, and the stigma they attach to mental illness. Cultural meanings of illness contribute to a person's motivation to seek treatment, how they cope with symptoms, how supportive their family or community is, where they seek help (mental health specialist, primary care provider, clergy, traditional healer, etc.), how they access services, and how well they fare in treatment (United States Department of Health and Human Services (USDHHS), 2001). Culture is present for the Veteran, the nurse, and even the VA healthcare system. Culture can be visualized as a rising sun, with major concepts radiating from the core of individuals, families, groups, communities, and institutions (Leininger, 2002).

Sensitivity and awareness of culture is called cultural competence and is an ongoing and fluid process. "Cultural competence… describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs" (Betancourt, Green & Carrillo, 2002, p. v). Cultural competence is integral for the P-MHN to develop rapport with each Veteran and help to identify meaningful goals and progress in his/her Recovery. This is particularly true in the acute psychiatric setting. Cultural competence is maintained by learning about new cultures, unique populations served (lesbian, gay, bisexual, transgender, queer (LGBTQ), military sexual trauma (MST), religious beliefs, etc.), being aware of current population trends, and listening to each Veteran share his/her story. The P-MHN must be self-aware and realize his/her own culture, perspective, values, and beliefs brought to each interaction. The intent of cultural competence in healthcare is to have meaningful and positive health outcomes for Veterans of diverse backgrounds and cultures. Through cultural awareness and competency, the P-MHN empowers the Veteran to be an active partner in his/her care and recovery.

Military Culture

What is a Veteran?

Whether active duty, discharged, retired, or reserves, a Veteran is someone who, at one point in their life, wrote a blank check made payable to "The United States of America" for the amount of, up to and including, their life. That is an honor.

And there are too many people in this country today who no longer understand that fact.

By an anonymous, proud American Veteran

The military has its own culture and each branch offers a distinct difference from the others. The above statement reflects the pride and the sacrifice that those who have served in the military have instilled in their very nature. Military cultural competence is necessary to develop a therapeutic rapport and alliance with the Veteran patient. Taking the time to get to know at least an overview of military culture demonstrates to the Veteran that the nurse does indeed care and is attempting to understand the Veteran's unique circumstances. Military cultural has its own unique aspects and is a vital component of a cultural nursing assessment. It is important for the P-MHN to understand and have knowledge about the military population served, demonstrate a regard for Veterans' culture, and understand the unique experiences and contributions of those who have served this country. The VA adds an additional cultural layer to the Veteran patient through the extension of health care, service connection, and other benefits related to years of service and/or injury sustained during service. Knowledge and understanding of military lifestyle, terminology, structure, branch specific identities and duties,

combat-related illness, and the impact of deployments and trauma are just a few cultural issues which the P-MHN must consider.

Military branches are separated into two categories, active duty or reserve members. Active duty service is a full time, permanent commitment to the military for a fixed amount of time. Reserve service is a part time commitment with the potential to be activated as necessary for a fixed amount of time. Reservists routinely train one weekend per month and two weeks per year. Active duty or reservist status has its own unique stressors and requirements. Active duty personnel are frequently moved to meet the needs of their branch of service. Reservists frequently have full-time jobs in their community and may have trouble readjusting to civilian life post deployment. An additional branch of the military that is present only within the Army and the Airforce are Guard members. They are state owned resources deployed within the continental United States (CONUS) by their state governor. Deployment outside of the continental United States (OCONUS) occurs only by presidential order. Guard members drill with the same frequency as Reservists.

Military Branch Description				
Branch	Term	Size (2015)	Mission and duties	Inception Date
Army	Soldier	490,326 Active duty 198,599 Reserve	To fight and win our nation's wars by providing prompt, sustained land dominance across the full range of military operations and spectrum of conflict in support of combatant commanders.	June 1775
Air Force	Airman	310,795 Active duty 69,127 Reserve	To deliver sovereign options for the defense of the USA and its global interests to fly and fight in air, space, and cyberspace.	September 1947
Navy	Sailor	326,253 Active duty 57,859 Reserve	To maintain, train and equip combat-ready Naval forces capable of winning wars, deterring aggression, and maintaining freedom of the seas.	October 1775
Marine Corps	Marine	183,787, Active duty 38,213 Reserve	The seizure or defense of advanced naval bases and other land operations to support Naval campaigns. The development of tactics, techniques, and equipment used by amphibious landing forces. Such other duties as the President may direct.	November 1775
Coast Guard	Guardian	40,075 Active duty 7,417 Reserve	To protect the public, environment, and US economic and security interests in any maritime region those interests may be at risk, including international waters, America's coasts, ports, and inland	August 1790

			waterways.	

The United States has been involved in a variety of military conflicts from formal war to military combat since the Proclamation of Independence. Each combat era has created a different culture of Veterans due to a variety of factors including but not limited to: political climate, current affairs, national regard for persons in service, and other contributing factors. In addition to voluntary application for military service, from 1940-1973, American men were inducted into military service by a lottery draft. "The draft" as it was frequently called, was controversial with US citizens arguing for or against it and ultimately led to our nation having an all-volunteer military in 1973.

The term "volunteer" does not adequately capture the status of military members who have served since 1973. To clarify, US citizens can voluntarily join the military if they meet standards of physical and mental health. However, once they have voluntarily joined, they have little input as to what they will do, where they are sent, how long their assignments (deployments) must be, and they must stay in the military until they have completed their initially contracted tenure. This is an important distinction, as it may affect the perspective of the Veteran seeking care in VA healthcare system. New and novice nurses should reflect on the meaning this may have for their Veterans.

Conflict	Timeline	Basic Information	Average age
World War II	1941 - 1945	The most widespread and deadliest war in history with over 100 million military personnel mobilized and 50-70 million fatalities. Significant events include the mass death of civilians (Holocaust) and the only use of nuclear weapons in warfare.	26
Korean War	1950 - 1953	Communist North Korea (supported by China) invaded non-communist South Korea. U.N. forces, principally U.S. troops, fought successfully to protect South Korea. The first armed conflict in the cold war (democracy vs. communism).	20
Vietnam War	1962 - 1973	North Vietnam wanted to reunite South Vietnam and itself under its Communist government. The U.S. supported South Vietnam. U.S. opposition to the war resulted in withdrawal of U.S. forces in 1973. North Vietnam defeated South Vietnam and took control of the country in 1975.	19
Persian Gulf War	1991	Saddam Hussein invaded and occupied neighboring Kuwait. Arab powers requested U.N. intervention. US all volunteer force. Operational names included Operation Desert Shield, Operation Desert Storm, and Operation Desert Sabre.	27

| War in Iraq
➢ Operation Iraqi Freedom (OIF)
➢ Operation New Dawn (OND) | 2003
-
2011

2010
-
2011 | The War in Iraq was initiated to remove any threat by presumed weapons of mass destruction.

U.S. all volunteer force. The largest and longest lasting mobilization of the Reserve and National Guard since the Korean War, resulting in multiple deployments for military personnel. | 30 |
| War in Afghanistan
➢ Operation Enduring Freedom (OEF) | 2001
-
2014 | After the September 11 attacks on the U.S., the War in Afghanistan was launched and aimed to stop the Taliban regime and destroy al Qaeda. | |

While it is beyond the scope of this module to provide the nurse with an extensive description of military culture and terms, military service members have, essentially, their own language. This language often consists of acronyms and three or four letter initials for commonly used terms. Linguistics vary among the different branches of the service, and military experiences differ widely amongst various conflicts. Knowledge and understanding of combat-related illness, the impact of deployments, and trauma are just a few issues which the P-MHN must consider in relation to military culture.

Female Veterans have other cultural considerations which must be assessed in the provision of nursing care. The female Veteran population continues to grow; women Veterans have different healthcare needs than males. Nursing assessment must include questions regarding pregnancy and/or nursing when appropriate, which can direct treatment and healthcare options, particularly in the mental health arena. There is a provision of care expectation for female Veterans in acute psychiatric settings requiring secure or lockable sleeping accommodations. VHA mandate requires the female Veteran is educated to such provisions upon admission and that the nurse documents such within the medical record (Dept. of VA, 2015). Mixed gender units must ensure safe sleeping and bathroom arrangements, including but not limited to, door locks and proximity to staff.

Advance Directives

The term "Mental Health Advance Directive" (MHAD) refers to a legal document with statutory authority that allows the Veteran to record his/her choices regarding future healthcare decisions prior to becoming incapable of making such decisions. "A mental health or psychiatric advance directive is for patients whose future decision-making capacity is at risk for becoming impaired due to mental illness" (VA, 2013, p. 3). VHA Directive 1004.02 requires the opportunity for the Veteran to indicate his/her preferences about future mental health care

in advance of losing decision-making ability. The P-MHN assesses for an existing MHAD at admission. The presence of a MHAD offers the P-MHN and interdisciplinary team guidance on Veteran goals and treatment preferences. The absence of a MHAD is an opportunity for the P-MHN to educate the Veteran on the importance of developing a MHAD and offer referral to the appropriate staff for MHAD completion. Mental health providers are required to facilitate discussions regarding future mental health care and treatment with Veterans diagnosed with serious mental illness (TJC, 2010a; VA, 2015).

To assist VA staff and Veterans in better understanding advance directives, there are two VA fact sheets available for review ([VA form 10-0137A](#) "Your Rights Regarding Advance Directives" and [VA form 10-0137B](#) "What You Should Know about Advance Directives") relating to advance healthcare planning. The P-MHN does not complete the MHAD with the Veteran, but provides education on the purpose, scope, and information to include in the MHAD. Some examples of information that may be important to discuss with the Veteran when approaching the subject of future mental healthcare planning preferences include but are not limited to:

- Potential signs of relapse and worsening psychiatric symptoms
- Measures that help to decrease feelings of emotional discomfort or distressing symptoms during a crisis
- Preferences for medications, therapies and other treatments (such as those that have worked in the past, as well as the names of medications that have not been helpful)
- Preferences for certain types of programs and/or facilities where he/she received treatment considered helpful in the past
- Information regarding who the Veteran might wish to be contacted during times of acute psychiatric illness. For example, they might want to offer instructions about who can take care of personal matters e.g. who can be contacted to care for pets or look after personal possessions or property, who can handle business matters such as pay rent or utilities, and/or other personally meaningful instructions he/she wants carried out while incapacitated.

When providing education on the MHAD, be certain to provide the Veteran with a copy of each of the two fact sheets and document in CPRS as evidence of Patient Education. Any discussions about MHADs, including providing education, are documented in a CPRS note titled "Advance Directive Discussion", even if the Veteran chooses not to complete or change a MHAD. Minor updates such as changes in contact information can be documented as an addendum to the MHAD, but any substantive changes require rescinding the MHAD. The preferred way to document advance planning discussions in CPRS is through use of the IMED consent. Veterans that already have a MHAD can present it to clinical staff at admission. This is noted in an "Advance Directive" CPRS note per local facility policy.

MHAD completion requires two witnesses to be considered legally binding. Witnesses may include any non-clinical VA staff, social workers, chaplains, or psychologists, although the preference is to have no staff sign who are directly involved in the Veteran's care. Non-staff persons (such as friends or neighbors 18 years of age or older) can witness, with the exception of anyone who may have a potential financial conflict with the Veteran (e.g. someone who

stands to possibly inherit from the Veteran). Each page of the MHAD is initialed and dated by the Veteran in the presence of the two witnesses. As the P-MHN, you will not be able to sign as a witness for the Veteran.

Important Points to Remember:
- As a reminder to the Veteran, professionals are obligated to provide treatment in emergent situations consistent with the standards of care, regardless of documented Veteran preference noted in the MHAD.
- There can be only one VA Mental Health/Psychiatric Advance Directive entered in CPRS.
- VA recognizes all State and Department of Defense (DoD) advance directives. If the Veteran has more than one state or federal form, please ensure they understand that the forms must not contain conflicting information.
- All forms can be found at website http://vaww.va.gov/vaforms/

Ethics

All RNs are expected to adhere to the Code of Ethics with Interpretive Statements. The P-MHN has a further obligation to consider unique ethical issues specific to the mental health population such as vulnerability and legal issues. These include but are not limited to involuntary treatment, restraint, seclusion, and commitment. As an advocate for the Veteran, the P-MHN must promote the development of autonomy and self-determination. Ethical concerns that arise must be reported to the ethics committee per facility policy.

Individuals with mental illness are guaranteed the same rights under federal and state laws as any other citizen. It is every person's civil right to be able to access or refuse treatment. If the refusal of care and/or treatment is deemed to pose a significant likelihood or imminent risk of harm to self or others, a patient may be committed as an involuntary patient.

The P-MHN must demonstrate compassion and respectfully encourage and advocate for the Veteran in overcoming the stigma and negativity related to mental illness. The P-MHN delivers care in a manner that preserves every patient's right for dignity, autonomy, and self-advocacy (ANA, APNA & ISPN, 2014, p. 67). The P-MHN has a responsibility to balance human rights with safety and the potential need for intervention when the individual lacks the ability to maintain his/her own safety or the safety of others.

The P-MHN must be aware of his/her own experiences, beliefs, and values and reconcile differences in order to provide compassionate and respectful care within ethical
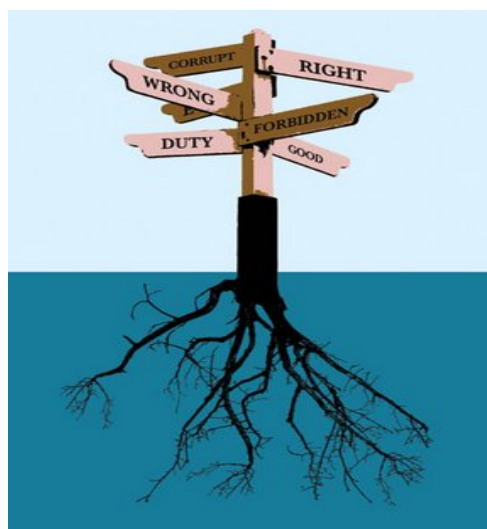
guidelines.   "The P-MHN monitors and carefully manages confidentiality, therapeutic self-disclosure, and professional boundaries through all forms of interaction (i.e., face –to-face, electronic record, social media)" (ANA, APNA & ISPN, 2014, p. 39-40). A high risk of vulnerability or exploitation exists in mental health care due to the private and intimate nature of the information received from the Veteran in order to create a therapeutic relationship. The P-MHN is obligated to establish appropriate boundaries with the Veteran and any guardians, family members, caregivers, and significant others. Therapeutic boundaries extend during and after the inpatient stay and include avoiding social media, any relationships, and/or intimate contact. The P-MHN must notify his/her supervisor immediately of any existing or prior relationship with an admitted Veteran or their family. In this situation, it is important for the P-MHN to know nursing care will be reassigned to an uninvolved staff. The P-MHN is to refrain from any access to Veteran information and ensure the treatment team addresses the provision and plan of care with the Veteran.

The P-MHN has a responsibility to be aware of legal and regulatory statutes relating to involuntary treatment. Involuntary treatment is guided by state law and individual facility policy. The guidelines and statutes required for an involuntary commitment vary from state to state. Please be familiar with your state policy and facility standard procedure for involuntary treatment/commitment.

Maintaining a safe, therapeutic milieu and least restrictive environment for every Veteran is the standard of care in the inpatient setting. All patients have the right to be free from restraint or seclusion as a means of coercion, discipline, convenience, or retaliation (TJC, 2010b & 2014). Restraint and/or seclusion is only used as a last resort when clinically justified and the Veteran's behavior is threatening the physical safety of him/herself or others. The P-MHN must be knowledgeable of what constitutes a restraint and/or seclusion and maintains competency in application and documentation of these interventions per individual facility policy. In an event where restraint or seclusion is deemed appropriate and clinically necessary, the P-MHN will preserve the dignity of the Veteran and minimize physical and emotional trauma.

*This section is not a comprehensive review of all ethical issues related to psychiatric mental health nursing practice, but a short list of those most frequently encountered.

Nurse Led Psychoeducational Groups

All registered nurses (RNs) working in the acute psychiatric setting have a responsibility to conduct effective psychoeducational (PE) groups. Conducting groups is often introduced in nursing academia, but nurses are not proficient upon graduation and/or when transferring from other clinical areas into the acute psychiatric setting. Conducting effective PE groups requires significant practice, ideally with expert mentorship. RNs new to the acute psychiatric

setting should consider additional training and education in creating, leading and documenting PE groups. *Leading Psychoeducational Groups: The Nurse's Role* (available at: http://vaww.va.gov/nursing/docs/cpp/mhRN_GroupGuide2015.pdf) and *Essential Skills and Strategies for Nurse Led Group Facilitation* (available in TMS at: https://myees.lrn.va.gov/Watch/Video%20Center.aspx?vid=4775871281001#top) provides additional information and training opportunities for those wanting to further develop these skills.

There are different types of groups. Activity groups may include things like exercise, accomplishing manual tasks, and improving leisure skills. Community groups focus on helping patients re-enter successful relationships with significant others, friends, family, and communities. Psychotherapeutic groups provide a therapeutic and safe environment to identify or explore Veteran-identified challenges and potential conflicts towards the goal of successful resolution. Nurses facilitating a psychotherapeutic group should have had extra training and/or graduate level education due to the potential complex nature and purpose of these groups. Psychotherapeutic groups are distinctly different from PE groups, as PE groups may be therapeutic, but the focus is not on interpersonal skill building.

Although adequate supervision, mentorship, and practice are required to conduct PE groups, nurses are able to, and have a responsibility to master the skills necessary to be an effective and efficient PE group leader. The emphasis of a PE group is to, "support teaching of physical health and mental health education for effective living, problem management, and mental health recovery" (VA ONS, 2013, p. 7). Specifically, the focus of a PE group is to provide education and knowledge on a specific topic (i.e. pain management, medication education, etc.) and skills building. PE groups may be conducted by the generalist P-MHN.

The concept of recovery is a key conceptual framework for PE groups and includes four specific dimensions: physical and mental health, a stable and safe home, purposeful and meaningful daily activity, and having community relationships and supportive social networks. Another critical framework underpinning PE groups is the therapeutic milieu for treatment. The P-MHN must actively engage in the facilitation of an environment that is safe, supportive, has structure, encourages social involvement, and affirms self-understanding and validation. It is important that the P-MHN learn the context and background of conceptual frameworks supporting PE groups.

In order for P-MHNs to effectively conduct PE groups, they must gain an understanding of the development of group processes and dynamics. Like any group, PE groups go through different stages of developing cohesiveness and functionality. RNs conducting PE groups are expected to help the group form rules or norms of expected behaviors. Specifically, the P-MHN helps the group identify the expected level of participation, learn how to deal with resistance among members, set expected communication patterns, define effective and healthy relationships within the group membership, identify acceptable non-verbal behaviors, sets the tone of the group, and facilitate expressed feelings of group members. The processes and dynamics of the PE group facilitate collective cohesiveness, which helps the group achieve its stated goals.

