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Mental Health Liaison

The official journal of the Mental Health Consultation Liaison Nurses Association of NSW and ACT.

The Mental Health Liaison journal aims to promote original research and scholarly papers about the complex speciality of mental health liaison practice. Papers such as original research, literature reviews, case studies, opinion pieces, practice papers, conference reviews, letters to the editor and guest editorials are invited. Papers are welcome from mental health nurses, social workers, psychologists, psychiatrist and other allied health professionals who work in the field of mental health liaison. Authors can expect to have their work widely circulated and be made available to professionals internationally.

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Editorial

Mental Health Liaison Nursing-Background and Future

Scott Brunero– Editor

The role of the mental health liaison nurse is a significant and expanding speciality within general health services. Mental health nurses in non traditional mental health settings have typically provided direct patient care, education and research which aims to enable the nurse in the generalist setting to provide care for people with mental illness. The continued emergence of the role has lead to various models and approaches to mental health liaison nursing being developed.

The history of this sub speciality in mental health nursing dates back to the early 1960's in North America with the increasing influence of holistic and patient centred nursing care. Johnson (1963) was the first to describe the role positioning it in a consultation framework. Patient referrals included, regression, depression, delirium, and panic reactions. Johnson (1963) goes on to refer to the other key area of her work as staff support; whereby she notes anxiety, frustration and hostility towards patients as reasons for staff consultation.

The 1970's saw the role more heavily involved in the hospital hierarchy, accountability, function and supervision. The role then describes interventions with other patient groups such as cardiac and burns patients. The first masters programme for the speciality was established in the early 1970's in the US. Papers describe the indirect and direct models of liaison nursing which called for the assessment of the complexity of emotional problems with medical-surgical patients. Consultation with general nurses aimed to improve staff skill through teaching, observational assessment and intervention skills. Liaison nurses taught formally and informally and through direct role modelling of care. The nursing role differs from the traditional psychiatry diagnostic model in that it involves non pathological areas, such as staff support and organisational consultation.

Meredith and Weatherhead (1980) saw two key components of their role 1. Educational-skill input into ward situations, 2. Stress relief for nursing staff-using a crisis intervention model and problem solving.

The North American literature argues the use of system theory and understanding of group processes in assessing organisational issues (Robinson 1987). Lewis and Levy (1982) in Roberts (1997) describe a theoretical framework combining the consultation liaison model with the nurse, the patient, the illness and the health care system. The task of the nurse is in "diagnosing the total consultation" Lewis and Levy (1982, p18). Stickney and Hall (1981) suggest the mental health liaison nurse primarily takes referrals from staff, families and patents with the focus being emotional support. Stickney and Hall (1981) argue that the nurse may act independently consulting to other nurses, or nursing hierarchy, or as a member of the multidisciplinary team.

The range of therapies used by mental health liaison nurses is described as; cognitive behaviour therapies, general counselling techniques, family therapy and client-centred therapies (Tunmore 1989). The 1990's saw rapid growth in the role with Tunmore and Thomas (1992) arguing the case for the use of Caplans model (1970) of mental health consultation. Caplans model (1970) has four domains; Client centred case consultation, Consultee centred case consultation, Programme centred administrative consultation, Consultee-centred administrative consultation. Regal and Davies (1995) defined the role further as a combination of consultation, clinical supervision, staff support, clinical input and research, seeing a large involvement in clinical supervision and practice development.

Robinette (1996) describes the role as serving patients directly and indirectly and also reports the role of "Facilitating organizational change". Robinette (1996) goes on to point out that mental health liaison nurses are trained in systems theory and learn to assess peoples feelings, motivations and interactions with others, suggesting they are able to help resolve interpersonal difficulties and conflicts among staff. Robinette (1996) argues that by not being employed in particular areas they are able to facilitate change by not being directly affected by it.

Gillete (1996) evaluated the role of the mental health liaison nurse in the emergency department, demonstrating the impact by reducing the length of stay for

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mental health consumers. Sharrock and Happell (2000, 2001a,b 2002 a,b) lead the publications in Australia citing several papers on the role. They Identify three core components 1) Case consultation: assessment of the patients problems through indirect consultation with the referrer or direct consultation with the patient. The Consultee is provided with recommendations education and support. 2) Administrative consultation: this is where the hospital requests the skills of a consultant to assist and develop organisational issues. 3) Liaison: this part of the role has a strong focus on education of staff in the recognition, management and prevention of psychosocial problems with their patients. This part of the role also focuses on the mental health liaison nurse acting as a resource to the individual staff member, offering immediate support, counselling, debriefing or referral to other appropriate services. A further two examples of models of mental health liaison have emerged recently with Merrit & Procoter (2010), examining the mental health liaison nurse role and its links to the interpersonal relations theory of nurse theorist Hildegard Peplau, and Brunero & Lamont (2010) exploring the mental health liaison nurse using a 'capacity building' approach.

The emerging literature base for mental health liaison nursing has allowed us to expand our roles and degree of diversity. Mental health liaison nurses are employed within police services, ambulance services, general practice areas and court liaison roles. The parameters of the mental health liaison nurse will continue to grow, be challenged and be accepted or rejected by our peers. What will continue to define our role is our continued networking and our ability to gather evidence, evaluate and increase our awareness of our speciality roles through publishing.