Because the overarching goal of PE groups is to teach members specific information and facilitate practice of skills or strategies, the P-MHN should have an adequate knowledge of teaching and leadership abilities. Several characteristics critical to PE group leadership include having a belief in the group process, self-confidence, having the courage to take risks and admit mistakes, being organized and flexible, having a tolerance for ambiguity, being self-aware, and having a sense of humor (Brown, 2011). Critical leadership skills center around the P-MHN who demonstrates the ability to care, show warmth towards others, possesses unconditional positive regard for participants, and is genuine with others (Yalom, 2005).

In any interaction with patients, especially in groups, there is the potential for challenge and conflict among members. In the facilitation of PE groups the P-MHN anticipates challenge and conflict and prepares effective strategies to manage these responses. Challenging Veteran behaviors can include over-participation (storytelling, monopolizing, attention-seeking, behaving as the leader's assistant) or under-participation (non-participation, socializing). There are at least five possible responses used to address challenge and conflict: holding a firm response (firm, clear, direct messages), distracting (delay, ignore, divert), soothing, compromising, and confronting (explore how participant's behavior is affecting the group). Confronting responses should not be confused with being aggressive; the P-MHN can practice effective confronting responses via role-play or brainstorming.

Many techniques can enhance the effective development, implementation, and evaluation of PE groups. These can include defining the content or focus of the group, completing a literature search on the topic, identifying strategies and materials needed, choosing group membership, type and size, constructing a framework of sessions, advertising the group schedule, choosing the location wisely, challenging your own expectations of groups, and defining measureable goals. The P-MHN can develop a short, simple evaluation and a lecture or guide to each PE group. The P-MHN may want to consider doing a pilot study to discover what does and does not work well. Specific teaching strategies that work well include using lecture, focused discussion, exercises (i.e. self-reflection), games, role-play, simulation, and various media.

PE groups are an effective means of creating a safe and supportive milieu and to facilitate recovery for Veterans living with mental health issues. While conducting PE groups requires skill, training, and mentorship it is a very effective nursing tool for the P-MHN to acquire and use. RNs working in the acute psychiatric setting have an obligation to learn to implement effective PE groups. Please review *Leading Psychoeducational Groups: The Nurse's Role* to further build on group leadership skills and knowledge.

Peer Support

The P-MHN must be aware of and collaborate with the interdisciplinary team members comprising the inpatient team. Peer support is an integral part of the interdisciplinary team and brings a unique skillset and perspective to acute mental health care

and recovery. "Peer Support is a promising best practice which provides role models for Veteran consumers of the Department of Veterans Affairs (VA) mental health care program to engender hope, demonstrate recovery, and teach advocacy skills" (VA, 2011, p. 1). The VA Peer Support Program was started and funded in 2005 and is now a required element of VA care for the seriously mentally ill (SMI) Veteran population.

Peer Support Services offers non-licensed support staff with lived experience of illness, life events, and/or treatment for mental illness and/or substance abuse. Peer Support Services are recovery oriented and provide an outlet of support for Veterans engaged in VA care. They provide a variety of mental health treatment programs under the supervision of a mental health provider. Peer Support Services can be offered in various programs, but are frequently found in Psychosocial Recovery and Rehabilitation Centers (PRRC), Residential Rehabilitation Treatment Programs (RRTPs), Mental Health Intensive Case Management (MHICM), Supported Employment (SE) programs, inpatient psychiatry, outpatient mental health, and substance use treatment programs.

The VA offers peer support training at a national level for persons hired into peer support positions. Each facility Peer Support Program may function differently to meet the identified needs of the SMI Veteran population. Some inpatient units have an assigned Peer Support Specialist or Technician, while others have peers rotate through the acute unit to reduce burnout. This is frequently up to the healthcare provider overseeing the functioning of the Peer Support Program at the facility level. Peer support should play an active role in contributing to the therapeutic environment of an inpatient acute unit and in providing therapeutic interventions to the inpatient population. They participate in treatment planning, defining individual goals, and supporting the Veteran toward recovery.

Peer Support Specialists can be a great resource for the P-MHN. The Peer Support Specialist can support the Veteran to set and achieve goals, provide hope for recovery, and can often engage the Veteran on a more personal and less clinical level. They may be able to provide candid feedback from Veterans regarding programming, unit functioning, and opportunities for improvement. The Peer Support Specialist is a wealth of information, a patient advocate, and a partner for the Veteran to navigate the complex VA healthcare system. They can provide services within inpatient and outpatient services, improving Veteran outcomes, and supporting recovery across lines of care and disciplines.

Trauma Informed Care

The ultimate goal of inpatient nursing is to stabilize the Veteran from crisis and transition them back to a less intensive level of care. Part of crisis stabilization is the provision of trauma informed care to support the Veteran through his/her crisis, avoid re-traumatization, and return them to the outpatient setting. The P-MHN provides trauma informed care

through awareness that all Veterans may have experienced trauma, a traumatic event(s), or moral injury. The Veteran may not be able to articulate or identify exposure to a trauma, but may be triggered by their surroundings. The P-MHN completes a brief assessment regarding history of abuse at admission and recognizes the Veteran may have experienced other forms of trauma. Trauma-informed approaches to care shift the clinical focus from, "What's wrong with you?" to "What happened to you?" The P-MHN provides trauma informed care by the following (Menschner & Maul, 2016):

- Recognition of the widespread impact of trauma
- Assessment of the signs and symptoms of trauma
- Integration of knowledge about trauma into policies, procedures, and clinical practice
- Avoidance of the creation of a treatment environment that can cause re-traumatization

Exposure to abuse, neglect, discrimination, and other adverse experiences increases lifelong potential for serious health problems and engaging in health-risk behaviors (Menschner & Maul, 2016). Evidence suggests that exposure to traumatic events, especially during childhood, heightens health risks on a long term basis (Felitti, et al., 1998). A therapeutic milieu is created by ensuring the Veteran is physically and emotionally safe on the unit. The P-MHN identifies clear expectations regarding treatment and the provision of inpatient services; this enhances trust.

> **Individual trauma results from an event, series of events or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.** (Menschner & Maul, 2016, p. 2)

There is no universal definition of trauma. According to SAMHSA's Trauma and Justice Strategic Initiative, "trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2012a, p. 2). Trauma should not be viewed narrowly but rather through a broader lens (SAMHSA, 2014, TIP 57). Many survivors lack insight regarding the connection between trauma and mental health problems. It is important for the P-MHN to understand the impact of trauma and the need to provide a trauma-informed approach to care. Trauma informed care is a component of mental health recovery. "Trauma is often a precursor to or associated with alcohol, drug use and mental health problems. Services and supports should be trauma-informed to foster safety and trust as well as promote choice, empowerment and collaboration" (SAMHSA, 2012a). Veterans with mental health disorders are more likely to have histories of trauma.

Type of Trauma	Definition & Outcomes
Natural Trauma	Acts of nature causing disruption in daily routines, living conditions. Indirect and direct community involvement (i.e. Red Cross assistance).
Human-caused	Caused by intentional or unintentional human failure. Survivors can

Trauma	experience anger, blame and struggle to understand motives for the act.
Group Trauma ➢ Community ➢ Cultural ➢ Historical ➢ Mass	Affect a group of people who may "shut down" in order to manage. First responders are likely to experience repeated traumas. **Community Trauma:** hate crimes, school shootings **Cultural Trauma:** erodes heritage or culture **Historical Trauma:** generational, affect an entire culture (i.e. the Holocaust) **Mass Trauma:** large number of people are affected (i.e. earthquakes)
Individual Trauma ➢ Interpersonal ➢ Developmental	**Interpersonal:** between two people who know each other (intimate partner violence) **Developmental:** Experience that occurs within a developmental stage (i.e. parent death, parent divorce, life-threatening illness, extreme economic hardship)
Political terror and war	Terroristic acts Refugees

Note. Adapted from SAMHSA, 2014, TIP 57, p. 33-44

Treatment Settings and Re-traumatization

The P-MHN recognizes that each Veteran brings his/her own history and experiences to the acute setting and offers support and hope toward recovery. Every effort is made to provide and therapeutic and healing environment and avoid traumatizing, or re-traumatizing a Veteran during their acute stay. Re-traumatization occurs when the Veteran's current experience makes them feel as though they are undergoing another trauma. Staff in treatment settings can re-traumatize the Veteran by being unaware of the Veteran's trauma history. For example, a Veteran who was a prisoner of war (POW) may relive their trauma if placed in a confined space. Or a Veteran with a history of Military Sexual Trauma (MST) may be triggered by a provider that has a similar mannerism as their attacker. Veterans who have experienced being confined or restrained (i.e. by intimate partner violence, sexual assault, etc.) may respond differently to the restraint and/or seclusion process.

The P-MHN creates a safe, trauma-informed care approach to support the Veteran in his/her recovery and move them toward discharge from the acute setting. The nurse empowers the Veteran to focus on the Veteran's strengths and responsibilities, and provides education to support informed choices. The P-MHN reinforces the Veteran's support system by maximizing collaboration opportunities between the Veteran, family, and staff during treatment planning.

Secondary Traumatic Stress in Staff

Caregivers are indirectly exposed to trauma through the provision of care; this is known as secondary traumatic stress and may contribute to turnover in mental health professionals. The P-MHN should be aware of the potential for secondary trauma and utilize physical, psychological, emotional, and spiritual self-care strategies to promote personal health and wellness. Become aware of your facility resources and protocols such as the Employee

Assistance Program and processes such as debriefing after a psychiatric or medical emergency on the inpatient unit.

Summary

Patient centered care is a cornerstone of the acute inpatient setting. It contributes to the Recovery model of care that drives mental health care in general and supports Veteran independence, autonomy, and empowerment, while balancing safety considerations and potential ethical issues present in the acute psychiatric setting. Patient centered care promotes recovery in Veterans with mental illness and establishes a cooperative partnership between clinical staff and the Veteran in defining care goals and inpatient stay expectations. Cultural awareness and sensitivity to individual factors is an important skill for the P-MHN. Awareness of potential MHAD, ethical issues present in providing involuntary clinical care, trauma informed care approaches and inclusion of interdisciplinary team members, specifically peer support specialists, create a patient centered care approach. Providing psychoeducation teaching in the group setting is a unique skillset for the P-MHN and further promotes recovery and patient-centered care for the informed Veteran. This module is not an exhaustive list of topics relevant to patient centered care, but is an overview of relevant approaches to this standard.

	✓	Knowledge Check
		I can identify three cultural structures.
		I am aware of the difference and relevance of military culture for Veteran patients.
		I can identify the rationale for completion of the mental health advance directive.
		I can discuss the role of the Peer Support Specialist.
		I can recognize appropriate group modalities for the generalist P-MHN.
		I can identify different types of trauma and determine how to coordinate trauma informed care.

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Psychiatric Nursing Assessment

Objectives:

1. Identify the core components of the psychiatric nursing assessment.
2. Identify the goal of suicide risk assessment.
3. Define which 2 characteristics are associated with the highest risk of suicide.
4. Name two substances of abuse that can cause death on withdrawal.
5. Identify the key component in the management of disruptive behaviors.

Introduction

The psychiatric nursing assessment is compiled by the nurse and includes a collection of subjective and objective data. This creates a comprehensive overview of the Veteran through examination of the physical, psychological, intellectual, social, and spiritual aspects of the individual. "The P-MHN collects and synthesizes comprehensive health data that are pertinent to the healthcare consumer's health and/or situation" (ANA, APNA & ISPN, 2014, p. 44). Assessment starts at admission and ends once the patient is discharged from inpatient care. The assessment process provides the P-MHN with a 'first look' of pertinent Veteran information and the opportunity to establish a professional, recovery oriented relationship with the

Veteran. Patient information includes but is not limited to: history, presenting symptoms, patient baseline, goals, strengths, weaknesses, and areas to address within the interdisciplinary team. The P-MHN synthesizes information obtained from interviews, behavioral observations, and other available sources to document in the admission assessment, serving as the foundation for the nursing care of the Veteran.

Ongoing shift assessment is a collection of different information, continues throughout the inpatient stay, and varies dependent on the role of the attending nurse and the presentation of the Veteran. The admission assessment is routinely more detailed and in-depth than the shift assessment. Shift assessments are completed multiple times per day (dependent on nursing shift schedules), detail information relevant to that shift, and build upon information from prior shifts. The P-MHN observes the Veteran during all interactions and critically assesses behavioral symptoms, reported complaints, physical presentation, and verbal communication. The P-MHN identifies presentation congruencies and incongruences that may warrant further assessment. Admission and shift assessment may include the psychiatric nursing assessment, suicide risk assessment, pain assessment, substance use or substance withdrawal assessment, disruptive behavior assessment, head-to-toe physical assessment, and/or other information relevant to the Veteran presentation during the time the P-MHN is assigned to him/her. Each piece of data is integrated into a comprehensive assessment which is documented in CPRS. Deviations are reported to the next shift and to the interdisciplinary team as clinically indicated.

Psychiatric Nursing Assessment

The psychiatric nursing assessment is a clinical assessment reflecting the Veteran's subjective report and the nurse's observations at the time of the interview. It is useful for baseline assessment, planning, and observing change over time. This is comparable to the physical head to toe exam in a general medicine setting. The P-MHN, in observation and interaction with the Veteran, documents such things as: physical appearance, behavior, cognition, verbal and non-verbal communication, speech patterns, thought content, perceptions, mood, affect, and insight or judgement. There are variations in the format of the psychiatric nursing assessment. Please follow your facility and unit guidelines in assessment and documentation.
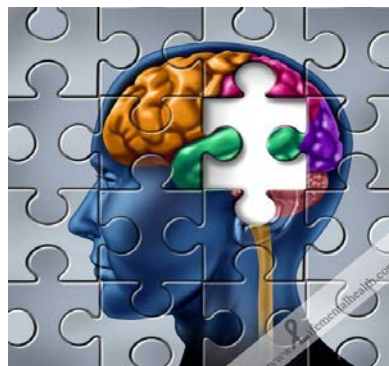
Component	Description	Documentation Sample Terms
Appearance	Physical characteristics (tattoos, scars), height/weight proportion, grooming and attire, level of hygiene, relationship between appearance and age	Normal hygiene, appropriate dress, disheveled, unkempt, body odor, underweight, appears older than stated age
Behavior	Eye contact, psychomotor activity, abnormal movements (e.g. tremors,	Calm, good eye contact, restless, psychomotor agitation, shuffled gait

	tardive dyskinesia)	
Attitude	Level of cooperation, general tone toward interviewer	Cooperative, guarded, hostile, uncooperative, deductive, evasive
Speech & Language	Rate, volume, tone of voice, language impediments	Slurred, stuttering, pressured, loud, soft, rapid, slow, poverty of
Mood	Pervasive and sustained subjective emotional state	Euthymic, depressed, labile, angry, anxious, euphoric, irritable
Affect	Observed emotional state	Normal, appropriate to situation, restricted, inappropriate, flat, blunted
Thought Process	Rate of thought, flow and organization, form of thought	Tangential, loose associations, disorganized, thought blocking, flight of ideas, circumstantial
Thought Content	Information offered in response to interview, beliefs, delusions, obsessions, concerns	Somatic complaints, sexual preoccupation, religiosity, guilt, persecution/paranoia, grandeur, suicidal, homicidal ideation
Perception	Experience and interpretation of sensory input, hallucinations, illusions, disassociation	Presence of auditory, visual, olfactory, tactile, gustatory hallucinations, illusions, multiple personality, de-realization
Cognition	Orientation, intelligence, level of consciousness, attention and concentration, ability to abstract	Oriented to person, place, time, situation, concrete thinking, disoriented, distractible
Insight	Self-awareness, understanding, acceptance of difficulties	Good, fair, poor
Judgment	Ability to make a decision or take action when presented with a situation	Good, fair, poor, impaired

Suicide Risk Assessment

Suicide is the 10th leading cause of death overall in the US within each age group 10-64 (Heron, 2016). For Veterans, the risk of suicide is thought to be 2-3 times greater than that of the general population. For certain groups of Veterans, such as the elderly with comorbid health problems, suicide is the leading cause of death. Approximately 65% of all Veterans who died from suicide in 2014 were 50 years of age or older. It is currently estimated that 20 Veterans die by suicide each day in the U.S. This is a noted decrease from the 2010 rate of 22 Veteran suicides per day (VA, 2016), reflecting progress secondary to implementation of VHA/DoD Suicide Prevention Strategies. The statistics regarding suicide completion continue to change as VHA and DOD implement new strategies

and interventions aimed at reducing Veteran suicide. However, we still have a long way to go before we reach our goal of zero Veteran suicides.

Assessing Suicide Risk

The ultimate goal of suicide risk assessment is to: identify patients who are in need of immediate intervention to prevent a suicidal act; determine the appropriate treatment setting to optimize safety; deliver clinical interventions; and formulate a treatment plan that reduces the risk for future suicidal thoughts or behaviors. (VA/DoD, 2013, p. 25)

For the P-MHN, suicide risk assessment, management, and prevention requires identification of specific and individual Veteran characteristics that may increase or decrease risk. Please refer to your facility level policy and protocol regarding the process for suicide risk assessment, management and prevention in various clinical settings. Environmental features that may increase or decrease the suicide risk during the acute inpatient stay must be identified, as well as those present when the Veteran is discharged home, through discussion with the Veteran and his/her support system. Suicide risk assessment is within the RN scope of practice with the appropriate training and documentation of competency. Because the P-MHN is available, interacts with Veterans 24/7, and promotes the therapeutic milieu, he/she is frequently the first to identify increased suicide risk or changes that influence risk factors.

The inpatient environment of care is an important component of suicide risk assessment, management and prevention, and is discussed in more detail in **Module 1**. Individual suicide risk assessment training includes general suicide information and statistics, describing risk and protective factors related to suicide, and the general nursing skills and interventions related to inpatient suicide prevention. Suicide risk assessment and management requires initial and ongoing training to develop competency, confidence, and consistent application. Suicide risk assessment and management competencies are available through the APNA (2015a & 2015b). Please review your individual facility policy and standards for how competency is measured.

Suicide and suicide attempts are generally driven by impulsive thoughts and actions. Most people have not decided on suicide up until the last moment before an attempt. This gives the P-MHN the opportunity to intervene, assess, and create an ongoing dialogue and therapeutic rapport with the suicidal Veteran in a way that offers safety, support, and dignity to the individual throughout the continuum of suicide risk. The P-MHN must ensure the Veteran's right to autonomy and self-determination while promoting and providing safe care until discharge goals are met or the Veteran is transitioned to another level of care. One primary safety intervention is controlling or reducing access to suicide means. This is offered through the safe environment of the inpatient setting, but is also an important education tool in transitioning the individual to the outpatient setting. Reducing accessibility to firearms, pills, or other lethal means may delay or prevent self-destructive acts. It is best to have the Veteran be a part of the process in limiting his/her own means accessibility as a way of supporting independence and autonomy.