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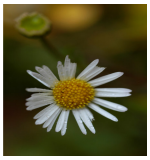
The sensual and the psychic



Key note address 2009 MHCLNA conference

Denis Casey

I wish to pay my respects to the traditional owners of this land and thank Bob Waterer and the Gurungie people for allowing me to be here today. I want to thank the executive of the MHCLNA for allowing me this opportunity to give the keynote address at this, the 9th annual conference of the MHCLNA, "Stones to Gems." When Melanie rang me to ask if I would give the keynote address, I was surprised, and this soon gave way to anxiety. I spent so much time displacing, that I found myself with an address which was sensual in the sense that I could feel the words walking around in the attic, but unable to be psychic enough to know in what order they would present themselves down the ladder. Not unlike I suppose, the way in which our patients might feel. In thinking where to start, I was reminded of the American tourist lost in the remote countryside of Ireland, whom after driving around for hours came upon an isolated farmlet and there spoke to the farmer.

He asked the Irishman;

"Can you tell me how to get from here to Dublin?"

The farmer replied;

"Well if I was going to Dublin I wouldn't start from here."

Stones to Gems made me think of the energy required for such a transformation. Coal requires temperatures of 2000 degrees centigrade and 50 times the earth's surface pressure to form even the smallest diamond. I think this is at times the amount of energy I expend in the mental equivalent of trying to understand the patient and myself in the hospital environment. What are our tools? How do we exert and release the pressure, raise and lower the temperature, to understand those who come unwillingly or unknowingly into our laboratory? I think our main tool is thinking because that is what is developed to be interposed between impulse and action. How do we, as William Osler said, "know the person with the disease, not the disease of the person."

Our relationship with the patient is both sensual and psychic. We are well placed to interpret if we must, but in doing so we have to have an understanding of the topography of the psyche. There is a history which we can draw on for inspiration and it is the works and thoughts of many of the early and more recent psychotherapists that I will touch briefly on today, if for no other reason than to pique your interest in something which has been the mainstay of psychiatry for many years.

Psychoanalysis was founded by Sigmund Freud. Along with Karl Marx and Charles Darwin, Freud is thought of as a prophet of the modern age. The western world culture is permeated by his thinking. His influence in forging the mentality of our age can be seen in psychology, sociology, anthropology, linguistics, philosophy, religious studies, economics, criminology, politics and art. I felt I wanted to understand not just Freud's work but also others whose insights are also valuable to our understanding of human affairs and the mind. Whilst Freud concentrated on the neuroses, other psychoanalysts devoted themselves to the psychotic nature of human affairs. Freud didn't think psychosis and narcissistic disorders could be treated with psychoanalysis but some of his followers thought differently.

Sigmund Freud concentrated on three areas; 1) The unconscious contents of the mind, desires and wishes which derive their energy from primary physical instincts, 2) An inquiry into the nature of dreams, and 3) The primary and secondary processes of thought between events in the conscious and the unconscious events of the mind. Later on, Freud gave us those words often used, the ID (instinctual trends), the ego (organized and realistic), and the super ego (critical and moralizing). Karl Abraham gave us insights into the developmental stages, such as the early and late oral phase and formulations on manic depressive psychosis. Sandor Ferenzi wrote on trauma theory and regression and there was Michael Balints' notion of the basic fault. He challenged

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Freud's ideas on transference and counter transference. Carl Jung theorized on archetypes and their relation to psychosis. Melanie Klein gave us perspectives on the paranoid schizoid position, on projective identification, the depressive position and on envy. Her object relations theory (the good and bad breast) is some of her most discussed theories. Stern wrote about the curiosity of subjective infant life and we now know from attachment and developmental research that early deprivation neglect and abuse or depression can have devastating affects on the personality and intelligence of babies. Wilfred Bion wrote of a new foundation for psycho analysis, emotional experiences and their links as the catalyst of emotions. He also wrote of the container and the contained, the psychotic part of the personality and transformations, memory, desire and 'O' (the God head).

Ronald Fairbairn, important but not well known, gave us his understanding of the importance of the relationship between the mother and the family in infant development. He formalised the existential perspective in psychoanalytic thinking. He believed in a unified ego and his insight into the difference between the psychoneurotic (who tends to treat situations in outer reality as if they were situations in inner reality) and the psychotic (who tends to treat situations in inner reality as if they were situations in outer reality).

Donald Winnicot describes the holding environment as; a psychical and physical place of safety that the child is not aware of, the subjective impotence of a symbiotic mother child relationship in which the baby is felt to be all powerful, and the objective reality in which the mother recedes and the baby becomes less omnipotent. Winnicott said "there is no such thing as a baby, just a nursing couple, the true self and the false self, ego and self as object".

Why should we concern ourselves about these concepts and formulations on the mind? We have numerous policies, procedures and guidelines and they are of benefit to a point but it is a failing to think these will somehow advance the understanding of the person before us. We must also navigate in an environment which provokes our own sensibilities; that is compassion, fatigue and institutional indifference mixed with lashings of emotional incontinence. It has helped me to sustain myself in patient care to have had regular supervision and also to be involved in the NSW Northern Rivers Institute of Psychoanalysis reading group. Having the opportunity to return to the teachings of Freud and others, in a deeper way than the quick skate over the ice of psychoanalytic thinking I had as a student. This has offered more insights to me than are found in the DSM for example. The DSM is very subjective and does not take into account the individuality of the person or the condition. It is a tool for diagnosing something into existence, a table if you like. The range of human personality is so broad, yet the DSM is relied on for the decision making between sane and insane. In the early 1900's, there were 22 mental disorders listed in the DSM. In the early 70's, the DSM was a thin booklet and homosexuality was a mental disorder. By the 80's, the manual was transformed, changing psychiatry, and homosexuality was no longer a medical condition, but many more diagnoses were added. By 1980 a total of 112 new mental disorders were approved. Many overlapped and chronic mental conditions such as schizophrenia were lost behind milder disorders or fears. The ability to see the normal from the pathological was becoming confusing. In 1994 Harpers magazine published a book review titled: The Encyclopedia of Insanity; A Psychiatric Handbook Lists Madness for Everyone. Today there are almost 400 disorders in the DSM. Not all of them listed as complete, as many are there by way of index and refer to research diagnosis as a part of ongoing field trials, and hence are found in the appendix of the DSM.