The P-MHN performs a self-harm risk assessment (non-suicidal and suicidal) upon admission and ongoing throughout the inpatient stay. The risk assessment includes but is not limited to:

- Individual risk factors (e.g. history of suicide attempt, co-occurring substance use, recent loss, etc.)
- Individual protective factors (e.g. supportive relationships, hobbies, religious support, etc.) *Protective factors are individually defined by the Veteran and are not prescriptive.
- Suicide risk assessment (history of attempts, family history of suicide/attempt, current intent, accessing means, thoughts of self-harm/guilt/hopelessness/helplessness, etc.)
- Potential triggers
- Warning signs of acute risk
- History of physical, emotional, or psychological trauma
- History of self-directed violence with suicidal or non-suicidal intent

There is no uniform tool for assessing suicide risk. The risk assessment starts in the outpatient setting and is ongoing throughout the inpatient stay. Each facility may utilize a different tool or set of questions to assess individual risk and apply interventions. Be familiar with your facility policy and resources to identify Veterans at risk for suicide and to connect them with the appropriate resources in the inpatient and outpatient setting. Suicide risk assessment for the outpatient Veteran is different than the inpatient Veteran. Inpatient suicide risk assessment is focused on the imminent suicide risk, crisis stabilization, and establishment of Veteran safety during the acute inpatient stay.

Safety Planning

Another important component of addressing and reducing suicide risk is the establishment of an individual safety plan or crisis plan. The safety plan includes positive social supports with contact information, protective factors, Veteran defined reasons to live, and potential therapeutic activities the Veteran will utilize when his/her suicidal thoughts/feelings increase. The role of the P-MHN in defining a safety plan is to listen and support the Veteran to identify interventions and healthy coping skills that staff can reinforce if/when needed. A suicide prevention fact sheet may be found at:
www.va.gov/opa/publications/factsheets/Suicide_Prevention_FactSheet_New_VA_Stats_070616_1400.pdf

Pain Assessment
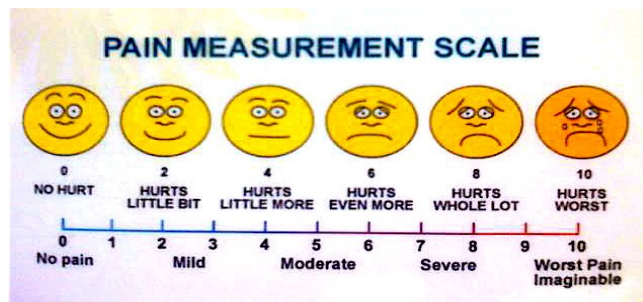
"Pain is one of the most difficult medical problems to diagnose and treat and can be a common symptom of several psychiatric disorders" (Marazziti, et. al., 2006, p. 1). Pain can lead to mobility changes, feelings of stress, lower appetite, sleep disturbances, and even agitation. In addition, chronic pain has the potential to lead to depression, lower self-esteem, isolative behaviors, and even hopelessness. The P-MHN must be aware of the possibility the Veteran may be unable to articulate physical problems or pain. A complete nursing assessment ensures physical problems and pain are addressed. Different pain rating scales are available to assess the severity and the intensity of pain. Several factors may influence these evaluations including: somatic conditions, the co-occurrence of psychiatric disorders, stress, personality characteristics, and the subjective experience of pain. Although nurses routinely assess for pain, the P-MHN must consider the mutual and reciprocal influence between pain and psychiatric disorders with special emphasis on the impact of pain on psychiatric disorders and vice versa. Factors influencing pain perception include the meaning of pain for the Veteran, the way the Veteran talks about the pain, his/her perception of pain, and its effect on his/her functioning. Cultural background, socio-economic conditions, psychological functioning, experiences, memory, and learning are some of the factors which may influence pain behaviors. A person's knowledge and expectation of potential pain can modify his/her response to the pain. It is important for the P-MHN to educate Veterans about their pain, the cause, the reasonable expectation and timeline for relief, and the effect of their mental health on pain and vice versa.

Although pain may come from an organic or psychological condition, suffering is real. Suffering is a term used in conjunction with pain, implying distress, and referring to a wide range of subjective states that may be physical or psychologic in origin. For example, anxiety disorders are associated with high somatic preoccupation levels and physical symptoms, some of which may be associated with increased muscle tension. Depression often interacts with pain to increase morbidity and mortality. Active or historical substance abuse causes a higher sensitivity to pain and increases tolerance to medications, predisposing these Veterans to higher pain levels and more risk of developing chronic pain.

Pain is a common problem that continues to be a struggle to assess and treat appropriately and effectively without causing undue consequences such as medication side effects, unnecessary surgeries, and addiction. Listening to the Veteran's experience of pain and providing emotional support is crucial. Education regarding treatment modalities such as medications, relaxation, massage, and distraction can be helpful to diminish the experience of pain and pain behaviors. The P-MHN needs to be aware that in most cases, psychiatric intervention can prove beneficial to decrease pain and suffering.

Substance Use / Withdrawal Assessment

Substance Use Disorder (SUD) occurs when the use of a substance, or substances, causes significant clinical or functional impairment including health problems, disability, and/or failure to meet one's responsibilities at work, school, and/or home. The P-MHN must be aware of the potential use or abuse of substances by each Veteran and for the potential of withdrawal. Screening for substance use and dependence/addiction is a part of the nursing admission assessment. An abnormal or positive screening result may raise suspicion about the presence of an SUD, while a normal or negative result suggests a low probability of SUD. SUD are diagnosed separately by substance (excluding caffeine) and have differing presenting symptomology. Various screening tools indicate potential problem areas of use or potential SUD. Proper use of screening tools and assessment of symptoms identifies the need for further assessment. Please be familiar with the tools and scales utilized at your facility in regards to SUD.

Assessing for Substance Use

Proper screening and assessment of SUD requires the P-MHN to have knowledge and understanding of SUD and familiarity with the many available screening and assessment tools. Accurate SUD assessment promotes appropriate diagnosis and treatment by the clinician. All nurses should be mindful that **_how_** assessment questions are posed is as important as the questions themselves. Simply asking Veterans how much they drink/use, often results in underreporting as the Veteran estimates lower than their actual use. A skilled P-MHN can collect information on substance type: how much, how often, how long, when and how much was last used, prior episodes of withdrawal or DTs, problems associated with use, and other relevant information related to the substance. Many times, a Veteran's long term successful recovery depends on the rapport that is established with their nurse and provider.

Tobacco/nicotine use is part of substance use screening and assessment done at admission. The rate of tobacco use amongst persons with mental illness is higher than the general public, even more so for persons with severe mental illness. Persons with mental illness die much younger than the general population primarily due to tobacco-related illness such as heart disease, cancer, cerebrovascular, and lung diseases (Colton & Manderscheid, 2006). Screening is also important because nicotine can interact with medications used to treat many mental illnesses. A handout on the interaction between nicotine and medications is available at: http://rxforchange.ucsf.edu/. Tobacco screening in the inpatient setting focuses on tobacco use, willingness to quit, and the need for nicotine replacement or other nicotine treatment medications while on a locked unit. The majority of VA facilities have clinical reminders for tobacco use screenings, counseling, intervention, and referral to treatment groups in the

outpatient setting. Please be familiar with your facility policy and process for tobacco treatment and withdrawal management.

Withdrawal Management

In order to properly treat and prevent associated SUD complications, it is critical for the P-MHN to complete a thorough and accurate assessment and be alerted to the Veteran exhibiting signs and symptoms of withdrawal, especially on admission to an inpatient unit. Without timely intervention, certain withdrawal, such as alcohol or benzodiazepine withdrawal, can lead to significant medical complications, morbidity and mortality. Many inpatient acute units offer facilitated withdrawal for Veterans with SUD and co-occurring mental illness. Nicotine replacement therapy (NRT) allows reduction of nicotine withdrawal in the inpatient setting and can support the Veteran toward recovery and toward identifying tobacco use as an issue.

**While abstinence from many substances produces withdrawal symptoms, alcohol and benzodiazepine withdrawal are characterized by a psychological and physiological reaction which can progress to withdrawal seizures and/or delirium tremens (DTs) and may lead to medical crisis and possibly death.

Withdrawal Timeline	Symptoms of Withdrawal	Assessment Tools Treatment Interventions
Alcohol 6 hrs-10 days	Nausea/vomiting, tremors, sweats, anxiety, agitation, tactile, auditory or visual disturbances, headache, increased heart rate and blood pressure	Clinical Institute Withdrawal Assessment Alcohol Revised Version (CIWA-Ar) q8hr for 3-5 days Encourage 2-4L water/day
Opiates 8 hrs-10 days	Negative mood, nausea/vomiting/diarrhea, fever, insomnia, runny nose/tearing, anxiety, goosebumps, yawning, sweating, muscle aches	Clinical Opiate Withdrawal Scale (COWS) q8hr for 3 days Can taper use over long term with buprenorphine, methadone, etc.
Stimulants 1-5 days	Fatigue, sleep difficulties including vivid/ unpleasant dreams, increased appetite, difficulty controlling irregular body movements	No withdrawal scale available Encourage 2-3L water/day
Benzodiazepines 1 day-8 weeks	Anxiety, insomnia, restlessness, agitation and irritability, poor concentration and memory, muscle tension and aches	Withdrawal scale not recommended, assess q3-4 hours and manage through benzodiazepine taper
Cannabis 1-2 weeks	Sleep difficulties, restlessness, nervousness, anger, anxiety, depression	Withdrawal scale not required
Tobacco/Nicotine	Headache, nausea, constipation/diarrhea, fatigue, drowsiness, insomnia, irritability, difficulty concentrating, anxiety, depressed	Withdrawal scale not required Nicotine Replacement

mood	Therapy (NRT)

Discussion of treatment options once acute withdrawal is complete is an ongoing conversation with the Veteran. Veteran education on SUD should include increased risk for overdose after the withdrawal process is complete due to a decreased tolerance of the substance. This is particularly true with opiates.

Disruptive Behavior

In the acute inpatient setting, it is important to create a safe environment for both Veterans and staff that is non-coercive, recovery based, and patient centered. "The P-MHN plays a critical role in the provision of care to persons in psychiatric settings. This role requires that nurses provide effective treatment and milieu leadership to maximize the individual's ability to effectively manage potentially dangerous behaviors" (APNA, 2014, para. 8). Empowerment of the Veteran is emphasized over staff control and the P-MHN works towards provision of opportunities of self-management for the Veteran. Prevention is the key to reducing the risk of dangerous behaviors and to reaching safety goals; it is the responsibility of the P-MHN to promote the Veteran's autonomy and sense of self control over his/her own behaviors (APA, APNA & ISPN, 2014).

Disruptive behavior is behavior by patients, patient families or patient representatives that is intimidating, threatening, or dangerous and may pose a threat to the health or safety of other patients, VA employees, or visitors at the facility; behavior that interferes with the delivery of safe medical care to other patients at the facility; or behavior that impedes the operations of the facility. (VA Office of Inspector General (OIG), 2013, p. 8)

Disruptive behavior may include but is not limited to: verbal abuse (profanity, racial slurs, name-calling, etc.), direct, indirect or implied threats, intimidation, physical/sexual abuse, brandishing of weapons, or behaviors of excess such as leaving incessant phone messages on a person's phone. Please be aware of your facility policy and process in relation to disruptive behavior reporting and management.

Managing Disruptive Behavior

P*revention* is the key component to the management of disruptive behaviors (APA, APNA & ISPN, 2014). A comprehensive assessment is conducted at admission and is on-going, allowing the Veteran to identify any situations which may trigger disruptive behaviors and identify past means which effectively reduced the behaviors. Risk factors for disruptive behaviors may include alcohol or drug consumption or withdrawal, psychosis, staffing issues (i.e. lack of

training or understaffing), unit design, long waits for service, and inadequate security. The leading risk factor and predictor of violent/disruptive behavior is a previous personal history of violence.

The P-MHN utilizes de-escalation skills and communication techniques to create a calm and safe environment, thereby decreasing situations resulting in disruptive behaviors. Skills may include but are not limited to: therapeutic limit setting, coordination with other clinicians to update treatment plans to include methods for reduction of escalated and disruptive behavior, participation in the VA Prevention and Management of Disruptive Behavior (PMDB) training, and appropriate documentation and reporting of disruptive behaviors when they occur which may result in a recommendation for a Patient Record Flag (PRF).

Each facility is mandated to have a Disruptive Behavior Committee to which disruptive behavior events are reported. The VA utilizes a secure reporting system which identifies incidents of disruptive behavior and assists to manage the violence risk. This system is designed to alert staff via PRF immediately of information needed to provide care and promote safety for the Veteran, staff and others. Federal regulation allows a facility to place restrictions on the Veteran regarding time, place and/or manner of care in order to ensure safety, however the facility may not terminate care for Veterans who are eligible for services.

In order for staff to consistently improve clinical skills in managing a safe and effective milieu, evidence-based training is important. PMDB training is an educational component of the VA Workplace Violence Prevention Program (WVPR) and consists of four distinct levels of training. All VA employees are required to complete TMS Level I training on sexual assault and violence awareness. Level II training focuses on customer service, assessment and identification of escalating behaviors and skills training to de-escalate violent situations in the workplace. Level III teaches methods for verbal limit setting and personal safety skills. Level IV progresses to containment skills for a disruptive individual. The level of training required is determined by the individual facility's Workplace Behavioral Risk Assessment (WBRA) report. For additional information regarding these training programs, access the Workplace Violence and Prevention Program (https://vaww.portal2.va.gov/sites/wvpp/SitePages/Home.aspx) website.

Summary

The psychiatric nursing assessment is a comprehensive process that frequently includes the mental status examination, suicide risk assessment, pain assessment, substance use or substance withdrawal assessment, disruptive behavior assessment, head-to-toe physical assessment, and other information relevant to the Veteran presentation during the time the P-MHN is assigned to him/her. P-MHN assessment starts at admission to the unit and continues via shift assessment throughout the duration of the Veteran's inpatient stay. Each piece is collected and documented in the Veteran chart with deviations reported to the next shift and to the interdisciplinary team as necessary. Assessment may be expanded or restricted as needed based on individual Veteran presentation and treatment plan goals. Please be familiar

with your facility processes, protocols and policies regarding individual assessment requirements in the acute psychiatric setting.

	✓	**Knowledge Check**
		I can identify the core components of the psychiatric nursing assessment.
		I can identify the goal of suicide risk assessment.
		I can define which 2 characteristics are associated with the highest risk of suicide.
		I can name two substances that can cause death on withdrawal.
		I can identify the key component in the management of disruptive behaviors.

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<u>**Module Five**</u>

<u>Mental Health Disorders</u>

Objectives:

1. Identify two evidence based therapies in PTSD treatment.
2. Describe two symptoms associated with depression in the affective, physical, cognitive, and behavioral domains.
3. Report which behaviors in mania have the potential to increase risk taking activities in the Veteran.
4. Discuss the impact that positive, negative, and cognitive symptoms could have on medication adherence in Veterans with schizophrenia.
5. List substances included in Opioid Use Disorder.

Introduction

The DSM-V provides criteria and a common language to facilitate diagnosis, treatment planning, and achieve consensual outcomes regarding mental disorders. Mental illness is a term that broadly describes conditions that affect behavior, emotions, and cognition. There is variability in the intensity, frequency and duration of symptoms, and the impact on day to day functioning. The experience of mental illness is unique to each person in manifestation of symptom clusters, response to those symptoms, recommended treatment, and the Veteran's own perceptions about what activities will support recovery.

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction

in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities (APA, 2013, p. 20).

Acute inpatient units treat Veterans with a myriad of mental health disorders. The most common admission diagnoses include but are not be limited to: Post-Traumatic Stress Disorder (PTSD), and depressive, bipolar, schizophrenia spectrum, and substance use disorders. This module will review the noted disorders with diagnostic criteria, disease process, treatment options, and applicable nursing interventions.

Mental illness can occur singularly or as a co-occurring disorder. A co-occurring disorder is a mental illness in combination with a substance use disorder, in which both conditions interact to produce symptoms and outcomes together, rather than as separate disorders. It is important for the P-MHN to keep in mind that diagnosis helps to direct clinical care, but can unintentionally stigmatize the Veteran patient. Each Veteran is a person first, diagnosis does not change who the person is. The Recovery model of care is discussed in further detail in **Module 2**.

Post-Traumatic Stress Disorder (PTSD)

Anxiety is a normal emotional response to a stressor or situation that may trigger the fight or flight response in support of survival. It provides the brain with feedback for making decisions on risk and potential harm in everyday and crisis situations. Anxiety, fear, and resulting behaviors may become a diagnosable disorder when it is disruptive to a person's life and is out of proportion to the danger or threat presented. The anxiety or fear is frequently excessive and intense and interferes with daily activities, is difficult to control, and causes significant distress or impairment in social, occupational or other important areas of functioning for greater than one month. Post-Traumatic Stress Disorder (PTSD) is an anxiety disorder diagnosable in approx. 3.5% of the adult US population and in 10-15% of the Veteran population. Approximately 20% of persons actually exposed to a traumatic event develop symptoms consistent with the diagnosis of PTSD.

PTSD Diagnosis and Disease Process

PTSD can occur at any age and is a mental health condition that develops after exposure to actual or threatened death, serious injury and/or sexual violation. A traumatic event may include: combat exposure, child sexual or physical abuse, terrorist attack, sexual/physical assault, serious accident (such as car wreck), or a natural disaster (such as fire, tornado, hurricane, flood or earthquake). Diagnostic criterion of PTSD include:
- Directly experiencing the traumatic event
- Witnessing the event in person
- Learning that a relative or close friend was exposed to a trauma

- Experiencing first-hand repeated or extreme exposure to aversive details of the event (first responders, medics, etc.) (APA, 2013)

PTSD Symptoms	
Intrusion symptoms	➢ Recurrent, involuntary, and intrusive memories ➢ Nightmares related to the trauma ➢ Intense or prolonged distress after exposure to traumatic reminders ➢ Marked physiologic reactivity after exposure to trauma-related stimuli
Avoidance	➢ Trauma-related thoughts or feelings ➢ Trauma-related external reminders (e.g. people, places, conversations, activities, objects, or situations) ➢ Disinterest in activities
Negative alterations in cognitions and mood	➢ Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs) ➢ Persistent (often distorted) negative beliefs and expectations about oneself or the world (e.g. "I am bad," "The world is completely dangerous") ➢ Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences ➢ Persistent negative trauma-related emotions (e.g. fear, horror, anger, guilt, or shame) ➢ Markedly diminished interest in (pre-traumatic) significant activities ➢ Feeling alienated from others (e.g. detachment or estrangement) ➢ Constricted affect: persistent inability to experience positive emotions
Alterations in arousal and reactivity	➢ Irritable or aggressive behavior ➢ Self-destructive or reckless behavior ➢ Hypervigilance ➢ Exaggerated startle response ➢ Problems in concentration ➢ Sleep disturbance

PTSD is sub-divided into Acute PTSD and Chronic PTSD. Acute PTSD includes symptoms lasting more than one month, but less than three months after exposure to trauma. Chronic PTSD includes symptoms lasting more than three months after exposure to trauma. The prevalence of PTSD increases with multiple traumatic event exposures and is experienced by females twice as often as males. PTSD can appear alone or more commonly with other co-occurring conditions (persistent difficulties in interpersonal relations, mood, chronic pain, sleep disturbances, somatization, and/or profound identity problems) or psychiatric disorders. Depression, abuse of substances, and/or anxiety disorders frequently co-occurs with PTSD.