Currently the DSM V is being rewritten with some secrecy, which requires a signed confidentiality agreement of every committee member involved in the rewrite. Could we see working diagnoses such as post traumatic bitterness disorder or ugliness disorder? a hypothetical disorder that raises the question, are all extreme emotional reactions a disorder? Premenstrual Dysphoric Disorder (PMDD), whilst not included as an official diagnosis by the American Psychiatric Association, is listed under the depressive disorders cluster. Not so much a case of if you have a disorder, but rather how much of a particular disorder do you have? So it is at least confusing to me and I worry about the impact of the dribble down affect, that these criteria have on patient care and the way in which our clinical guidelines, departmental guidelines and the health industry that more closely determines our work, are written and revised.

So to that other part of our formulary of care, medication. We are relied on heavily to know about the use of antipsychotics, antidepressants, mood stabilizers, anxiolytics and sedatives. Patients and colleagues rely on us to give informed advice about the benefits and side effects of the psychopharmacological arsenal. In no small part, this reliance on medication has come about as a matter of political changes to the public health, mental health landscape and the ever present monkey on the back, finance. Psychotherapy, once a mainstay in public mental health and somewhat inexpensive, was thought of as too costly because of increased lengths of patient stays in hospital. Soon those hospitals would disappear and mental health care was expected to be provided in an environment hardly conducive to the same.

In a move to brevity and self reliance, and a push into community care, medication became the new mainstay. In the mid 90's, 240,000 SSRI scripts were written, and by 2007, it was five and a half million. We have MIMs packed with antidepressants, antipsychotics, mood stabilizers, anxiolytics, sedatives and hypnotics. They all have similar actions,

with minor variations on their applicability to specific illnesses and disorders. So I am drawn more and more to that part of my training that for a long time didn't really get much air; that is the exploration of the mental landscape. When I think about our role I have words in my mind:

"Timing, the importance of being earnest, compassion, memory, desire, transference, countertransference, projection, tension, anxiety, not knowing, wonder, insight".

I think Freud, Ferenzi, Abraham, Klein, Jung, Balint, Winnicott, Fairbairn, Bion and Symington to name a few of the analytic/therapeutic thinkers have all offered these words ideas and more. It is just that the words, our thoughts about the words, the meaning of those thoughts and the sensual feeling we arrive at as a consequence of being with our patients are not to be dismissed. The connection between you and the patient, the ability to psychically hold them, contain them and yourself in this psychic plane is to me a most important part of our role. It has become common to think and talk about the mind as being something or somewhere, like an organ in the body, yet no examination has pinned it down to any location. We refer to the mind as an entity:

"It crossed my mind"
"Are you out of your mind?"
"Be mindful"
"Mindfulness"
"It skipped my mind"
"Bear this in mind
"Can't get you out of my mind"

What happened to describing the patient as we see them or as they project; as bitter, fearful, shame racked, guilty, sad, melancholic, catastrophically grief ridden, ridiculously happy, sexy, lustful and psychotic with grief. Wilfred Bion said, "when we speak of a new reality, it is the emergence of truth." Not unlike Archimedes insight into the theory of displacement and volume when he ran down the street shouting "Eureka Eureka I've got it I've got it." This, from a man who had an insight because he sat in a bath and watched his body volume displace the water. Freud put forward the idea of free floating attention to dispose the mind to make that transition from sensual to mental. I find this quote from Wilfred Bion quite helpful: "To be attached to the sensual, prevents that transition from one to the other and therefore blocks understanding." It is this psychological state of attachment to the sensual which needs to be relinquished. In other words a positive act of refraining from memory and desire.

Buddhists refer to NIRODHA; cessation of thirst from transient things. Dukkha is the attachment to the transient aspects of this world that brings about suffering and Tanha, a thirst for the sensual things of life, including inner imaginative impressions, which have a much greater pull over the psyche. What about our moments of reverie in the thick of a busy emergency department? What chance of a deep real understanding, what clear insights are we having? I think we can have clear insight because we are subject to many distortions, real and theoretical. This means we must ignore coherence as it is clearly ignoring us and accept incoherence and incomprehension, enduring this until the new apprehension approaches. We must tolerate not knowing.

I sometimes have a sense of some tension between the patient and I, and I am sure you have felt it too. It is I think, an anxiety, and it is fundamentally important, your sense of it is just as important for you to analyse, as it is to analyse the patient. Why did you just have that thought? A 'foreign body' thought from somewhere then becomes personally significant. Why did you think about something at the moment you did? Was it what the patient said or didn't say, did or didn't do? It is an intuition or an insight and you have interpreted something. Like the symptoms that the patient presents with, often there is a meaning there that requires your interpretation between the sensual and the psychic. The patient who says to you "I have asthma and I think it's psychological," could just as well be trying not to say "I am unable to love."

The more obvious presentation of the patient who tells you they have been shot in the thigh and no nurse or doctor understands this ambulant loon, and no one has looked under the garment, only to have you, the interpreter see the essence of this psychic message and look under the clothes and see the sensual reality of a festering boil. Wilfred Bion said, "abstraction enables us to deal with things in general rather than deal with many concrete examples, thus enhancing the task of thinking." It is significant that the languages we use for psychic reality are words derived from a sensuous background and therefore not suited to the analytic part of our work; poetry and art would be better. I wonder what our colleagues would think of asking our patients to draw for us on our assessments and notes with colored crayons and what would they think if we described our patients through a poem.

True emotional understanding is at the core, the general sense, of all the theories and practical work in the relationships we have with our patients. The insight and growth is not just from an intellectual understanding. When the patient deals us transference, we may not like what we feel, and we may just have to feel it without shying away. We may not be the holder of the emotional truth and there is more often than not, the likelihood that we will learn this in the least private, soft or sedate way. It is at these times that supervision can provide valuable insights. I have been having clinical supervision for many years, both individually and as part of a larger group. By chance, I was to have supervision with a psycho-

analyst. I was afraid because I did not know what to expect and my neuroses swelled like bee stings. I was sure I would be exposed, my ego split and my super ego emasculated. I thought that this sort of supervision would be of little value to me in an emergency department or general ward setting. So there, how wrong I was. I can only report to you how helpful this has been in clinical practice. This 'extra vision' as we call it allows my colleagues and I to discuss our patients, ourselves and our relationship with them on a background of understanding the theoretical frameworks of and instruments to investigate the mind. When I am with a patient, whether it is in an acute setting or ward, I think of them differently; certainly not as a diagnostic criteria or as a problem to be medicated but as a person, who once was and is still able to be the baby, the child, the mother, the father.

I also want to encourage you to think about starting your own psychoanalytic study group. My group is designed as an introduction to psychoanalytic and psychotherapeutic ideas. It is aimed at clinicians interested in learning about and understanding psychoanalytic thoughts, ideas and concepts. No prior knowledge is required but those with an understanding of same are welcome to attend and re affirm their knowledge. It is a worthwhile experience and an opportunity to think about how you might apply psychoanalytic and psychotherapeutic theories in your practice.

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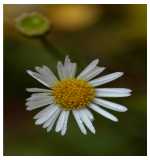
Protected engagement time (PET) in general hospitals and its influence on the nurse patient relationship



Scott Lamont

Abstract
Within surgical and medical areas of general hospitals, nursing time that is engaged with developing therapeutic relationships with patients is limited and often lost to the expense of time spent engaged in technical aspects of care. These two instrumental case studies involving patients with a cerebrovascular accident and removal of a cervical meningioma, explore the potential of 'protected engagement time' (PET) with patients presenting with complex needs in the general hospital setting. Using this framework, PET enabled nursing staff on two units to better identify and meet the psychological needs of these patients, and ultimately develop a stronger nurse patient relationship.

Key words: nursing, therapeutic relationship, empathy, engagement.

Introduction

Nursing is a unique and dynamic profession which involves fulfilling many different roles (McCarthy & Aquino-Russell 2009; Fallowfield et al 2001). Peplau (1997) reported some of these roles to involve being a stranger, teacher, leader, surrogate, counsellor and resource person. Nurses are in continuous and direct contact with patients, and as such, spend extended periods of time with patients (Sheldon & Ellington 2008; Hamilton & Martin 2007). This places them in a unique position to develop therapeutic relationships, via skilled and goal directed interventions. A therapeutic relationship is reported to be the central component of nursing care (Stein-Parbury 2005).

The therapeutic relationship within nursing has its origins in Peplau's (1952) interpersonal relations theory. Despite its underpinnings being based within psychiatric nursing, Peplau believed that her theory was applicable to all specialities within nursing (McNaughton 2005), and moved thinking away from a patriarchal model of nursing to one of collaboration and inclusiveness (Sheldon & Ellington 2008). Several other nursing theorists have ascribed to the centrality of the therapeutic relationship within nursing: Orlando's (1961) theory of the deliberative nursing process, Paterson & Zderad's (1976) humanistic nursing, Duldts (1985) humanising nursing communication theory, Orem's (1985) self care model, and Neuman's (1989) systems model. The therapeutic relationship may enable a greater understanding and engagement within care, whilst facilitating a more rapid transition to independence for patients (Marchese 2006). Engagement is seen as a critical part of the nurse patient relationship, with interpersonal skills such as active listening and empathy being reported as integral to the development of this relationship (Stein-Parbury 2005; McCabe 2004). The development of a trusting empathic relationship with patients has been demonstrated to lead to the following positive health outcomes: relief from pain, improved pulse and respiratory rates, and clients' self reporting of a reduction in worry and distress (Reynolds & Scott 2000). Nurses who displayed high levels of empathy to institutionalised elderly patients found that these patients experienced improvement of self concept, as understood by a reduction in dehumanisation and depersonalisation (Williams 1979). Reynolds and Scott (2000), report that the quality of patient self-disclosure was found to be associated with the level of empathy used by nurses. Sheldon & Ellington (2008), report that effective nurse patient communication improves patient outcomes, with respect to the reduction of anxiety, treatment adherence and satisfaction with care. Whilst there is a focus on mental health nursing within the literature, the need for building a therapeutic relationship with patients in generalist hospital

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settings is still relevant and contemporary. The competing dynamics of the busy nursing schedule within some clinical specialities, communication skill level, ward culture and milieu can negatively impact on the development of therapeutic relationships (Gordon et al 2008). This may result in nurses spending less time actively listening, engaging and building a rapport with patients, and more time with the technical and documentation aspects of care.