Some people fully recover from PTSD within 3 months (about 50%) and others have symptoms lasting over 1 year, or even for the rest of their life. Anniversaries of traumatic events are often very difficult to cope with. Many people with PTSD repeatedly relive the trauma in their thoughts during the day or in nightmares when they sleep. Research suggests the earlier the treatment, the better the prognosis of PTSD (VA, 2015).

Evidence Based Practice in PTSD Treatment

Cognitive Behavioral Therapy (CBT) is the most effective treatment for PTSD (National Center for PTSD, 2015). CBT helps the patient learn how memories or beliefs of their trauma have influenced their life and relearn responses to the trauma. It can decrease PTSD symptoms like anxiety and depression and can improve sleep. CBT frequently is accomplished in 8-15 weekly sessions. Potential challenges for the Veteran during CBT include initial difficulty discussing the trauma and increased, or more intense symptoms at the beginning of therapy. Other evidence based treatments or therapies include:

- **Cognitive Processing Therapy (CPT)** – Veteran and therapist review the thoughts and self-talk of the patient regarding the trauma. Together, they determine whether those thoughts are accurate or inaccurate. Can be individual or group therapy.
- **Prolonged Exposure (PE)** – Repeated exposure to the thoughts, feelings and situations the Veteran has avoided reducing reaction to triggers and helping them relearn that reminders of the trauma do not have to be avoided. Done individually with a therapist.

Psychotherapy with CBT or exposure therapy can be conducted individually or within a group usually by a provider or psychologist. Medication is often used alongside psychotherapy to help reduce anxiety symptoms while a person develops positive coping skills and tools to improve their response to anxiety (see further information on medications in **Module 6**). Medications do not cure PTSD, but can help reduce symptoms while a person learns other tools for dealing with their anxiety.

Nursing Intervention

Complimentary and integrative medicine practices such as acupuncture, meditation, mindfulness, etc. are effective treatment options for PTSD. The P-MHN has many tools to offer the Veteran with PTSD to improve coping skills and quality of life. In the inpatient acute setting, awareness and management of the therapeutic milieu and staffing is of utmost importance. Veterans with PTSD may find it difficult to build rapport or trusting relationships with providers. Veterans living with PTSD often exhibit irritability, aggression, and risky behaviors. These symptoms may be misinterpreted as a personal affront; they are symptoms of the illness and require clinical assessment and intervention skills. Consistency and reliability are important factors in overcoming these barriers to care. The P-MHN should be especially sensitive to staffing and roommate assignments as a part of practicing trauma informed care (i.e. assigning a female staff person to a female Veteran who was a victim of sexual trauma). Noise levels in the milieu, especially at night, can worsen insomnia and increase irritability in the Veteran who suffers from PTSD. Room assignments should take into account the activities and noise levels around the doors and the nursing station. Due to the heightened arousal response, it is beneficial for the P-MHN to approach the Veteran from the front to avoid startling them unexpectedly. If needing to wake up the Veteran, do not touch him/her, but say his/her name from a few feet away as the startle reflex can be impressive. The P-MHN should be aware of resources within the community and the VA for on-going PTSD support. Please see **Appendix J**

for a list of nursing interventions appropriate for the Veteran with PTSD in the acute care setting. For additional information regarding PTSD and treatments please see: http://www.ptsd.va.gov/professional/PTSD-overview/index.asp

Depressive Disorders

Depressive disorders include disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder (APA, 2013). There is no identified single cause for developing a depressive disorder; it can occur spontaneously or can be triggered by trauma, loss, stress, etc. Depression can be the result of biological illness, or may result from a combination of genetic, environmental, psychological, and other biological factors. There are numerous chronic medical illnesses (coronary artery disease, diabetes, cancer, multiple sclerosis, chronic pain, Parkinson's disease, etc.) that may trigger the development of clinical depression. Depression can occur at any age; the average age of onset is the mid-20's.

Diagnosis and Disease Process

Diagnosis is based on symptomatology, timeframe of symptoms, previous episodes, and functioning level. Diagnosis can be complicated because depression can be part of bipolar disorder or other mental illness and the description of symptoms is dependent on cultural background. Depressive disorders can co-occur with other disorders such as: anxiety, PTSD, and substance use disorders. Further complicating the clinical picture, underlying medical issues can mimic a major depressive episode, as can side effects of medications (beta blockers or anti-hypertensives). It is important to have a medical exam with labs to rule out thyroid disease, anemia, vitamin deficiencies, and other possible physical causes of depressive symptoms.

Area of Impact	Symptoms
Affective	Feelings of sadness, emptiness, hopelessness, worthlessness, despair, apathy, anhedonia
Physical	Sleep disturbances (insomnia or hypersomnia), change in appetite (increase or decrease), fatigue or lethargy.
Cognitive	Confusion, indecisiveness, decreased concentration, Low self-esteem, feelings of excessive or inappropriate guilt (may be delusional), recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation with/without a specific plan,

	suicide attempt
Behavioral	Psychomotor agitation or decrease, decreased verbal communication, decreased hygiene, social isolation

Treatment

Depressive disorders can be a devastating illness with poor quality of life, decreased productivity, and increased mortality from suicide. Major Depressive Disorder (MDD) is the most prevalent and incapacitating form of depression. It can present as a single episode or as recurrent episodes. Persons with depressive disorders often suffer from social stigma, relationship conflict, and loss of employment. Fortunately, depressive disorders are responsive to a variety of treatment options and frequently respond favorably to psychotherapy (cognitive, behavioral, or combination therapy) and antidepressant medications.

Electroconvulsive Therapy (ECT) is a safe and effective treatment for severe, treatment-resistant depression. The two major advantages of ECT are that it works quicker than medication and/or psychotherapy and older individuals respond to ECT much more quickly than medication (usually in the first week). ECT is delivered under general anesthesia. Electrodes are placed to precise locations of the head and an electric current is passed through the brain, causing a brief seizure in the brain. The patient usually awakens 5-10 minutes after the procedure ends. Typically, ECT is administered three times per week until the depression improves (usually 6-12 treatments). Some patients need maintenance ECT treatment to maintain relief from symptoms. The most common side effects of ECT include: headache, upset stomach, muscle aches, and memory loss (National Institute of Mental Health (NIMH), 2016).

Rapid Transcranial Magnetic Stimulation (rTMS) is a treatment used to stimulate brain cells in persons with depression who have not responded other therapies (Hotzheimer, 2016 & Hutchinson, 2015). It is an outpatient treatment administered through a large electromagnetic coil placed against the scalp to deliver a high intensity current, creating powerful magnetic fields that change the way brain cells function (Varcarolis, 2013). rTMS is different from ECT as it does not require general anesthesia or induce seizures. Treatment is painless and is typically administered daily in 40 minute session for four to six week. rTMS has been shown to be most effective in patients with medication-resistant depression; those with moderate depression have little to no positive response (Varcarolis, 2013). Contraindications to rTMS include uncontrolled seizure disorders, implanted devices (pacemaker, cochlear implants, etc.), and unstable medical disorders (Hotzheimer, 2016 & Hutchinson, 2015). Side effects include headache, scalp discomfort, facial muscle tingling, and lightheadedness. This is a relatively new treatment modality and long-term risks of treatment are unknown.

Nursing Intervention

The P-MHN recognizes that symptoms of depression are normal in certain situations or with certain experiences. It is important to distinguish between normal grief, or the grieving process, and a major depressive episode. The nurse must assess for depression, suicidality,

anxiety, and psychotic symptoms. Veterans who suffer with depression later in life may present with cognitive changes. Older Veterans are at increased risk for depression related to psychosocial vulnerabilities and chronic medical illness. The P-MHN tailors interventions to the Veteran to include: encouraging 'normal' activities, establishing rapport, offering hope for Recovery, providing support and encouragement in meeting goals, and teaching symptom management. Please see **Appendix J** for further nursing intervention options for the depressed Veteran in the acute setting.

Bipolar Disorder

Bipolar disorder is an episodic, potentially life-long, mental illness that causes dramatic shifts in mood, energy and the ability to think clearly. Diagnosis is based on symptomatology, timeframe of symptoms, previous episodes, and level of functioning. Diagnosis can be complex, but effective treatment can lead to positive outcomes for many. The symptoms and severity of bipolar disorder vary widely, but are characterized by high and low moods known as mania and depression. Symptoms can occur at any point in life; the average age of onset is 25. Bipolar disorder can co-occur with a range of other disorders (substance use, anxiety disorders, etc.).
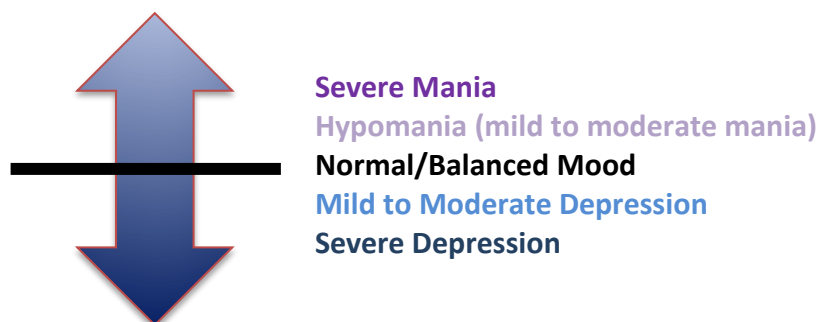
Diagnostic Category	Diagnostic Criteria
Bipolar I	Mood ranges from mania to depression, can have psychotic features at the high or low end. Mania must last most of the day, every day, for at least 1 week and cause marked impairment in social or occupational functioning. It often necessitates hospitalization.
Bipolar II	Minor episodes of elevated mood fluctuating with periods of severe depression
Cyclothymia	Brief periods of hypomania alternating with brief periods of depression
Substance/medication or medical condition induced bipolar	Onset related to substance/medication or medical condition

Diagnosis and Disease Process

Diagnosis of bipolar disorder can be missed as persons generally do not complain about hypomanic states, but focus primarily on symptoms of depression, leading to a diagnosis of depression. Hypomania is a milder form of mania with no psychotic symptoms; the person can function "normally" in social situations, at work, or school. People with psychotic symptoms may incorrectly be diagnosed as having schizophrenia. Each category of bipolar disorder presents differently. Bipolar symptoms range from distinct manic or depressed states within a specific period of time. Persons with mixed episodes experience both extremes simultaneously or in rapid sequence. Some people will have episodes of mania or hypomania many times,

others rarely. In all categories of bipolar, social difficulties are common (social stigma, loss of employment, marital break-up, etc.).

Severe Mania
Hypomania (mild to moderate mania)
Normal/Balanced Mood
Mild to Moderate Depression
Severe Depression

Phases	Signs and Symptoms
Mania Hypomania to Mania	Extreme irritability, invincibility/unrealistic belief in oneself, inflated self-esteem, grandiosity, decreased sleep, pressured speech or talking more than usual, racing thoughts, distractibility, psychomotor agitation, excessively risky behavior (reckless driving, spending sprees, risky sexual behavior, etc.), hallucinations, delusions ➢ People in manic states are often unaware of the negative consequences of their actions
Depressed Mild to Severe	Intense sadness/despair, anhedonia, reduced energy, fatigue, sleep difficulty (sleeping too much or insomnia), change in appetite (eating too much or too little), difficulty concentrating, remembering, making decisions, feelings of guilt, helplessness, hopelessness, thoughts of death or suicide, delusions, psychosis

** Suicide is an ever-present danger. Some people become suicidal in manic or mixed states, especially since judgement is impaired.

Treatment

The cornerstone treatment modality for bipolar disorder is psychopharmacology for rapid symptom control. Due to the complexity of the disorder (co-occurring with substance abuse, medical co-morbidities, etc.), it is important to achieve symptom remission and return to the highest level of functioning. There are numerous classes of medication that can be prescribed based on presentation of symptoms (hypomania, mania, depression, or mixed) including the presence of psychosis and/or suicidality/homicidality. Medication management may include mood stabilizers, antipsychotics, antidepressants, and anti-epileptics (see **Module 6**). Medications are reassessed and readjusted based on Veteran response to the treatment, plasma medication levels including blood chemistry, presence of side effects, and the Veteran's perception of burden or clinical effectiveness. ECT may be considered as a treatment option once other options fail.

Clinical Guidelines for those in remission from acute mania recommend adjunctive psychotherapy interventions with CBT, which is identified as having the most evidence toward improved health outcomes. Elements of CBT include education on symptoms and interventions, problem solving and more adaptive thinking. Family therapy, interpersonal therapy, and

psychoeducation are identified as having fair evidence. Group psychoeducation covering topics such as bipolar illness, early relapse identification and management, and communication with providers and prescribers can provide support, reinforcement, and validation to the Veteran.

Nursing Interventions

The P-MHN recognizes that during periods of increased mood and/or mania the Veteran may exhibit a lack of impulse control or awareness of consequences. During times of depression the Veteran may isolate more and be difficult to engage in treatment. For the Veteran with bipolar disorder, the P-MHN ensures the assessment includes suicide risk, agitation, or signs of escalation, anxiety, grandiosity, and psychosis. Nursing interventions supporting the Veteran with bipolar disorder include maintaining safety on the unit, gradually increasing activity or social interactions as tolerated, providing adequate food and fluids, monitoring sleep, reducing stimulation, encouraging anxiety reduction techniques, and structuring activities according to need and the Veteran's level of functioning. Please see **Appendix J** regarding nursing interventions appropriate for use in the acute setting for the Veteran with Bipolar Disorder.

Schizophrenia Spectrum and other Psychotic Disorders

Schizophrenia spectrum and other psychotic disorders are defined by one or more of the following five domains of psychotic symptoms: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms. Disorders in this category include schizophrenia, schizoaffective disorder, delusional disorder, schizophreniform disorder, and catatonia. Prior to publication of the DSM-V, schizophrenia was diagnosed with subtypes (paranoid, disorganized, catatonic, undifferentiated, and residual). The subtypes were removed with the updated DSM; staff or providers which used the previous DSM versions may still use those terms when describing or discussing schizophrenia and different patient presentations. Schizophrenia is the most commonly diagnosed disorder in this spectrum and is the primary focus in this section.
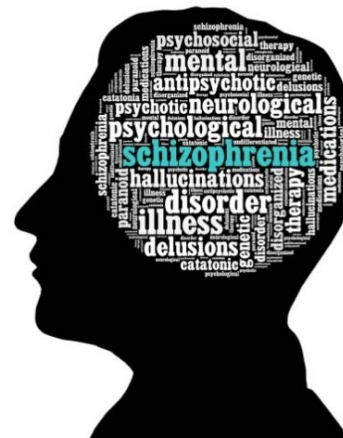
Schizophrenia Spectrum Diagnosis and Disease Process

Schizophrenia is a complex, persistent mental illness associated with self-care, social, and occupational/education/role dysfunction with a constellation of emotional, cognitive, and behavioral symptoms. The average age of onset is late teens to early 20's in men and late 20's to early 30's in women. It is associated with co-occurring mental (MDD, PTSD, OCD, anxiety, etc.) and physical illnesses (diabetes, nicotine dependence, heart disease, metabolic syndrome, etc.). Cultural and religious context and language barriers need to be taken into consideration in the P-MHN assessment, diagnosis and treatment as there may be differences in perspective among clinicians, the Veteran, and the support system.

Schizophrenia develops in phases:

- Premorbid – relatively normal functioning; stressor may set the stage for the illness
- Prodromal – change in baseline functioning with increasing impairment over course of weeks, months or years; may experience irritability, depressed mood, social withdrawal, role changes; appearance of positive symptoms may signal onset of psychosis
- 1st psychotic episode – acute stage (floridly psychotic)
- Recovery stage / Stabilization

Positive Symptoms	Delusions	- False/fixed/irrational beliefs that do not change despite evidence to the contrary - One common form is *persecutory delusion* in which person believes he/she will be harmed or harassed - Other examples: *referential delusion* in which a person believes gestures, environmental cues are directed at him/her: *paranoid delusion* in which a person believes another is "out to get him"
	Hallucinations	- Perceptual distortions occurring outside of the individual in which person hears, sees, feels, tastes or smells things that others do not - Auditory are more common than visual or tactile; heard as noises or voices which may or may not be familiar and may be critical or threatening; - Voices telling the person to do something harmful or dangerous can be described as *command hallucinations* and must be assessed immediately - May be experienced as part of a normal religious experience in some cultures
	Disorganized Thinking / Speech	- Information processing is interrupted that interfere with communication - Thoughts and accompanying speech may be described as loose associations, tangential, incoherent and/or illogical - Speech may be pressured and/or impoverished (brief, limited, nonspontaneous)
	Disorganized Motor Behavior	- Unpredictable outbursts of agitation/inappropriate laughter which can interfere with goal directed behavior such as activities of daily living - Catatonia: not exclusive to schizophrenia; motor behavior that ranges from not responding/ moving very little to motor excitement
Negative Symptoms	Avolition	Decreased motivation; difficulty starting or participating in activity; disinterest in activity
	Alogia	Reduction in amount of speech
	Anhedonia	Decreased ability to experience pleasure
	Asociality	Decreased interest in socializing which can impact developing and sustaining relationships

Symptoms of schizophrenia are categorized as positive or negative. Positive symptoms include delusions, hallucinations, disorganized thinking /speech, and disorganized motor behavior. Negative symptoms refer to diminished emotional expression or avolition and are observed in facial expression, eye contact, and speech intonation. Persons with negative symptoms are sometimes described as emotionally flat. Negative symptoms are sometimes confused with clinical depression.

In addition to positive and negative symptoms, schizophrenia disorders can commonly present with cognitive symptoms that interfere with executive functioning (memory, decision making ability, judgment, and problem solving). Social cognitive impairment including difficulty focusing, attending and interpreting situations, events, and the intentions of others, and lack of awareness or insight into the mental illness can be a symptom associated with schizophrenia spectrum disorders. This can often impact the Veteran's adherence to medication or recommended treatment. Other symptoms may include:

- inappropriate affect
- dysphoria
- anxiety
- phobias
- hostility/anger/ aggression
- disturbed sleep pattern
- disinterest in eating/food
- somatic complaints

Schizoaffective Disorder

Schizoaffective disorder is diagnosed less often than schizophrenia and occurs in 0.3% of the population; men often develop the disorder at an earlier age (National Alliance for the Mentally Ill (NAMI), 2015b). It is characterized by persistent symptoms of schizophrenia along with mood symptoms of mania or depression. Generally, schizophrenic symptoms will be present even when mood symptoms are not. When mood symptoms do appear, psychotic symptoms may worsen. Mood symptoms must be present for a minimum of half of the illness duration from onset of the first psychosis in order to meet the DSM-V diagnostic criteria (Malaspina, et. al, 2015). Schizoaffective Disorder is often misdiagnosed as it shares symptoms of multiple other mental health disorders. Compared to schizophrenia, Veterans diagnosed with schizoaffective disorder may be higher functioning as they experience the positive symptoms of schizophrenia and have less negative symptoms. Further information on schizoaffective disorder can be found in the DSM-V.