McCabe (2004), in a study of patient experiences within the generalist setting, reports that nurses were primarily task orientated and lacked a patient-centred approach. A study by Chant et al (2002) highlighted a perception amongst student nurses of the need to look busy and that talking was not perceived as part of routine work. Mackintosh (2000) supports this by arguing that communication skills have been neglected within the generalist setting as a result of the tension between the technical and caring aspects of contemporary nursing practice. Mackintosh (2000) describes the resulting attrition of patient -centred care, where the belief develops that talking to patients is not perceived as an essential of care and that real work involves only the 'technical and medical aspects of care.'

The concept of 'protected time' with patients was developed in the United Kingdom and is reported within mental health practice (Lamont & Stein-Parbury 2008; Oxfordshire and Buckinghamshire Mental Health Service 2009; Norfolk and Waveney Mental Health 2009; Mersey Care NHS Trust 2007; Kent 2005). The term is used to describe designated periods where units or wards may be closed to visitors and non-therapeutic activities, allowing for the therapeutic and purposeful engagement with patients. Protected Engagement Time (PET) is described within this paper as time which engages a patient for the purpose of strengthening the nurse patient relationship, where the protected time is valued and respected. Its use in the following case studies will highlight some potential benefits of applying PET within a general clinical setting.

Method

The following two case studies occurred at a 500 bed General Hospital within the metropolitan suburbs of Sydney. Both patients were referred to the Mental Health Liaison Nursing Team (MHLN). These particular case studies are instrumental case studies which are used to enable a greater understanding of an issue, where the case is of secondary interest to the situation being described (Stake 1995). Such cases can be looked at in detail and depth, whist allowing a researcher to pursue the external interest, which in these cases is the PET (Baxter & Jack 2008). Informed consent to present the information contained within these cases was obtained from both patients and the cases have been de-identified, with pseudonyms used to protect anonymity.

Case 1 *Clinical background*

Terry is 61 years of age and was admitted following a cerebrovascular accident (CVA). He had been unemployed during the previous 4 years and had a history of hypertension and alcohol abuse. He was experiencing a left sided hemiplegia and his speech was severely impaired due to dysphasia. To aid communication, the use of a 'communication board' was suggested. The board contained 3 components: one with pictures and descriptive words of basic activities of daily living such as toileting and showering, one with pictures and words of behaviours such as eating and drinking, and one with pictures and words of emotions. The primary nursing problem was his food intake. Since admission he had little to no food, often eating a spoonful of food or a half slice of bread per day. His wife reported that this was inconsistent with his pre-morbid eating habits. The primary reason hypothesised by the treating team for his poor eating was the possibility of an underlying depressive illness, secondary to the CVA, as there was no dysphagia present. When approached with food, he would respond by waving nursing staff away. No objective signs or symptoms of depression were elicited during routine observations or interventions. Nursing staff did report the presence of irritability and described difficulty engaging him during aspects of routine care. This inability to form an alliance with patients has been reported within the nursing literature as frustrating for nursing staff (Gallop et al 1993).

Mental health liaison nursing referral

The mental health liaison nursing staff were requested to provide input on day 6 of his admission, due to the perceived difficulty in engaging him. On introduction, the MHLN spent time introducing themself and asking if he was familiar with the communication board as a tool for expressing his needs. The interaction lacked specific structure and was geared simply towards spending time with the patient in an empathic manner (Reynolds et al 1999). This interaction highlighted, through the use of questioning and the communication board, that the patient was angry in relation to his stroke and hospitalisation. At this time, the MHLN validated this anger and informed him that it was important for nursing staff to understand what he was experiencing, in order to meet his physical and psychological needs. In discussion with the ward nursing staff, the MHLN discovered that the picture board was underused with little attention to the psychological component of the board. The MHLN advised that nursing staff set aside PET throughout each shift to attempt to purposefully engage Terry and build rapport, beyond the technical aspects of care. The MHLN advised that specific attention be given to the emotional component of the communication board, providing basic emotional component of the communication board, providing basic emotional support at this time. The allocated

nurse would spend three periods of 10 minutes each shift with him and was advised to use the communication board within each session in an attempt to explore needs and engage purposefully.

Clinical progress

During the subsequent week, PET was used to engage Terry and develop rapport. The MHLN remained involved in a consultative manner during this period. The referral for an underlying depression appeared to be a 'red herring' in this case. Barker (2003) argues that the resolution of a person's problems begin with the process of identifying and understanding what those problems are as opposed to attaching classifications to them. Research within the stroke setting has shown that nurses, with their primary focus being physical care, are likely to communicate and engage superficially with patients during routine care, whilst neglecting the psychological or social needs of patients (Gordon et al 2008). Nursing staff managed to elicit through the use of the communication board that he was homesick and wanted to go for a beer. He consistently pointed towards the angry face on the board throughout subsequent sessions. This presence of anger in post stroke patients has been reported in the literature (Kim et al 2002). Tan Jia Xing (2009) suggests that patients who display anger may be hiding feelings of frustration, and only through meaningful interaction, will such frustrations become explicit.

Through subsequent engagement, nursing staff elicited that he felt a loss of pride and control over his life. Nursing staff began to recognise and report a reduction in his irritability towards staff and believed this to be related to the PET. During this second week, his dietary intake gradually improved and through the use of the communication board, nursing staff were able to elicit that his anger was the reason for his reluctance in eating. It was hypothesised this may have been one of the only things in his life that he exercised some control over during this period. Due to the emergence of a therapeutic relationship and subsequent improvement in the patient's engagement with treatment, the MHLN disengaged at this time, however remained available upon request. The PET enabled protected time beyond routine tasks, to engage in meaningful patient-centred interaction, which is often compromised following a stroke (Gordon et al 2008). Gordon et al (2008) argue that the development of a therapeutic relationship is essential within stroke rehabilitation nursing. This facilitates the provision of information and psychological support in enabling patients to adjust and come to terms with the stroke. Gordon et al (2008) suggest that increased time resources are necessary to facilitate a therapeutic relationship, when communication problems exist. In this case, the PET was perceived to be the medium which allowed for accurate assessment and formulation of the underlying reasons for the poor dietary intake..

Case 2 ***Clinical background***

Sally is a 74 year old lady admitted for removal of a benign cervical meningioma. Sally has a longstanding history of anxiety and depression with 'prominent cluster B traits.' She has had 33 presentations to the local Emergency Department in the preceding 4 years for 'suicidal ideation' secondary to anxiety and depression. Sally describes chronic pain in her left hand following a fall 2 years previously, for which she regularly attended a pain clinic. Staff reported Sally as 'catastrophising' and being overly 'reliant and dependent.' This behaviour reportedly manifested via frequent shouting for nursing staff, ringing of the call bell and requests for analgesia. Nursing staff also reported Sally as being 'tearful, irritable and hostile,' as a result of what she described as being in severe pain and not being taken seriously by nursing and medical staff. Sally had also made several verbal complaints regarding members of nursing staff. These behaviours were consistent with previous admissions to the aged care psychiatry unit, where Sally had spent some time following 'crisis' presentations to the Emergency Department. She was being cared for within in a 4 bed dormitory and fellow patients had made complaints regarding her behaviour.

Mental health liaison nursing referral

The MHLN was requested to provide input by the Consultation Liaison Psychiatrist on day 3 post operatively, due to the difficult behaviours that nursing staff were experiencing. Sally was compliant with her prescribed antidepressant and it was considered that there were no outstanding or acute mental health issues. The MHLN had a brief introduction and discussion with Sally, where she made reference to not knowing what was happening or what staff expected her to do when in so much pain. Sally also stated that members of staff avoided her and ignored her. The MHLN initially met with the Nurse Unit Manager (NUM) and Clinical Nurse Consultant of the unit, and then the clinical nurses, to discuss management issues and proposed management avenues. The MHLN subsequently developed a management plan which incorporated PET, in an attempt to address the following issues:

1) Poor understanding of what is happening to or what is expected from Sally:

A process was discussed where the allocated nurse would spend a few moments at the beginning of each shift and introduce themself. The nurse would then inform Sally that they would spend two dedicated periods of 10-15 minutes with her during the shift to explore her concerns, frustrations and any other issues. The nurse was to let Sally know as near to possible when this would be and organise their workload to accommodate this. It was advised that this structure would be helpful in freeing up time as opposed

to consuming it. Sally was asked to write down her frustrations and concerns on paper in between PET sessions, as this would inform the therapeutic engagement time. The nurse was advised to inform Sally of all appointments, routine and structure of the day (e.g. medical reviews, physio and mental health consultations) and provide this in written form. If there were any changes or delays to routine or appointments, Sally was to be informed and kept abreast of any issues relating to them. It was perceived that transparency was central here, as a lack of transparency may lead to maladaptive behaviours.

2) Irritability / Hostility:

The nurse was asked to assess for any potential underlying issues such as pain, insomnia, anxiety or poor coping skills. The subsequent offering of reassurance and the provision of any appropriate pharmacological interventions would hopefully minimise these behaviours. Staff also sought advice on how to respond to overt hostility. It was advised to explain in a measured and non-confrontational manner that certain ways of communicating were not helpful to purposeful interaction and that staff would resume communication when appropriate communication was achieved. It was also advised that this may need to be reinforced several times. Staff were advised not to personalise any hostility and to validate, where appropriate, any frustration, as some frustration is reasonable given the circumstances of hospitalisation and illness. They were also advised to look beyond the behaviour towards the need which was being communicated. A discussion took place whereby the inclusion of humour and discussion of personal interests may be helpful in redirecting hostility back to appropriate communication.