Treatment

Treatment of schizoaffective disorder typically includes antipsychotic medications along with mood stabilizers and/or antidepressants, psychotherapy, self-management strategies, and education. Clinical Practice Guidelines for schizophrenia indicate "the most common contributors to symptom relapse are antipsychotic medication nonadherence, substance use, and stressful life events, although relapses are not uncommon as a result of the natural course of illness despite continuing treatment" (APA, 2004, p. 10). Psychopharmacology is considered a priority intervention in acute psychosis, particularly if the person is at risk for suicidality,

aggression and agitation, or is suffering from the effects of acute symptoms. Antipsychotics are often the class of medications selected, however, other medications such as benzodiazepines, antidepressants, mood stabilizers, and medications that treat side effects may be considered (see **Module 6** for more information on medications). Assessment of medication acceptance by engaging in discussion of the pros and cons of medication options and Veteran preference is critical in developing a therapeutic alliance and partnership going forward.

Psychosocial interventions can assist the Veteran to decrease environmental stimuli, enhance safety, provide structure, and predictability. Psychoeducation can offer clear and concrete information to the Veteran, according to his/her ability and the support system on illness management, stress reduction, violence prevention, coping skills, and community support groups such as NAMI. During the stabilization phase which continues after discharge, additional treatment options such as social skills training and CBT may assist transition into the community and foster recovery.

Nursing Interventions

Many Veterans with schizophrenia spectrum and psychotic disorders tend to isolate from others. They may be uncomfortable when other people violate their personal space. Be mindful of personal space by respecting limits; speak in a calm, respectful manner, while maintaining comfortable eye contact. A small act of kindness, such as offering a shower, clean clothes or a meal is one of the fastest and easiest was to develop a therapeutic relationship. Medication teaching is important, but often becomes more complex when a Veteran is suspicious or mistrustful. It is important to assess the Veteran's ongoing cognitive functioning, literacy, and ability to learn and retain information when approaching any teaching. It may be helpful to state the specific symptom that the medication will target ("This medication, Zyprexa, will help with your thinking"). It may be less beneficial to discuss every potential side effect or negative outcome associated with the medication. Nursing goals are to increase the Veteran's knowledge and understanding of his/her treatment. This can be accomplished by encouraging the Veteran's involvement and investment in his/her treatment and recovery.

The P-MHN must always be safety conscious. The vast majority of Veterans with schizophrenia spectrum or psychotic disorders are not violent toward others. Look for cues of increasing agitation (such as pacing, cursing, yelling, or responding to internal stimuli) and intervene early. It may be necessary to decrease stimuli by providing time out in the Veteran's room or the quiet room and offering medications as needed. Encourage the Veteran to maintain control and explain that medication may help them relax and feel better. **Do not attempt to approach or touch a Veteran experiencing paranoia or actively hallucinating.** It is best to have other staff and/or security in close proximity when addressing a hostile patient as a show of support, previously known as a 'show of force'. Continue to offer choices to the patient, maintain his or her dignity, and use physical interventions only after all other interventions have been thoroughly explored. Please see **Appendix J** for a list of nursing interventions appropriate for the Veteran with schizophrenia spectrum and other psychotic disorders in the acute care setting.

Substance Use Disorder

The DSM-V has combined Substance Abuse and Substance Dependence into a single disorder; Substance Use Disorder (SUD). SUD occurs when the use of substances causes significant clinical or functional impairment including health problems, disability, and/or failure to meet one's responsibilities at work, school, and/or home. SUD can be diagnosed for alcohol, tobacco, cannabis, stimulants, hallucinogens, and/or opiates. Substance Use Disorder is a clinical diagnosis marked by ongoing use of a substance over time which causes impairment.

Diagnosis and Disease Process

SUD diagnosis is based on a pathological set of behaviors related to the use of the substance and falls into four main categories: impaired control, social impairment, risky use, and pharmacological (tolerance/withdrawal) criteria. SUD is characterized by the level of severity, (mild, moderate, severe) which is determined by the number of diagnostic criteria met. Each substance, excluding caffeine, is defined as a separate use disorder, but almost all substances are diagnosed referring to the same criteria.

Disorder	Screening Tool	Symptoms
Alcohol Use Disorder (AUD) : Moderate Use = 1 drink/day (women) up to 2 / day (men)	Audit-C CAGE	Problems controlling alcohol intake, continued use despite problems associated with drinking, tolerance of the substance, ingestion of substance leading to risky situations, and/or withdrawal symptoms.
Tobacco Use Disorder: Dependence on the drug nicotine contained within tobacco products.	Fagerstrom Tolerance Questionnaire	Use of larger quantities over time, cravings, failure to control use and/or cessation of usage, continued use in spite of adverse social or interpersonal consequences, tolerance, continued used despite awareness of psychological/physical problems directly linked to usage, withdrawal symptoms after reduction/cessation.
Cannabis Use Disorder: The most widely used drug in the United State after alcohol and tobacco.		Disruptions in functioning due to use, tolerance, cravings, and development of withdrawal symptoms.

Stimulant Use Disorder: Stimulants include amphetamines, methamphetamine, and cocaine and are administered orally, nasally, or IV.		Cravings, failure to control use, continued use in spite of difficulties with responsibilities or social functioning, tolerance, increased time to obtain and use substance, withdrawal symptoms after reduction/cessation of use.
Hallucinogen Use Disorder: Chemically synthesized (LSD) or natural (psilocybin mushrooms, peyote) substances produce visual and auditory hallucinations, feelings of detachment, and distortions in reality.		Cravings, failure to control use, continued use in spite of difficulties with responsibilities or social functioning, tolerance and increased time to obtain and use the substance.
Opioid Use Disorder: Substances include illegal opiates (heroin) and prescription opiates (oxycodone, hydrocodone, fentanyl, etc.)		Strong desire for the substance, lack of control of usage or to reduce usage, continued use in spite of difficulties with responsibilities or social functioning, tolerance, increased time to obtain and use substance and withdrawal symptoms.

Treatment Options

There are many treatment program options available both within the VA and through local resources. The VA offers outpatient, intensive outpatient, and residential treatment programs for SUD throughout the nation. Substance abuse treatment programs provide clinical treatment, intervention and therapy for Veterans willing and interested in lowering or stopping their substance use. Some programs offer a 'specialized' focus on PTSD, Seriously Mentally Ill (SMI), female veterans, SUD, etc. Other programs exist to promote risk reduction and reduce harm to the actively using Veteran such as: needle exchange programs, housing first programs (for the homeless and actively using Veteran), and other resources that reduce the risk of harm for Veterans with active substance use. The Opiate Education and Naloxone Distribution (OEND) program focuses on harm reduction through naloxone education to high risk opiate users, their significant others and providers to prevent, recognize and respond to opiate overdose. Naloxone kits are supplied to the high risk Veteran for overdose intervention and reversal prior to arrival of emergency responders.

Discussion on treatment options once acute withdrawal is complete is an ongoing conversation with the Veteran. Veteran education on SUD includes discussion regarding increased risk for overdose after the withdrawal process is complete due to a decreased tolerance of the substance. This is particularly true with opiates.

Nursing Intervention

The P-MHN "maintains therapeutic and professional interpersonal relationships with appropriate professional role boundaries …and …demonstrates a commitment to practicing self-care, managing stress, and connecting with self and others" (ANA, APNA & ISPN, 2014, p. 67). This emulates healthy living choices and personal management and gives the nurse a solid foundation for promoting positive changes to the Veteran. The P-MHN must be mindful of key concepts regarding SUD such as stigma, recovery-oriented care, and the potential impact each may have on the Veteran during his/her treatment and recovery. All treatment team members including the nurse must be alert for the potential of transference and countertransference and conduct a self-check for any bias he/she may have regarding SUD which may negatively impact the Veteran's treatment and recovery**.**

It is important to be familiar with your facility protocol and resources to support your inpatient Veterans in moving through the stages of change until they are ready to address their SUD. Motivational interviewing (MI) is a very useful treatment philosophy and skillset to acquire that can aid the nurse in facilitating Veteran behavioral change.

Specialized Addictions Certification

The P-MHN working regularly with Veterans suffering with addictions can take the professional initiative to improve his/her clinical skills and interventions related to addiction and substance use. Nurses can better prepare themselves to provide evidence based substance abuse care by preparing for and completing the certification for addictions nursing (CARN) through the International Nurses Society on Addictions (IntNSA). Additionally, it is important that the P-MHN keep their practice up-to-date with regular continuing education on mental health nursing and on new drugs of abuse, assessing and treating addictions.

Summary

Knowledge of mental health disorders provides context and guidance for the P-MHN in applying the nursing process as a member of the interdisciplinary team. It is important to consider how the integration of the nursing process in assessment, diagnosis, outcomes identification, planning, implementation, and evaluation can improve symptom remission and promote recovery. There are numerous other mental health diagnoses that Veterans may have contributing to their clinical mental health status and recovery. This module reviewed only the most prevalent diagnoses in the acute clinical setting. The DSM-V is the diagnostic manual for clinical diagnosis and treatment and is a valuable tool in researching other mental health diagnoses, symptoms and treatment options.

	✓	Knowledge Check
		I can identify which treatment options are evidence based therapies to reduce anxiety and develop coping skills in Veterans with PTSD symptoms such as anxiety, depression and insomnia.
		I can identify four separate nursing interventions to address symptoms of depression.

	I can recognize symptoms of mania.
	I can differentiate between positive and negative symptoms of schizophrenia spectrum disorders.
	I am aware of potential treatment options of opiate use disorder.

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Psychopharmacology

Objectives:

1. Identify the two classifications of antipsychotics.
2. Recognize Extrapyramidal Symptoms (EPS).
3. Identify four symptoms of Neuroleptic Malignant Syndrome.
4. Name two classes of antidepressant medications.

Introduction

Mental health treatment has evolved since psychopharmacology emerged as a treatment option in the 1950's when thorazine was 'discovered' by accident. As with many other treatment options, medication does not cure mental illness, but can control and treat symptoms and reduce relapse. Since the 1950's, psychopharmacology has emerged as a multi-billion dollar industry with pharmaceutical companies advertising products directly to the general public in the US. The P-MHN must be knowledgeable regarding pharmacologic treatment options, appropriate medication responses, side effects, and drug/drug interactions. Psychopharmacology now includes multiple classes of medications to include: antipsychotics, mood stabilizers, antidepressants, and anxiolytics (see **Appendix K** for a brief review). Over-the-counter, herbal, and other alternative medicines or treatment options are utilized by Veterans, but are outside the purview of this module.

Antipsychotics

Antipsychotics were introduced in the early 1950's as a treatment for psychiatric behavior with the discovery of thorazine. They target psychotic symptoms such as: hallucinations, delusions, and disorganized thinking. Typically, psychotic symptoms lessen by the 6th week of treatment. There are two classes of antipsychotics: typical and atypical. Traditional, or typical antipsychotics, include the older medications used to treat psychosis. Atypical antipsychotics include the newer medications. Antipsychotic medications accumulate in fat and are non-addictive. Overdose is rarely fatal. All of the antipsychotic medications have similar effectiveness, but they have different side effects.

Clozaril is an atypical antipsychotic medication with special considerations for use due to the potential for harm related to the possible side effects. VHA has a national protocol related to the prescribing and management of Veterans on clozaril (VA, 2008). Briefly, clozaril is indicated for Veterans who are 'treatment resistant' or who have failed two courses of other drug therapy. Clozaril treats both the positive and negative symptoms of psychotic disorders and has a low incidence of extrapyramidal symptoms (EPS). It can reverse tardive dyskinesia. One of the potential side effects of clozaril is neutropenia, which requires the Veteran to be monitored with weekly bloodwork for the development of agranulocytosis. The Veteran must be compliant with treatment and able to meet the requirement of weekly labs to ensure his/her safety through the duration of treatment. Other side effects of clozaril include: drowsiness/sedation, orthostatic hypotension, tachycardia, seizures, constipation and hyper-salivation.

Typical Antipsychotic Medications	
Generic Name	Trade Name
Chlorpromazine	Thorazine
Chlorprothixene	Taractan
Fluphenazine	Prolixin*
Haloperidol	Haldol*
Loxapine	Loxitane
Mesoridazine	Serentil
Perphenazine	Trilafon
Pimozide (Tourette's Syndrome)	Orap
Thioridazine	Mellaril
Thiothixene	Navane
Trifluoperazine	Stelazine

*Available in Decanoate Injection

Atypical Antipsychotic Medications	
Generic Name	Trade Name
Aripiprazole	Abilify
Clozapine	Clozaril
Lurasidone	Latuda
Olanzapine	Zyprexa
Quetiapine	Seroquel
Paliperidone	Invega Sustenna*, Trinza*
Risperidone	Risperdal, Consta*
Ziprasadone	Geodon

*Long acting injection

The P-MHN must be aware and assess for side effects of antipsychotic medications. Common side effects usually disappear after the first few weeks of treatment and include:

- Drowsiness/Sedation
- Rapid heartbeat

- Dizziness when changing position

Other side effects include:
- Sunburn / skin rashes (photosensitivity)
- Weight gain
- Decrease in sexual ability or interest
- Medication related movement disorders

Anticholinergic effects include:
- Postural hypotension (especially Thorazine)
- Dry mouth
- Constipation
- Urinary retention

Endocrine side effects include:
- Gynecomastia
- Lactation
- Menstrual irregularities
- Increased libido in women
- Impotence in men

Extrapyramidal Symptoms (EPS) can be a side effect of antipsychotic medications. Assessment tools such as the Assessment for Involuntary Movement Scale (AIMS) give the nurse a baseline to track and monitor EPS.

Extrapyramidal Side Effects (EPS)	
Parkinsonian Symptoms	Fine tremors Pill rolling tremor of the fingers Drooling
Dystonia	Sudden spasm of muscles of the neck and face twisting to the side Eyes uncontrollably rolling back into the head A variety of abnormal facial and head movements combined with increased salivation • Treated with IM medication Benadryl 50 mg or Cogentin 2 mg
Akathisia	Restlessness and inability to sit still Twitching or crawling sensation in muscles • Consider substitution with another antipsychotic medication
Tardive Dyskinesia (TD)	Purposeless involuntary movements such as lip smacking, pill rolling, etc. Due to long term use of typical antipsychotics Irreversible Occurs over time Can occur up to 12 months after discontinuation of medication

Antiparkinson drugs are routinely used with typical antipsychotics to counteract EPS or neurological side effects. PRN orders for these drugs may be written when a Veteran has a concurrent PRN antipsychotic order for control of agitation. Although antiparkinson medications are utilized to reduce side effects of typical antipsychotics, they also potential anticholinergic side effects including:

- Cognitive impairment
- Delirium or intestinal stasis (rare)
- Dry mouth and blurred vision

Antiparkinson Medications	
Generic Name	**Trade Name**
Trihexyphenidyl	Artane
Benztropine	Cogentin
Biperiden	Akineton
Diphenhydramine	Benadryl

Neuroleptic Malignant Syndrome (**NMS**) is a rare condition that can occur with antipsychotic or neuroleptic medication use and is related to the blocking of dopamine in the brain. This is a **medical emergency** that can be fatal and result in cardiac and/or renal failure. The P-MHN must be aware of the potential for NMS and recognize potential signs and symptoms to include:

- Hyperthermia (fever >38.0 Celsius/100.4 Fahrenheit)
- Altered Mental Status
- Muscle Rigidity and/or other EPS (See **Appendix L** for definitions):
    - Cogwheeling
    - Hypersalivation
    - Retrocollis
    - Shuffling gait
    - Flexor – extensor posturing
    - Akinesia
    - Tremor
    - Choreiform movement
    - Dystonic Movement (Opisthotonos, Trismus, Blepharospasm, Oculogyric Crisis)
    - *YouTube is a great source to visualize the manifestation of these symptoms*
- Autonomic Dysfunction:
    - Hypertension
    - Skin Pallor
    - Tachycardia
    - Flushing
    - Tachypnea
    - Incontinence
    - Diaphoresis
- Other symptoms may include:
    - Dysphagia
    - Dypsnea
    - Abnormal reflexes
    - Mutism
    - Seizures
    - Elevated WBC & CPK

If NMS occurs, medication must be discontinued immediately. Further treatment and supportive care of IV fluids /electrolytes and cooling the patient is required along with monitoring respiratory, cardiac and renal functioning. In the case of NMS response, medication should only be re-challenged carefully after 2 weeks.

Mood Stabilizers

Mood stabilizers can be used to treat mania and/or depression, hyperactivity, sleep disturbances, aggressive behavior and pressured speech. Medication will diminish severe

manic symptoms in 5-14 days, but it may take several months until the condition is fully controlled.

Mood Stabilizing Medications	
Generic Name	Trade Name
Carbamazepine (Antiseizure)	Tegretol
Divalproex Sodium (Antiseizure)	Depakote
Lithium Carbonate (Mood Stabilizer)	Eskalith, Lithane, Lithobid
Gabapentin	Neurontin
Topiramate	Topamax
Lamotrigine	Lamictal

Lithium Carbonate is the gold standard medication for bipolar disorder. It is a naturally occurring salt effective in controlling behaviors associated with bipolar disorder, as a first line treatment for mania and in combination with antipsychotics for the management of agitation. It must be used within certain parameters for safety. When starting lithium, it is advisable to obtain baseline labs (i.e. electrolytes, serum creatinine, TSH, pregnancy screen as warranted, etc.). Lithium is listed as a Category D drug for pregnancy by the FDA. Lithium lab monitoring is recommended at least every 6 months for stable patients, or more frequently if clinically indicated (VA/DOD, 2010 & APA, 2010). The Veteran must consume adequate fluids and salt when on lithium. Therapeutic blood level of **0.6 – 1.2 meq/L** must be reached before behavioral effect occurs. Blood levels >1.2meq/L is lithium toxicity; 2.0meq/L can be lethal. If lithium treatment is effective, it is likely the Veteran will be on it indefinitely.

Lithium is processed primarily through the kidneys and can cause kidney irritation, especially in high doses, but also in Veterans who are not well hydrated (excessive caffeine or alcohol use, on a diuretic, decreased fluid intake, hyponatremia, cardiovascular dx, use of NSAIDS, or having vomiting/diarrhea). In severe cases, this may lead to kidney failure and dialysis. Lithium can decrease the effectiveness of the thyroid, causing an increase in the TSH and hypothyroidism, which is reversible. Side effects usually disappear as therapeutic level is established and may include:

- Fine tremor of the hands
- Abdominal cramps
- Nausea and vomiting
- Diarrhea
- Weight gain
- Polyuria
- Polydipsia
- Skin rashes

Lithium Toxicity is a dangerous complication of lithium therapy. A toxic lithium level (>1.2 mEq/Liter) requires immediate action to lower it. The provider may lower the lithium dose or decrease the use of other interacting medications. Appropriate nursing interventions include patient education regarding early and late stage toxicity symptoms, increasing hydration, increasing salt intake (when appropriate), limiting caffeine consumption, and limiting sweating. Lithium toxicity presents differently in early or late stages.

Symptoms of the early stages of Lithium toxicity:

- Sluggishness, lethargy
- Fine tremor fingers or muscle
- Twitching
- Ataxia
- Slurred speech

- Anorexia
- Nausea
- Vomiting
- Diarrhea

Symptoms of the later stages of Lithium toxicity:

- Semi-consciousness
- Coma
- Seizures

- Cardiac impairment
- Death

Depakote and Tegretol (antiseizure medications): Tegretol (Carbamazepine) was synthesized in 1957 and widely used as a treatment for epilepsy. In the early 1970's it was successfully used by the Japanese for bipolar patients who did not respond to Lithium. It increases liver enzymes, speeds up the metabolism of other drugs, and may be more effective for "rapid cycling" bipolar patients. Depakote (Valproic acid) was identified in the late 1960's as effective treatment for mania and schizoaffective disorders. Anti-seizure medications can be helpful in the treatment of depression, agitation in patients with schizophrenia, alcohol/benzodiazepine withdrawal and/or in decreasing impulsivity or aggression.

- Tegretol therapeutic level = 4-12 mg/L. Side effects include: sedation/drowsiness (will subside), diplopia, change in baseline coordination.
- Depakote therapeutic level = 50-100 mg/L. Side effects include: hepatotoxicity (rare), thrombocytopenia (bruising/bleeding), sedation, ataxia, tremor, weight gain and alopecia

Antidepressant Medications

Antidepressants are prescribed for depression lasting 2 weeks or more that interferes with a person's ability to carry out daily tasks and to enjoy activities. They target symptoms of depressed mood, sleep/appetite disturbances and decreased concentration. Clinical practice guidelines for the management of major depressive disorder direct the use of evidence-based psychotherapy and/or pharmacotherapy (VA/DoD, 2016). No antidepressant is superior to another, if dosed appropriately each can be effective in treating depression. They are not addictive. Antidepressants take time to work; response may not occur until 2 to 4 weeks after the first dose. Select depressive symptoms may lessen early in treatment, while others improve later. Energy, sleeping, and eating patterns often improve before the depressed mood lifts. **During this time, the P-MHN must be aware of the patient's suicidal ideation and/or intent. The Veteran may have the increased energy to carry out a suicidal plan, prior to their mood improving.** There are four classes of antidepressants:

- **SSRIs** (Serotonin Selective Reuptake Inhibitors) include Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs) and Serotonin (5H2A) Receptor Antagonists
  - First line antidepressant treatment option

- o Sexual dysfunction is common.
- o Common side effect of insomnia and/or sedation
- **DNRIs** (Dopamine and Norepinephrine Reuptake Inhibitors)
    - o Wellbutrin (Bupropion) increases potential for seizures
    - o Bupropion is the least likely to produce sexual dysfunction and can be used to treat sexual dysfunction.
- **TCAs** (Tricyclic Antidepressants and Tetracyclic Antidepressants)
    - o Overdose can be lethal and/or cause significant renal and cardiac complications
- **MAOIs** (Monoamine Oxidase Inhibitors)
    - o Not routinely used unless the patient has been unsuccessful on other antidepressants
    - o Patient must comply with a low tyramine diet.
    - o Can cause orthostatic hypotension
    - o Can have serious side effects if taken with tricyclics, certain foods or some cold remedies such as:
        - ▪ Hypertensive crisis
        - ▪ Hyperpyrexic states with myoclonus
        - ▪ Severe headaches
        - ▪ Cerebrovascular accidents

Foods to be avoided with Monoamine Oxidase Inhibitors		
Foods to definitely avoid	Beer, red wine	Dry sausage
	Fava or Italian green beans	Brewer's yeast
	Smoked fish	Liver (beef or chicken)
	Aged cheese (cottage and cream cheese are allowed)	
Foods to avoid in excess	Alcohol	Ripe avocado
	Yogurt	Bananas (ripe)
	Soy sauce	
Foods that are okay in regular quantities	Chocolate	Figs
	Meat tenderizers	Raisins
	Caffeine containing beverages	

Antidepressant treatment is indicated for a minimum of several months and can last to a year or more. The most common cause of treatment failure is an inadequate medication trial. It is important to not abruptly discontinue antidepressant medications. If the Veteran experiences no response at 4 to 6 weeks, the provider may consider switching, combining or augmenting the therapy. Antidepressants can cause "rebound mania" in patients with bipolar disorder. Common side effects of antidepressants include:

- Dry mouth
- Constipation/diarrhea
- Urinary retention/hesitancy
- Blurred vision
- Increased blood pressure
- Appetite changes
- Weight gain (TCAs)
- Tremor
- Sexual dysfunction (all classes)

There are numerous considerations in Antidepressant Treatment:
- Anticonvulsants (e.g. Carbamazepine) may be added to antidepressants especially for the person with multiple depressive episodes or with prominent symptoms of impulsivity, irritability, or anxiety.
- Electroconvulsive Therapy (ECT) may be used in treatment of refractory depression but it should be followed with maintenance antidepressant therapy.
- Baseline T_4 or TSH labs are useful to monitor for TSH suppression.
- Select antidepressants can be used as anxiolytic agents for generalized anxiety disorders, social phobia, Obsessive Compulsive Disorder (OCD) and PTSD.

Antidepressant Medications		
Generic Name	Trade Name	Class
Amitriptyline	Elavil	TCA
Bupropion	Wellbutrin	DNRI
Citalopram	Celexa	SSRI
Clomipramine	Anafranil	TCA
Desipramine	Norpramin	TCA
Doxepin	Sinequan	TCA
Fluvoxamine	Luvox	SSRI
Fluoxetine	Prozac	SSRI
Imipramine	Tofranil	TCA
Mirtazapine	Remeron	Other
Nortriptyline	Pamelor	TCA
Paroxetine	Paxil	SSRI
Phenelzine	Nardil	MAOI
Sertraline	Zoloft	SSRI
Tranylcypromine	Parnate	MAOI
Trazodone	Desyrel	Other
Trimipramine	Surmontil	TCA
Venlafaxine	Effexor	SSRI

Depression is a mental illness but can also be a side effect of common medications including but not limited to:

- Stimulant Withdrawal
- Antiparkinson Medications
- Anabolic Steroids
- Benzodiazepines
- Digitalis
- Clonidine
- Glucocorticoids
- Calcium Channel Blockers
- H2 Blockers
- Interferon
- Opiates
- Antihyperlipidemics (statins)
- Beta Blockers
- Metoclopramide
- ACE Inhibitors
- Oral Contraceptives

Antianxiety Medications

Anxiety includes panic, phobia, obsessive compulsive disorder (OCD) and PTSD. SSRIs and/or benzodiazepines are used frequently to treat anxiety disorders. Anxiolytics were discovered in the 1950's and were utilized singularly for treating anxiety until 1990 when Prozac was developed. Benzodiazepines have high abuse and addiction potential and can be lethal when combined with alcohol or opiates. They are indicated for short term management of severe anxiety and/or behavioral agitation and should be used sparingly. Current management of anxiety disorders frequently offers a combination of medication therapy and CBT. Non-addictive medications such as SSRIs, buspar, mood stabilizers and beta blockers are commonly used to treat anxiety. Tobacco use can interfere with the intended effects of antianxiety medication.

Antianxiety Medications		
Generic Name	**Trade Name**	**Class**
Diphenhydramine	Benadryl	Antihistamine
Hydroxyzine Pamoate	Vistaril	Antihistamine
Propanolol	Inderal	Beta Blocker
Clonidine	Catapres	Nonadrenergic
Buspirone	Buspar	Anxiolytic
Citalopram	Celexa	SSRI
Escitalopram	Lexapro	SSRI
Fluvoxamine	Luvox	SSRI
Fluoxetine	Prozac	SSRI
Paroxetine	Paxil	SSRI
Sertraline	Zoloft	SSRI
Venlafaxine	Effexor	SSRI
Alprazolam	Xanax	Benzodiazepine
Clonazepam	Klonopin	Benzodiazepine
Diazepam	Valium	Benzodiazepine
Lorazepam	Ativan	Benzodiazepine
Temazepam	Restoril	Benzodiazepine

Medications useful in treating anxiety:
- **Antihistamines** (Benadryl, Vistaril) – used for the treatment of anxiety and tension associated with psychoneurotic conditions or physical disease states. Also indicated for pruritus due to allergic conditions.
- **Non-adrenergic agents** (Beta blockers, Propanolol) **and alpha 2 receptor agonists** (Clonidine) – used to ameliorate symptoms of anxiety. Often useful in relieving akathisia in patients on neuroleptics and hand tremors secondary to lithium. Side effects include bradycardia, hypotension, weakness, fatigue, clouded sensorium, impotence, GI upset and bronchospasm.

- **Buspar** – a non-sedating anxiolytic with little potential for addiction or abuse. Educate the Veteran that this medication is non-sedating and will not create the same physiological effect as sedating agents. Offers an opportunity to work on practicing other coping skills for managing anxiety.
- **SSRIs** – most commonly used medication in treating anxiety disorders. They have less abuse potential and are used for long-term treatment of anxiety. They frequently take 2-3 weeks to take effect and 6-8 weeks for maximum effectiveness.
- **Benzodiazepines** –high addiction and misuse potential. Common side effects include: drowsiness, fatigue, confusion, loss of coordination and mental slowing. Of note, this class of medication can have a paradoxical effect. The P-MHN should monitor for efficacy of this medication and for any unintended side effects.

Medication Teaching

Medication teaching is important, but often becomes more complex when a patient is suspicious or mistrustful about medication. It is important to assess the Veteran's ongoing cognitive functioning, literacy and ability to learn and retain information when approaching any teaching. It may be helpful to state the specific symptom that the medication will target ("This medication, Zyprexa, will help with your thinking"). It may be less beneficial to discuss every potential side effect or negative outcome associated with each medication, as that may increase the Veteran's anxiety. Explore with the Veteran the potential barriers to medication adherence such as cost, difficulty swallowing, difficulty remembering to take medications, challenges in getting refills, unwanted side effects, etc.

Summary

Pharmacologic treatment for mental illness has come a long way in a short period of time. The newer medications were created to improve upon the older versions by adding more benefits and fewer side effects. Emerging technology may further change and influence psychopharmacology, including pharmacogenetics testing for medication efficacy and individual medication metabolism. By understanding medications, expected side effects and knowing what symptoms to watch for, the P-MHN can educate Veterans to promptly recognize their own side effects or mental health relapse, promoting recovery and further engaging the Veteran in treatment and care.

✓	Knowledge Check
	I can name the two classifications of antipsychotic medications.
	I can differentiate between the multiple classifications of antidepressant medications.
	I can list four symptoms of Neuroleptic Malignant Syndrome (NMS).
	I can describe Tardive Dyskinesia.
	I can describe the purpose of a mood stabilizer.

Resources

American Psychiatric Association. (2010). Practice Guideline for the treatment of patients with
bipolar disorder. 2nd Ed. Retrieved from
http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf

Department of Veteran Affairs (VA). (December 2008). Clozapine Patient Management
Protocol (CPMP). VHA Handbook 1160.02. Retrieved
from http://www1.va.gov/vhapublications/publications.cfm?pub=2

VA/DOD (2010). Clinical practice guidelines management of bipolar disorder in adults (BD).
Retrieved from http://www.healthquality.va.gov/guidelines/MH/bd/bd_306_sum.pdf

VA/DOD (2016). Clinical practice guideline for the management of major depressive disorder.
Retrieved from
http://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf

Module 7

<u>Professional Development</u>

Objectives:

1. Identify the wide variety of opportunities for professional development within the specialty psychiatric-mental health nursing.
2. Identify 5 different ONS approved specialty certifications in psychiatric nursing.
3. Engage in professional development through learning and practicing specific therapeutic skills.
4. Engage in professional development through mentoring; both as a mentor and a mentee.

Introduction

Nurses entering the mental health care field have a plethora of opportunities to develop their practice from novice to expert. Entering a new area of nursing practice can seem overwhelming. Those of us mentoring new nurses can speak to the rapidity of developing a sense of being stuck or burned out. The good news is that there are a variety of areas within psychiatric - mental health nursing to transition to. The purpose of this module is to provide information on the potential of professional growth over the course of a career. Professional growth is facilitated through (but not limited to) certification, training, mentorship and the application of new knowledge and skills.

Certification

Psychiatric - mental health nursing has numerous diverse opportunities to progress from novice to expert practice. Although transitioning to a new specialty can feel overwhelming at times, we

would like to share a few resources that can lead you towards continued professional growth in clinical skill development, knowledge, leadership, advocacy, and policy.

It is important for new nurses to know that there are specific certifications unique to psychiatric nursing. The Office of Nursing Service (ONS) provides a list (click for link) of approved nursing certifications. Certifications relevant to the P-MHN are described in the table below. More details about completion requirements and practice implications for each certification can be found by clicking on the provided link.

Let's Get Certified Campaign

U.S. Department of Veterans Affairs | U.S. Department of Defense

Certification	Designation	Organization	Link
Psychiatric Mental Health Nurse	RN-BC	American Nurse Credentialing Center (ANCC)	www.nursecredentialing.org
Certified Addictions Registered Nurse	CARN	Addictions Nursing Certification Board (ANCB)	www.IntNSA.org
Certified Pain Practitioner	CPP	The American Academy of Pain Management	www.aapainmanage.org
Sexual Assault Nurse Examiner	SANE	Forensic Nursing Certification Board	www.iafn.org
Clinical Nurse Leader	CNL	American Association of Colleges of Nursing	http://www.aacn.nche.edu/cnl

Training and Resources

Many education and training opportunities are offered through the VA's Learning Resource Services, Talent Management System (TMS) and other locally available training options often on your facility SharePoint. A complete list is beyond the scope of this module.

Some useful areas of expertise include but are not limited to: Motivational Interviewing (MI), Cognitive Behavioral Therapy for Insomnia (CBT-I) and Mental Health First Aid (MHFA). Courses for these valuable skills are frequently available through local colleges and universities. Nurses currently in school are encouraged to review academic courses that may qualify as an elective to required coursework. The below links provide non-academic links to information and training:
- Motivational Interviewing: http://www.motivationalinterviewing.org/
- CBT-I: http://deploymentpsych.org/treatments/cognitive-behavioral-therapy-insomnia-cbt-i
- MHFA: https://www.mentalhealthfirstaid.org/cs/

National and state mental health nursing conferences are very useful for the P-MHN. Information about a select list of nursing organizations and their conferences can be found at:

- American Psychiatric Nurses Association (for state conferences, click on chapter links): http://www.apna.org/i4a/pages/index.cfm?pageid=1
- Contemporary Forums (Psychiatric and Behavioral Issues): http://contemporaryforums.com/specialties/psychiatric-behavioral-issues.html
- International Society of Psychiatric-Mental Health Nurses: http://www.ispn-psych.org/html/conferences.html
- International Nurses Society on Addictions: http://www.intnsa.org/conference

It is important for the P-MHN to stay current in clinical knowledge and skills. If your VA does not have an active journal club, consider initiating one. Below is a list of professional journals in the area of psychiatric mental health nursing. These journals can be accessed for free through the VA National Library (http://www.va.gov/library/):

- **Journal of the American Psychiatric Nurses Association** (JAPNA): Peer reviewed clinical and research articles relevant to the P-MHN. Authors describe critical and timely analyses of the emerging issues and trends in psychiatric nursing, and present innovative models of practice related to mental health care systems. JAPNA publishes original research and practice-focused articles, and features editorials, interviews, briefings, and letters to the editors. The Journal's expert content provides psychiatric nurses with the newest effective nursing practices, innovative therapeutic approaches, significant information trends, and useful, clinically-focused research in psychiatric-mental health nursing and its related subspecialties.
- **Journal of Psychosocial Nursing**: A monthly, peer-reviewed journal for the P-MHN in a variety of community and institutional settings. It provides the most up-to-date, practical information available for today's psychosocial nurse, including short contributions about psychopharmacology, mental health care of older adults, and child/adolescent disorders and issues.
- **Perspectives in Psychiatric Care** (PPC): provides advanced practice nurses with current research, clinical application, and knowledge about psychiatric nursing, prescriptive treatment, and education. The journal publishes peer-reviewed papers that reflect clinical practice issues, psychobiological information, and integrative perspectives that are evidence-based. It includes regular columns on the biology of mental illness and pharmacology, the art of prescribing, integrative perspectives, and private practice issues.
- **Archives of Psychiatric Nursing**: disseminates original, peer-reviewed research of interest to the P-MHN including theory, practice and research applications related to all ages, special populations, settings, and interdisciplinary collaborations in both the public and private sectors.

Psychology, Psychiatry, and Social Work journals also provide a wealth of information including:

- **Psychiatric Services**: published monthly by the American Psychiatric Association. The journal focuses on issues related to the delivery of mental health services, especially for

people with severe mental illness in community-based treatment programs: http://ps.psychiatryonline.org/
- **The Psychosocial Rehabilitation Journal**: focuses on recovery-oriented care and rehabilitation of persons with mental health problems: http://www.uspra.org/knowledge-center/psychiatric-rehabilitation-journal

Mentoring

Mentoring is the process in which a subject matter expert (mentor) shares wisdom, with the goal of developing a less experienced person. Coaching is engaging in a partnership (between mentor and mentee) to facilitate learning, improve performance and create desired outcomes resulting in professional growth for the mentee and the mentor. It is an opportunity for collaboration in the development of novice nurses and is an opportunity for expert nurses to identify patterns or gaps in knowledge and skills. VHA has a mentor certification program that utilizes the GROW model for measuring success and outcomes of mentors and mentees. Any nurse may participate in the mentor program, if available in their location.

The new nurse may choose to formally participate in a VHA mentor program, but may also elect to request an informal mentor from experienced staff available on the unit. The informal mentoring relationship is well suited for the new nurse to gain constructive feedback as he/she develops clinical and interpersonal skills. Mentor selection requires consideration of personality 'fit', as well as traits that may improve the new nurse's experience with a mentor. Positive mentor traits may include, but are not limited to (Cho, Ramanan & Feldman, 2011 in Moran, Burson & Conrad, 2014, p. 223-224):

- Having enthusiasm, compassion, selflessness
- Acting as career guide, tailor to the mentee
- Willing/able to make a time commitment
- Supporting personal/professional balance
- Displaying effective communication skills
- Earning respect in the workplace by peers and senior administrators
- Being politically astute
- Understanding organizational nuances
- Having the ability to network with multiple departments and high-level executives
- Possessing the expertise in the area that the mentee requires

Novice nurses should carefully consider their selection of a mentor. The right mentor/mentee relationship can be meaningful and productive. In approaching a potential mentor (Moran, Burson, Conrad, 2014, p. 228):

- Convey gratitude for the help
- Be well prepared

- Honor the meeting arrangements
- Use time efficiently
- Make it a two-way relationship

Additional useful links on mentoring, such as the GROW model and recommendations by Jean Watson can be found online.

Summary

While academic education is irreplaceable, actual clinical practice is priceless. Expertise can take time to develop. Nurses entering the psychiatric - mental health nursing field bring a wealth of new knowledge and personal experiences that inform their developing clinical practice. The novice nurse should keep in mind that building a career in PMH nursing is a process. Various training and development programs exist to foster the new nurse's professional growth; these can be formal programs or more informal mentoring with expert staff on the inpatient unit.