Clinical progress

PET was used in an attempt to adequately assess and meet the needs of Sally, which was hoped would lead to a greater level of therapeutic interaction and appropriate engagement. The MHLN remained involved in a consultative manner during this period. On day 3 of the plan, the NUM reported that staff were frustrated as they had initially experienced an increase in the 'difficult behaviours.' The MHLN reported that such behaviours can increase on occasions before improvements are made and that it's acceptable for staff to get frustrated when dealing with difficult behaviour, if such frustration has an appropriate forum for discussion. The NUM reported that there was a perception that the management plan was not working and as such had subsided. The MHLN convened a meeting with the nursing staff upon request from the NUM, as some nursing staff were reluctant to Sally being allocated to them. The ensuing meeting highlighted that the management plan had not been conveyed to all members of nursing staff, nor was it readily visible or available to staff. As a result, there was a lack of consistency in facilitating the management plan, leading to what could be described as 'splitting behaviours.' The MHLN advised regarding the importance of consistency and that too many staff changes with their own differing management styles can be confusing and compromising to a structured plan. The nursing staff were also asked to consider careful staff allocation, as some members of staff are able to cope better with difficult behaviours than others. It is argued that successful nurse patient relationships require staff to be unbiased, in order to best meet the individual needs of patients (Marchese 2006). Therapeutic engagement is argued to be heavily influenced by not only the availability of staff, but also the responsiveness of such staff in situations of need. The nursing staff were asked to implement the PET plan again, ensuring that each handover of care and shift change was aware of the plan, to be consistent in its application and to provide continuity with minimal staff changes. Some members of nursing staff expressed frustration and asserted that there was no time in their day to provide 'one to one nursing.' Fallowfield et al (2001) report that one of the characteristics which nurses find difficult to manage is that of overly demanding patients, when nursing staff perceive that no 'real problem' exists. It was also advised to consider the needs of the other patients within the workload of the allocated nurse, in order to support them being consistent with the PET. Time management is reported within the literature as an important issue for nurses in creating equilibrium between the specific needs of individual patients and the general needs of others (Hobbs 2009). It is argued that although clinicians may regret the inability to establish more effective relationships with patients, they may also be concerned that recommendations which aim to counteract this, require the expenditure of time (Kornfeld et al 2009).

Over the next 7 days, nursing staff reported some reduction in what they deemed difficult behaviours. Haley (2007), reports that it is common for patients to have difficulty in understanding their medical condition and the management of this, particularly during hospitalisation. The PET was used to engage Sally in her own care, whilst providing education and support with respect to her recovery. Specific allocated staff members reported that they were beginning to develop some rapport with Sally, which led to a greater degree of therapeutic engagement. Nursing staff reported that although they were not able to resolve many of Sally's issues, these issues had less intensity and emotional distress attached to them. There are reports in the literature of patient concerns, which are neither explored or acknowledged by nursing staff, and that nurses, due to discomfort, may in fact use avoidant strategies when faced with cues that express emotions or distress (Sheldon & Ellington 2008). Poor communication has been argued to be the primary reason for complaints against physicians (Shapiro et al 2009), and is

likely to contribute highly within the nursing profession.

The continuity of allocated nursing staff minimised inconsistent approaches and complaints towards various members of staff. Nursing staff reported that they found the PET somewhat draining and overwhelming at first, especially when the acuity of their other patient load was high. They also reported, that a greater amount of their time was previously being consumed by Sally in running backwards and forwards, and getting little else done. Kornfeld et al (2009) support the assertion that when effectively applied, processes which proactively engage patients can avert more time consuming problems. Kornfeld et al (2009) argue that serious illness/hospitalisation may effect regressive behaviours and create dependency upon clinicians. Any resulting sense of powerlessness can produce unconscious and inexplicable behaviours by patients. It is this awareness that is reported to allow clinicians the opportunity to look at avenues of restoring a sense of control for patients (Kornfeld et al 2009). In this case, the PET was used to provide a structured forum to discuss concerns and attempt to meet the needs of Sally. The provision of emotional and psychological support within this framework, appeared to instil a sense of worth, with a subsequent reduction in irritability, hostility, pain and complaints.

Implications for Nursing Practice

Developing and sustaining the capacity of general hospital staff to develop therapeutic relationships in contemporary health care is a challenge (Tan Jia Xing 2009). Although nurses can not ignore the technical components of work, it is argued that efficiency and time management can allow for greater periods of therapeutic engagement (Tan Jia Xing 2009). There is a need for generalist nursing staff to increase the value they place on the therapeutic relationship alongside technical skills or routine aspects of clinical care; however, this can arguably only be achieved via supportive work environments (Kennedy & Ellington 2008).

Contemporary nursing involves an ever widening range of activities and responsibilities (Hamilton & Martin 2007). Despite the perception that spending time with patients is part of the job (Soong & Soobratty 2007), this time must have structure, purpose and meaning to maximise therapeutic interaction (Hamilton & Martin 2007). Patients require the presence of empathic and responsive nurses to express intense emotions during periods of care and to receive commensurate emotional support (Hamilton & Martin 2007).

Nursing staff have a role in providing enabling environments for such interactions to take place (Gordon et al 2008), but what skills do nurses have in enabling these therapeutic interactions? Communication is reported to be a core nursing skill, but one in which nurses have arguably received inadequate training (Fallowfield et al 2001). The literature supports this with studies highlighting a shortage of communication skills training, in particular, where intense or confronting emotions are displayed by patients (Haley 2007). Specific communication skills are required when anger or sadness is present (Sheldon & Ellington 2008). Processes which aim to capture patients' unique perspectives of illness and care are warranted, to develop a greater understanding of needs (Davidson et al 2004). Ultimately, nursing specialities must identify specific outcomes that are directly influenced by therapeutic interaction (Kennedy & Ellington 2008).