Other Useful Links

Talent Management System (TMS): VA education website: http://www.tms.va.gov

U.S. Department of Veteran Affairs: National Center for PTSD:
http://www.ptsd.va.gov/index.asp

U.S. Department of Veteran Affairs: Office of Nursing Service:
http://vaww.va.gov/nursing/index.asp

U.S. Department of Veteran Affairs: Mental Health Home page:
http://vaww.mentalhealth.va.gov/index.asp

Substance Abuse and Mental Health Services Administration:
https://www.samhsa.gov/

National Alliance for Mental Illness:
http://www.nami.org/

Psychiatric Rehabilitation Association:
http://www.psychrehabassociation.org/

GROW model for mentoring:
https://www.mindtools.com/pages/article/newLDR_89.htm

Model of Caring Mentorship for Nursing:
http://www.watsoncaringscience.org/images/features/library/Wagner_CoachingJ_Nurs_Staff_Dev_2007.pdf

✓	Knowledge Check
	I am mindful of the wide variety of opportunities for professional development within the specialty of psychiatric-mental health nursing.
	I can identify the 5 different types of mental health specialty certifications that are approved by ONS.
	I can engage in professional development through learning and

		practicing specific therapeutic skills.
		I know how to engage in professional development through mentoring, both as a mentor and as a mentee.

Resources

Cho, C. S., Ramanan, R. A., & Feldman, M. D. (2011). Defining the ideal qualities of mentorship: A qualitative analysis of the characteristics of outstanding mentors. *American Journal of Medicine*, 124(5), 453-458.

Miller, W. R., & Rollnick, S, R. (2013). *Motivational interviewing: Helping people change (3ʳᵈ ed.).* New York, NY: The Guilford Press.

Moran, K., Burson, R., Conrad, D. (2014). *The doctor of nursing practice scholarly project: A framework for success*. Burlington, MA: Jones & Bartlett.

Appendix A – List of Potentially Hazardous Items

Sample list of items that can have the potential for self- harm or harm to others.   *This list is not all inclusive and is subject to change based on milieu and patient assessment. Please refer to your facility policy for a specific hazardous items (previously referred to as contraband) list.

Aerosol sprays and shaving cream
Alcohol-containing products (mouthwash, aftershave, cologne, cosmetics and candy)
Ballpoint pens, pencils
Bandanas, Scarves, hats & head gear
Belts, suspenders
Bobbie pins, paperclips
Chains (neck, wrist, etc.)
Cigarette lighters, matches, chewing tobacco
Dental floss
Electronic devices (cameras, cell phone, beepers, razors, radios, games, laptops, hair dryers, recording devices)
Glass, mirrors, cups, bowls, plates
Jewelry (except watches)
Kerlix dressings, Panty hose, TED hose
Keys
Luggage (suitcases, back packs, or duffel bags)
Medications (including OTC medications, herbs, vitamins, lotions & ointments)
Nail files, clippers, scissors, and tweezers
Occupational Therapy/Rec Therapy supplies (models, metal, plastic, paint & glue)
Plastic bags, Garbage bags
Plastic flatware
Rattail combs, picks, brushes
Razor blades, shavers
Soda cans, plastic and glass bottles
Spiral notebooks
Steel-toed, heavy heeled boots or shoes
Strings, ribbon, twine, ropes, shoe laces
Strings in hooded jackets, sweatpants
Underwire Bras
Walkers/prosthetics/Canes (when not in use)

Appendix B – Evaluation of the Therapeutic Milieu Exemplar

Evaluation of the Therapeutic Milieu
Exemplar

An exemplar is a story of a real Veteran that is told in order to illustrate an RN's practice/experience. The exemplar is written in the first person. It describes in detail a particular clinical situation that includes the nurse's thoughts, feelings, intentions, actions, critical thinking and decision-making processes.

In order to meet the competency requirements your exemplar should include:

- Identifying the milieu concepts important to both the Veteran and the staff member
- Incorporating knowledge of the therapeutic milieu into the staff member's clinical practice

Name:

Date: Unit or Program:

Brief Background

1. Veteran History and Diagnosis
2. Describe in some detail how the therapeutic milieu influenced the Veteran's treatment progress.
   - Your relationship in the situation
   - Physician involvement (if important)

Action Taken

3. How did you manage the milieu issue?
4. Your motivation for action
5. What problems did you anticipate and how did that affect your decision making?

Outcome

6. Was the outcome positive as a result of your intervention?
7. How did your action affect the outcome of the situation?
8. If not positive, what do you or other team members needed to do differently?

Debrief/Significance

9. How did this story change you personally or professionally?

Appendix C - Unit Guideline Consent Example

Cincinnati VA Medical Center
Mental Health Care Line

VA | U.S. Department of Veterans Affairs

7 North Unit Guidelines

1. **For your safety there are a few items not permitted on the unit. These items include but are not limited to:**

- Electronics
- Medications
- Tobacco products, lighters/matches
- Weapons of any kind
- Toxins (hair spray, aerosols, cologne, mouthwash, make-up products)
- Wallets/cash: These may be kept with the Veteran (except for any laminated/plastic cards), but they become the Veteran's responsibility

- Cell phones and chargers
- Keys
- Pens
- Razors
- Shoe strings
- Belts
- Plastic items
- Sharp items
- Glass items

2. **Food Guidelines:**
- Food/beverages are not permitted in the rooms.
- Staff may not handle Veteran's money
- Veterans may not order food for delivery. However, visitors may bring in food for the Veterans, but it must be consumed during the visit. Any leftovers are to be brought home with visitor or thrown away.
- Food cannot be stored for Veterans.
- Meal times are as follows: 0645, 1200, 1700.
- Snack times are as follows (when snacks are available): 1030, 1400, 1930. Snacks will not be provided other than at designated snack times except in the case of low blood sugar.

3. **Please remember that this is a shared space. Be respectful of other Veterans and the staff on the unit. Please avoid:**

- Threats against other Veterans or staff
- Physical harm of other Veterans or staff

- Destruction of property
- Sexual misconduct

By signing, I state that I have read, understand and agree to abide by the above rules.

Veteran's signature _____   Date _____

Appendix D - Community Meeting Template

Classes, Groups & Activities

Community Meeting

Staff responsible	Mental Health Staff
	Stakeholders, Residents of 7 North

Type of group   Discussion: program community issue

Program Objective
As a result of participating in this program, you will be able to verbalize a successful treatment program experience.

Group/Activity Objective(s) during meetings you will be able to:
1. Become more proactive in discussion of the treatment community issues
2. State concerns in an meaningful and effective manner
3. Share information, concerns, problem-solve and offer constructive feedback to others
4. Identify satisfaction/dissatisfaction with your treatment

Group Process	Topics
• Introduction of staff & Veterans • Orientation of new Veterans to the treatment community • Recognize individual or group accomplshments • Anonymous Comments Box • Questions & Answers	• Patient rights and responsibilities • Community rules • Privilege levels • Community generated topics • Satisfaction/Dissatisfaction with treatment

Describe at least one community issue you addressed at this meeting.

I attended this group?	Yes	No
Were you comfortable bringing up your issue?	Yes	No
Was the problem successfully resolved?	Yes	No
Did you communicate well with others?	Yes	No
Was this group helpful to you?	Yes	No

_____
          (Veteran signature)

Appendix E - TREATMENT PROGRAM SCHEDULE & PROGRESS LOG EXAMPLE

Understanding Your Treatment

The following pages contain the Treatment Program Schedule – a complete listing of all classes, groups and activities offered by the Acute Inpatient Psychiatry Treatment Team. You will be assigned to a treatment track based on your strengths, needs, abilities and preferences.

Please:
1. Personalize the schedule to meet your specific treatment needs by reviewing it with your nurse.
2. Sign it to show that you agree with the plan.
3. Review your schedule and be sure that you understand it.
4. Use the schedule to guide your daily routine.

Attendance and participation in your treatment results in your empowerment.

Mental Health Disorders Track

Weekdays		M	T	W	T	F
8:00 – 8:30	Exercise and Fitness/Restorative Yoga	X	X	X	X	X
8:30 – 9:15	Writing for Mental Health Recovery	X				X
	Medication Education		X			
	Management of Pain				X	
	Personal Writing and Journaling			X		
9:15 – 9:30	Break					
9:30 – 10:30	Coping with Mental Health Symptoms	X	X	X	X	X
10:30 – 10:45	Break					
10:45-11:45	Social Interaction	X	X	X		X
	Social Skills Training				X	
	Life Skills	X		X		X
	Task Completion		X		X	
11:45 – 1:00	Medications, lunch & break					
1:00 – 2:00	Psychotherapy	X	X	X	X	X
2:00 – 2:30	Break					
2:30 – 3:15	Addictive Behaviors and Mental Illness	X				
	Eating for Health and Wellness		X			
	Personal Spirtuality			X		
	Community Meeting				X	
	Leisure Awareness					X
3:15 – 8:15	Medications, Dinner, Evening Activities, Visiting Hours					
6:15 – 7:00	Creative Expression	X		X		
	Partnering with Care Team Members		X		X	
	Personal Writing and Journaling					X

Community Resocialization Activities occur every other Thursday.

Family & Friends Program (SAFE) is available. Check with staff for times and dates.

Weekend Program Track   *Visiting Hours are until 8:00 PM every evening.

	Saturdays	Sundays
10:00 – 11:00	Medication Education	Protestant Religious Services
11:00 – 11:45	Recovery in Action	Roman Catholic Mass
11:45 – 1:00	Medications, Lunch & Break	Medications, Lunch & Break
1:00 – 1:45	Free Time	Keeping Current in My Life and Community
2:00 – 3:00	Personal Writing time and Journaling	Health Problems and Mental Illness
3:00 – 6:15	**Medications, Dinner, Break & Visiting Hours***	**Medications, Dinner, Break & Visiting Hours***
6:15 – 7:00	Creative Expression Group	Getting Ready for Monday

Co-Occurring Disorders Track

Weekdays		M	T	W	T	F
9:15 – 10:00	Personal WritingTime and Journaling		X		X	
10:00 – 11:30	Substance Abuse Education	X	X	X	X	X
11:30 – 1:00	Medications, lunch & break					
1:00 – 3:00	Substance Abuse Education		X	X	X	
2:30 – 3:15	Addictive Behaviors and Mental Illness	X				X
3:15 – 8:15	Medications, Dinner, Evening Activities and Visiting hours					

Treatment Progress Log		
Patient name_____		
Staff signature documents successful verbal / written completion of the class, group or activity workbook section.		
Daily Class/Group/Activity	**Staff Signature**	**Date**
Coping with Symptoms		
Writing for Mental Health Recovery & Plan		
Social Interaction/Social Skills Training		
Medication Education (twice a week)		
Psychotherapy/Sensory Therapy		
Creative Expression		
Exercise and Fitness/Yoga		
Enrichment Classes	**Staff Signature**	**Date**
Addictive Behaviors and Mental Illness		
Mental Illness and Health		
Eating for Health and Wellness		
Keeping Current in My Life and Community		
Personal Writing Time and Journaling		
Spirituality Group		
Leisure Awareness		
Sleep Hygiene		
Substance Abuse Education		
Management of Pain		

_____

    (Veteran signature)

Appendix F – ASSESSMENT DOCUMENTATION EXAMPLE

A 67-year-old American male Veteran was admitted yesterday to the inpatient psychiatric unit with a diagnosis of Major Depressive Disorder and reported suicidal thoughts with a plan to overdose on medications. He has been married and living with his wife for 43 years until recently when she was transferred to a nursing home due to a recent stroke after a fall. The Veteran was brought to the hospital by his daughter who came by the Veteran's home, found him crying and he revealed his plan when the daughter questioned him. The Veteran came into the hospital voluntarily.

Since arriving, the Veteran has been observed to be sad with a flat affect and tearful at times. He was recorded to sleep only 4.5 hours with frequent wakefulness and difficulty going back to sleep. The Veteran has made no gestures of self-harm since admission. Today he has been in the community area sitting alone by the wall and has not interacted with peers even when addressed. It appears he has not showered or shaved and has a strong body odor. When walking, he looks at the floor, shuffles and moves slowly, sometimes holding onto the railing. At times he is noted to have fine upper extremity tremors and some shortness of breath. The Veteran refused to take his morning medications stating he didn't think he needed them. When questioned by the nurse, the Veteran responded to his name, knew where he was and was aware of the date and time. He told the nurse his thoughts at admission of taking his pills was due to his wife being placed in the nursing home and feelings of sadness, fear of being alone, and guilt that it was his fault she fell. The Veteran continues to express sadness but denies any plan to harm himself. Document an assessment of this case scenario on the provided template.

Data: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Commitment Status:
☐ Voluntary, ☐ Detained, ☐ Pending evaluation
Suicidal:
☐ Yes* ☐ No   *If yes, complete Suicide Risk Assessment
Homicidal: ☐ Yes* ☐ No   *If yes, address in narrative.
Level: ☐ One, ☐ Two, ☐ Three
Observation Status:
☐ None, ☐ Close Observation, ☐ Suicide Monitoring.
Observation Requirement:
☐ None, ☐ 15 minute checks, ☐ 1:1
	EPS noted: ☐ Yes ☐ No
	If Yes: _____
	Exercised: ☐ Yes ☐ No
	If Yes: _____
	Sexually Inappropriate: ☐ Yes ☐ No
	Sleep Assessment:
	   ☐ Slept through the night, well rested
	   ☐ Slept through the night, restless
	   ☐ Irregular sleep pattern
	   ☐ Required a nap

Mental Status:

Level of Consciousness:	Speech:
☐ Alert, ☐ Awake, ☐ Lethargic, ☐ Comatose	☐ Normal rate/rhythm, ☐ Coherent, ☐ Slow, ☐ Rapid,
Orientation: ☐ x3, ☐ Person, ☐ Place, ☐ Date	☐ Pressured, ☐ Hesitant, ☐ Mumbling, ☐ Staccato,
Appearance:	☐ Paraphasic, ☐ Neologisms, ☐ Word salad,
☐ Well groomed, , ☐ Neat/clean,	☐ Disorganized, ☐ Circumstantial, ☐ Clang association,
☐ Age appropriate, ☐ Disheveled,	☐ Driveling, ☐ Dysarthric, ☐ Impoverished, ☐ Logical,
☐ Inappropriate, ☐ Meticulous	☐ Perseveration, ☐ Aphasic, ☐ Tangential,
Attitude:	☐ Sequential
☐ Cooperative, ☐ Uncooperative, ☐ Indifferent,	Thought Content:
☐ Congenial, ☐ Irritable, ☐ Impulsive,	☐ Normal, ☐ Logical, ☐ Ideas of Reference,
☐ Intense, ☐ Refuses treatment,	☐ Delusions (see below), ☐ Grandiosity, ☐ Guilt,
Motor behavior/movements:	☐ Thoughts of Death, ☐ Wishes for death,
☐ Agitated, ☐ Hyperactive, ☐ Fidgety,	☐ Worthlessness, ☐ Helplessness, ☐ Compulsions
☐ Rigidity, ☐ Hypoactive, ☐ Posturing,	☐ Hopelessness, ☐ Somatic Preoccupation, ☐ Paucity,
☐ Cogwheeling, ☐ Catalepsy, ☐ Waxy flexibility,	☐ Religious preoccupation, ☐ Phobias, ☐ Obsessions
☐ Compulsions, ☐ Stereotypical, ☐ Pill rolling,	Delusions:
☐ Tongue protrusions, ☐ Oral-buccal,	☐ None, ☐ Mood congruent, ☐ Mood incongruent,
☐ No gait disturbance,	☐ Paranoid, ☐ Persecutory, ☐ Religious, ☐ Erotic,
☐ No abnormal movement observed	☐ Jealous, ☐ Somatic, ☐ Grandiose, ☐ Mixed
Affect:	Hallucinations:
☐ Normal range, ☐ Constricted, ☐ Blunted,	☐ None, ☐ Visual, ☐ Auditory, ☐ Unfamiliar voice,
☐ Flat, ☐ Labile, ☐ Stable, ☐ Intense,	☐ Familiar voice, ☐ Olfactory, ☐ Tactile,
☐ Expansive, ☐ Restricted	☐ Command to hurt self, ☐ Command to hurt others,
☐ Appropriate to content,	☐ Other: _____
☐ Inappropriate to content	Other perceptual distortions:
Mood:	☐ None, ☐ Hypnagogic, ☐ Hypnopompic, ☐ Illusions,
☐ Euthymic, ☐ Dysphoric, ☐ Depressed, ☐ Sad,	☐ Flashbacks, ☐ Thought broadcasting, ☐ Deja vu
☐ Pessimistic, ☐ Expansive, ☐ Euphoric,	☐ Thoughts/actions/feelings being imposed on
☐ Irritable, ☐ Angry, ☐ Anxious, ☐ Hypomanic,	patient (control), ☐ Thoughts actions/feelings not
☐ Hopeless, ☐ Helpless, ☐ Elated, ☐ Guilty,	one's own (alienation)

Nursing Intervention:

☐ Monitor and document signs and symptoms to establish baseline and track progress.	☐ Encourage development of coping skills
☐ Monitor treatment response and problem-solve with patient.	☐ Support patient in problem solving and completing tasks as needed.
☐ Provide medications as ordered.	☐ Encourage group attendance to support social skills and promote recovery.
☐ Maintain a safe, therapeutic and recovery oriented environment.	☐ Monitor vital signs daily, additionally as needed.
☐ Encourage interaction and functioning as an active member of the milieu	☐ Encourage the patient to contract for safety and report distressing thought or impulses to staff.
	☐ _____

Patient Response: | **Patient Degree of Understanding:**

☐ Cooperative, able to make needs known	☐ Patient verbalizes understanding
☐ Initiates problem solving and completes tasks without prompting	☐ Patient returns demonstration appropriately
☐ Has difficulty or is inconsistent following directions or making needs known	☐ Patient needs reinforcement
☐ Resistive to treatment	☐ _____
☐ Needs frequent redirection	
☐ Unable to follow direction	
☐ _____	

Appendix G – Sample Group Note

Title: Psychoeducation Group: Coping with Symptoms

Facilitated by (names)
Topic: major depression and effective coping skills.
Time spent in group: one hour
Group members in attendance: _____(#).
Group objectives: The individual will:
      (1) Gain a basic understanding of major depression.
      (2) State one effective coping skill to incorporate into his/her recovery plan.

The psychoeducation group reviewed the mental, physical and behavioral symptoms of and coping strategies for depression. These strategies involved positive re-framing of negative thoughts, journaling, and use of ABC worksheets based on cognitive behavioral concepts. Training included lecture and discussion. Verbal participation was used to evaluate each group member's understanding and knowledge of major depression. Questions were invited throughout the session to further clarify members' issues or concerns. Sharing and interaction among members was (strong/moderate/limited) with (some/much) facilitation by the group leader being needed. Two prominent themes that emerged during dialogue involved the hopelessness and sadness associated with depression that becomes a significant barrier to effective living. The members were attentive and involved in the content and the group dialogue. All members completed the individual ABC worksheets and other handouts.

Veteran response: The Veteran was attentive and engaged in the content and group discussion. Took on an informal leadership role in promoting discussion and providing meaningful feedback to other members that was well received. His/her behavior increased the group's cohesion. Affect brightened within the context of his/her participation, however remained depressed overall. The Veteran explored his/her recent loss and the psychosocial stressors that have increased his/her depression symptoms. Thought content was linear and reality based. He/she did not endorse any suicidal ideation during this session.

Plan: Reinforce active treatment involvement in groups and encourage further exploration of depression symptoms and effective coping skills during 1-to-1 meetings.

Appendix H – GROUP NOTE TEMPLATE

Psycho-education Group: Coping with Symptoms
Facilitated by: _____
The one-hour psychoeducation group had _____ members. The group's objectives included:
_____.
The topic was _____.
Mental, physical, and behavioral symptoms of _____ were covered.
Coping strategies for management of _____ were identified.
These strategies included: _____.
Verbal participation was used to evaluate each group member's understanding and knowledge
of _____ .
Questions were invited throughout the group session in order to further clarify group members'
issues.
Sharing and interaction among group members was (strong/moderate/limited) with
(some/much) facilitation by the group leader being needed.
Several members offered insight and were self-aware during the group discussion.
The majority of the group members were attentive and involved in the group work.
All members completed the individual written work and coping strategies (or other topic)
worksheets.

Individual Group Member Notes (Please describe more fully the behavior)
  o   Attentive and engaged but did not verbally participate.
  o   Eyes closed but connected to the group process.
  o   Behavior was facilitative and increased the group's cohesion.
  o   Able to verbalize past life events that are similar to present issues and ways that he/she
      will be able to emerge from these past issues.
  o   Feels hopeful that he/she should be able to weather the current crisis.
  o   _____ symptom burden is overwhelming to him/her.
  o   Discussed focusing on positive aspects of life to rediscover hope.
  o   Derived therapeutic benefit from the session and is able to individualize at least one of
      the group objectives that will be incorporated into his/her plan for mental health
      recovery.
  o   **Risk Information is to be part of the individual group member note if indicated:** No
      evidence of voiced expression of suicidal/homicidal ideation, plan or intent. No acute
      distress noted.

Assessment/Plan:

Affect: (Describe current emotional response during session)

Plan: Continue to reinforce active treatment involvement in the provided groups and
encourage further exploration of _____ symptoms and effective coping skills during
1:1 meetings with nursing and other mental health staff.

Appendix I – TREATMENT PLAN PROCESS CROSSWALK

This table indicates a cross-walk of the APNA Scope and Standards of Practice and the Joint Commission Standards specific to the role of the P-MHN in the treatment planning process and documentation.

Treatment Plan Process and Documentation

APNA Scope and Standards of Practice	*TJC Standards for Plan of Care for Hospital and Behavioral Health Programs*
Prioritizes elements of care based on safety and the level of risk of harm to self or others.	A preliminary plan should be developed to address safety. The plan may focus on risks such as harm to self or others, elopement, sexual reactiveness or any other immediate safety concerns.
Establishes and plans priorities with the healthcare consumer, family, and others as appropriate.	The plan for care, treatment or services addresses the family involvement, environmental, and social factors.
Includes strategies in the plan that addresses each of the identified diagnoses or issues, which may include strategies for promotion and restoration of health, and prevention of illness, injury and disease.	The expressed needs, strengths, preferences and goals of the individual served are collected from screening and assessment. These sources provide a foundation for planning individualized care, treatment, and/or services. *Goals should build on the individual's strengths.* Barriers that might need to be considered include co-occurring illnesses, cognitive and communication disorders, developmental, vision, physical or hearing disabilities, and/or environmental and social factors.
Considers the economic impact of the plan (e.g. average LOS, nurse is aware of InterQual criteria for initial and continued stays, financial burden to the consumer, etc.)	
Assist patient in securing treatment or services in the least restrictive environment.	TJC requirements on communication to the next level of care (step-down, IOP, residential, etc.).
Includes an implementation pathway or timeline in the plan and provide for continuity in the plan.	Reasons for deferring a goal are documented. The activities detailed in the plan of care, treatment or services are designed to occur in a time frame that meets the physical health care needs of the individual served.
Utilizes the plan to provide direction to other members of the healthcare team.	The organization has a process to receive or share relevant information on the individual served to facilitate coordination and continuity when individuals are referred to other care, treatment or service providers.
Documents the plan using standardized language or recognized terminology.	Goals are expressed in a manner that captures the individual's words or ideas.
Utilizes current available research in planning care.	
The P-MHN modifies the plan based on ongoing assessment of the patient's response and other outcome indicators.	The P-MHN re-evaluates, and when necessary revises the goals and objectives in response to his or her care, treatment or services. If no changes occur, the goals and objectives are reevaluated at a specified time interval.

Appendix J – NURSING INTERVENTIONS IN THE ACUTE SETTING

The following list is not all inclusive, but offers suggestions on interventions and healthy lifestyle options for the Veteran struggling with mental health issues.

Relaxation – intentional deep relaxation includes various psychological changes including a decrease in heart rate, respiration rate, blood pressure, skeletal muscle tension, metabolic rate and oxygen consumption. Daily deep relaxation practice for 20-30 minutes can produce a general level of relaxation. Deep relaxation reduces general anxiety and the frequency and severity of panic attacks. It also prevents stress from accumulating over time. Deep relaxation can increase energy levels and productivity, improve concentration and memory, and reduce insomnia and fatigue. Relaxation can be 'practiced' through abdominal or diaphragmatic breathing, progressive muscle relaxation, passive muscle relaxation, guided imagery or visualization of a peaceful scene, meditation, biofeedback, sensory deprivation, yoga, and/or listening to calming music (Bourne, 2010, p.82).

Exercise - reduces skeletal muscle tension, increases or enhances metabolism, and allows discharge of pent-up frustration. It releases endorphins, improves oxygenation of the blood and brain, improves circulation, digestion and elimination while decreasing cholesterol levels and blood pressure. Exercise can reduce depression and insomnia and improve response to anxiety.

Breathing skills – breathing exercises can reduce heart rate and blood pressure. As with any other skill, it must be practiced to be most effective. Deep breathing reduces tension, anxiety and irritability.

Meditation/Mindfulness - teaches one to step back and witness automatic thoughts and reactive patterns without judgment allowing a state of freedom from the suffering created in one's own mind. There is no right or wrong way to be mindful, it is about consciously observing yourself in the moment without believing, or disbelieving, one's own evaluation of experience or feelings (Hayes, 2005, p.107).

Lifestyle changes – creating intentional 'downtime', altering attitudes about perfection or control, staying active with a routine during waking hours, avoiding alcohol/sedatives, quitting smoking, using relaxation techniques, practicing good sleep hygiene, and eating healthy.

Sleep Hygiene – poor sleep habits can exacerbate anxiety symptoms. Good sleep hygiene improves the body's response to anxiety. It is helpful to exercise at least 20 minutes during the day, set a sleep schedule with sleep and wake times the same every day, wind down the last hour or so of the day (no activities that are strenuous or activating), develop a sleep ritual, reduce noise at night, and block out excess light. Sleep hygiene is also what NOT to do. Do not try to force sleep, if you can't sleep after 20 minutes, get up and do a relaxing activity and then return to bed when sleepy. Do not eat a heavy meal, drink a lot of alcohol, consume too much caffeine, or smoke cigarettes before going to bed. Try not to nap during the day as this may

interfere with the established sleep schedule. Accept that some nights it may just be more difficult to sleep.

Nutrition – What a person ingests impacts biochemistry, physiology and moods.

> **Caffeine** is a stimulant and can aggravate anxiety and even trigger panic attacks. It makes insomnia worse and can exacerbate poor sleep habits. It can be helpful to eliminate caffeine from the diet completely, but even reducing it, or limiting consumption to the early day (no caffeine after 2pm) can be worthwhile in improving sleep habits and reducing anxiety symptoms.
> **Nicotine** is a stimulant that causes increased physiological arousal, vasoconstriction, and makes the heart work harder. People who use tobacco or nicotine often feel that having a cigarette tends to calm their nerves, and while it does so in the immediate term, in the long term the physical outcomes of nicotine actually promote anxiety. Quitting or reducing tobacco and nicotine use, can have a positive effect on anxiety or panic.

> Various foods can also cause anxiety-like symptoms; some people are more sensitive to having physical reactions to various foods such as; added dyes or hormones in food, refined sugar, synthetic sweeteners or processed food. A person can keep a journal of what they are eating and their moods to evaluate if their diet is contributing to their moods and symptoms. Paying attention to correlations between diet and mood can be helpful in identifying triggers to feelings or physical responses.

Medication teaching is important, but often becomes complex when a Veteran is suspicious or mistrustful. It is important to assess the Veteran's ongoing cognitive functioning, literacy and ability to learn and retain information when approaching any teaching. It may be helpful to state the specific symptom that the medication will target ("This medication, Zyprexa, will help with your thinking"). It may be less beneficial to discuss every potential side effect or negative outcome associated with each medication, as that may increase the Veteran's anxiety. Explore with the Veteran the potential barriers to medication adherence such as cost, difficulty swallowing, difficulty remembering to take medications, challenges in getting refills, unwanted side effects, etc.

Medication teaching in the inpatient setting can be challenging for the P-MHN and the Veteran patient. Nonadherence to psychiatric medications is frequently a contributing factor to inpatient admission. The P-MHN works towards a collaborative partnership with the Veteran regarding medication administration and planning with a goal of ongoing maintenance in the outpatient setting. Medication compliance is a term frequently used within medical and mental healthcare, but is not preferred by the P-MHN due to its association with coercion. Regardless of voluntary or involuntary care status, the hope is to form a partnership with the Veteran in a recovery oriented approach to wellness, including medication adherence.

Nursing assessment is central in establishing readiness to learn. Factors such as cognitive capability, symptom relief, literacy, preferred method of learning, and presence of

environmental stimuli can impact the Veteran's ability to learn and retain information on the inpatient unit. Psychiatric medication can reduce symptoms, relieve distress and improve ability to engage in other recovery oriented services. Remission of symptoms is not the only path for recovery, there are many other evidence based practices, interventions, and care options that help facilitate recovery. Veteran autonomy and independence is supported as the Veteran determines his/her own recovery; this may include declining medications. The interdisciplinary team reviews potential barriers to medication adherence throughout the inpatient admission. Assessment is the foundation for developing an interdisciplinary plan of care. The importance of a therapeutic alliance and ability to engage in non-judgmental discussion with the Veteran about his/her experience with psychiatric medications including actual or potential barriers can open up a more meaningful dialogue of understanding and respect between the team and the Veteran.

Barriers to full medication adherence may include but are not limited to:

Personal beliefs	*Medication is harmful, ineffective, not needed, not necessary for recovery, not natural * Fear of dependence or addiction * Cultural or spiritual practices * Previous negative or traumatic experiences * Preference of illness symptoms (i.e. mania, feeling exuberance, perceived power, etc.) *
Relationships	*Distrust of providers * Perception of intrusion and inconvenience with frequency of medication follow-up appointments * Inability to reliably communicate with prescriber * Reliance on family or other services for medication monitoring * Family or significant others not supportive of medications as an intervention * Intimidation and/or stigma *
Perception of medication side effects	*Interference with daily functioning (i.e. work, school, socialization, driving, child care, nutrition, sex, etc.) * Amount of actual or potential side effects with psychiatric and/or other medications * Discomfort * Embarrassment *
Clinical Issues	*Ability to swallow * Cognitive impairment * Active substance use * Polypharmacy * Visual deficits * Dexterity *
Practical Matters	*Cost * Transportation * Process of obtaining refills * Ability to open bottles*

Appendix K - A REVIEW OF PSYCHOPHARMACOLOGY

Psychopharmacological responsive states include:

- Delusions
- Hallucinations
- Schizophrenia
- Psychosis
- Depression
- Acute Mania
- Acute Hypomania

DRUGS	DISORDER
Antipsychotics	- Schizophrenia Disorder - Schizoaffective Disorder - Bipolar Disorder, Manic Phase - Agitated Organic Disorders - Borderline Personality Disorder - Major Depression with Psychotic Features - Treatment – Resistant Major Depression
Antimanics	- Bipolar Disorder - Major Depression (Single Episode or Recurrent) - Schizoaffective Disorder - Impulse Disorders - Cyclothymic Disorder - Borderline Personality Disorder
Antidepressants	- Major Depressive Disorders - Agoraphobia with Panic - Panic - Social Phobias - Bipolar Disorders, Depressed (with Lithium) - Generalized Anxiety Disorder - Psychogenic Pan Disorder
Antianxiety or Anxiolytics	- Generalized Anxiety Disorder - Anxiety symptoms in other psychiatric disorders - Detoxification of Alcohol Dependence

Appendix L – GLOSSARY OF MENTAL HEALTH TERMS/PHRASES

Akathisia	Can manifest as a complete inability to sit still, with an undeniable urge to be moving constantly.
Aphasic	A loss or impairment (dysphasia) of symbolic function of speech related to the comprehension an expression of meaning by means of words.
Blunted affect	minimal emotional response
Catalepsy	An abnormal state characterized by a trancelike level of consciousness and postural rigidity. It occurs in hypnosis and certain organic and psychological disorders such as schizophrenia, epilepsy, and hysteria. cataleptic, adj.
Choreiform	Resembling rapid jerky movements of chorea (irregular, spasmodic, involuntary in limbs or facial muscles)
Circumstantial	A pattern of speech characterized by delay in getting to the point because of interpolation of unnecessary details and irrelevant remarks to avoid making a direct statements or answering the question.
Clang association	A mental connection of dissociated words made because of similarity in the sounds of the words used to describe the ideas
Cog wheeling	A condition of excessive tone of the skeletal muscles; increased resistance of muscle to passive stretching. Manifests as jerky movements of the muscles when engaged in passive stretching
Congruent	the individual's affect is consistent with the situation
Diplopia	Perception of 2 images of a single object; double vision
Disorganized	Lacking order or methodical arrangement or function
Driveling	Double talk; jargon where the utterance of vocal sounds is tightly linked and syntax preserved but meaning is lost
Dysarthric	Imperfection in the motor component of verbal expression (difficulty articulating words)
Dyskinesia	A movement disorder involving repetitive, involuntary, and purposeless body or facial movements. An individual may or may not be aware of these movements.
Dysphoric	An emotional state characterized by anxiety, depression, or unease
Dystonia	A muscle tension disorder involving very strong muscle contractions. The uncontrollable muscle contractions can cause unusual twisting of parts of the body, especially the neck. The condition can be extremely painful.
Euthymic	Pertaining to a normal mood in which the range of emotions is neither depressed nor highly elevated
Festinating (gait)	A gait where the patient involuntarily moves with short, accelerated steps
Flat affect	Immobile facial expression or a blank look
Gynecomastia	An abnormal growth of breast tissue and/or glandular material in a male
Hypnagogic hallucinations	Dream-like auditory or visual hallucinations that occur while falling asleep
Hypnopompic	A vivid, dreamlike hallucination occurring on awakening
Hypomanic	A psychological state similar to, but milder than mania, characterized by an

	elevated or agitated mood and commonly occurring in people with bipolar disorder
Impoverished	Lack of richness in content. Limited or depleted
Incongruent	The individual's affect is inconsistent with the situation or reported mood
Intense	The individual's affect increases the level of tension in the area regardless of the situation at hand
Labile	Characterized by rapid changes in emotion unrelated to external events or stimuli
Neologisms	The coining or use of new words
Oculogyric	Movement of the eyes (in crisis) a dystonic reaction characterized by a prolonged involuntary upward deviation of the eyes
Opisthotonos	A form of spasm where the head and heels are bent backward and body bowed forward in extreme hyperextension
Oral-buccal	Involuntary mouth and facial movements including tongue protrusion, grimacing, lip smacking, pursing or puckering, and other involuntary movements of the face, neck, or tongue muscles
Paraphasic	A defect where normal flow of words is interrupted by inappropriate words and phrases, characterized by inability to find coordinating words to express meaning.
Perseveration	Uncontrollable repetition of a word, phrase, or gesture despite absence or cessation of a stimulus (like a reoccurring song or thought in your head)
Pill rolling	A circular movement of the opposed tips of the thumb and the index finger
Poverty of Speech	Speech characterized by brief and/or empty replies to questions. It should not be confused with shyness or reluctance to talk.
Pressured	Excessive and rapid speech (also called logorrhea)
Restricted	Reduction in the intensity of affect, to a somewhat lesser degree than is characteristic of blunted affect
Retrocollis	A spasm where the head is drawn back
Stable	Patient has returned to baseline level of functioning, or crisis has resolved and patient is no longer experiencing symptoms they are unable to manage
Tangential	Superficial relevance only; digression from topic on a tangent
Thought broadcasting	Belief that others can hear or are aware of an individual's thoughts. Is a positive symptom of schizophrenia
Tongue protrusion	Inability to keep tongue in the mouth
Trismus	A persistent contraction of the masseter muscle with difficulty opening the mouth (lockjaw)
Waxy flexibility	A cataleptic state, frequently observed in catatonic schizophrenia, in which the limbs maintain the positions in which they are placed for an indefinite period. Also called flexibilitas cerea.
Word salad	Incoherent speech consisting of real and imaginary words which lack comprehensive meaning.

ADDITIONAL MISCELLANEOUS TERMS

Commitment status	The act or practice of a person being admitted to a psychiatric hospital, or other mental health facility either voluntarily or involuntarily. Voluntary hospitalization allows the person to freely choose to discharge from the facility by utilizing the proper process. Involuntary hospitalization results in a period of commitment established in compliance with state legal guidelines. Involuntary commitment may also be referred to as "detained", "on a hold", or state variations regarding verbiage of such.
EPS (Extrapyramidal symptoms)	A set of common side effects with antipsychotic medication use. EPS consists of dyskinesias (movement disorders) and/or dystonias (muscle tension disorders). There is a 50% chance EPS will diminish with stopping the causal medication.
Observation Status	Increased visual observation of a patient to promote safety and prevent harm. Can be initiated for a variety of risks; suicidality, aggressive behavior, risk for self-harm, high fall risk, confusion, inability to appropriately follow direction, use of high-risk medical equipment, etc. Observation status is defined at the facility level by policy or SOP. Usually consists of close observation or suicide monitoring with different frequencies of monitoring, i.e. 1:1 (arm's length, line of sight), 1:2 medical equipment observation, 15-minute checks, random checks, or hourly checks.
Sexually inappropriate	All individuals—regardless of age or medical condition—need love, touch, companionship, and intimacy. What is considered inappropriate can be determined by a number of factors such as age, culture, religious beliefs, etc. Common examples include lewd or suggestive language, implied sexual acts (e.g. requesting unnecessary genital care, viewing pornography in public, etc.), and overt sexual acts (e.g. touching, grabbing, or disrobing of self or others, public masturbation, etc.).

Resources

http://medical-dictionary.thefreedictionary.com
http://stanfordmedicine25.stanford.edu/the25/im.html
Varcarolis, E. (2014). Essentials of psychiatric mental health nursing: Revised reprint (2ND Ed.).
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