Conclusion

This paper illustrates the use of Protected Engagement Time within a general hospital setting. The use of PET with these patients allowed nursing staff to develop a rapport and subsequent relationship, and ultimately facilitate a problem solving approach (Soong and Soobratty 2007). The care that PET afforded within this paper is underpinned by a 'Capacity Building Approach' (Brunero & Lamont 2010). This approach allows the MHLN to engage in supporting generalist nursing staff to meet the specific psychological needs of the patients, where the MHLN is a 'consultant' as opposed to the primary person providing an intervention (Brunero & Lamont 2010).

This approach is arguably necessary, given the scarcity of MHLN roles and the prevalence of psychological care needs within generalist settings. Within the busy environments of medical and surgical units, the time available to nursing staff for developing therapeutic relationships with patients is consistently challenged. A proactive model of nursing care which incorporates PET, will arguably free up some time when presented with challenging behaviours. Folkman & Greer (2000) report on the importance of maintaining psychological wellbeing during serious illness. Mental health liaison nursing has an important consultative role in supporting nursing teams to achieve this in general hospitals.

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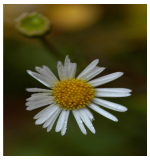

Targeted violence in schools

Darrin Cowan, David Donohue, Joel Murchie

Abstract
There are a number of individuals identified by police, who are at potentially high risk for committing serious crimes such as homicide or multiple homicides. Many of these individuals are known to police, mental health services and/or other services. This paper reviews the literature on potential preventive models for violence in schools. The targeted violence initiative focuses on offenders who engage in stalking behaviour prior to serious assault or murder, and perpetrators of mass homicide. These initiatives propose to gather information on individuals across agencies and apply a proven threat assessment process in order to identify an individual at risk of committing these offences. Mental health liaison nurses who liaise closely with police services, youth health, educational and other services maybe in a position to aid in the assessment and identification of this population.

Key Words: Violence, crime, schools, mental disorder

Introduction

There are a number of individuals identified by police, who are at potentially high risk for committing serious crimes such as homicide or multiple homicides. The literature refers to these people as perpetrators of 'targeted violence'. According to Reddy et al (2001), the defining element of targeted violence is that the perpetrator selects a target prior to the violent incident. Research also indicates that many of these individuals are known to both police, mental health services and/or other services before they commit a serious crime. In addition, the offenders have often given clear indication, either in the form of direct threats, or through the expression of other risk factors that the event is imminent. In Australia between 1 July 1989 and 30 June 1999, there were 13 mass murder incidents (where the number of victims was 4 or more) that resulted in the death of 94 persons (Mouzos 2000). The data in this period is skewed by the presence of two infamous incidents with 42 of the deaths being accounted for by two individuals. Martin Bryant who killed 35 people at Port Arthur in 1996 and Wade Frankum who killed 8 including himself at Strathfield in 1991. In the 2005-2006 period there were no incidents where 3 or more victims were killed in NSW (Davies & Mouzos 2007). Given the available data, and allowing for a very low base rate, on average Australia records approximately 1 mass murder incident per year. School violence in Australia has an even lower base rate. Only one targeted shooting has occurred in an Australian educational institution. On October 21 1992, Huan Yun Xiang shot dead two classmates at Monash University in Melbourne. This contrasts markedly with data from the United States (US) where there were 233 school homicides between 1992 and 1998 (Mohandie 2002).

From the information provided so far, it may seem that the issue of targeted violence in schools is an American problem which has no relevance to Australia. It is important to note some salient points here. Firstly it would be incorrect to assume that the US is the only place that experiences targeted violence in its schools. The US for a variety of reasons has a relatively high rate of such incidents. One of the likely reasons, and one which is discussed in both media and research literature is access to guns. One should however be cautious about assuming that limited access to guns will necessarily mean that there is a limited threat. A significant number of school killings around the world have been perpetrated without

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the aid of a gun. Of the 13 mass murder incidents in Australia between 1989 and 1999, approximately half did not include a firearm (Mouzos 2000).

Aim and Method

The aim of this paper is to review the literature on this group of individuals and discuss potential interventions to prevent violence. A search of the literature using, PsychInfo, Medline, CINNAHL, Australian Federal police database, Australian institute of criminology database and Google scholar was conducted using the following search terms; violence, risk assessment/management, threat, forensic mental health and threat assessment. As will be outlined, these individuals share common features with other mass killers around the world. They have characteristics and behaviours that in many cases serve to alert authorities to their plans. There is an absence of strategies to formally identify and manage such people. The evidence suggests that there are individuals in our community who, given their personal makeup, mental state, access to means and the coalescing of other circumstances are capable of perpetrating a terrible tragedy.

Threat Assessment

Currently there appears to be no motivation in the community to engage in a process of pro-active risk assessments. In addition incidents of this nature have a very low frequency, but have extremely high impact in the community when they occur. They attract intense media and political attention. If we return briefly to the statistics it would appear that the United States has an extremely high rate of school homicides, 233 events between 1992 and 1998. These statistics however must be viewed in the broader context. Cornell (2006) notes that in the same time period, for the same age group there were 24,406 homicides outside of the school setting. In the 5 to 19 year old age group, school homicides accounted for 0.0008% of total deaths. This is significant because such low base rates have a major impact on the way in which the assessment of risk occurs. The literature refers to 2 basic approaches to risk assessment. These are generally known as clinical versus actuarial. (Borum 1996; Heilbrun 1997; Litwack et al 1993; Melton et al 1997; Monahan 1996; Webster 1997).

In the past 15 years, weight of support has leant towards actuarial methods of risk assessment. Borum (1996) concludes, "Fairly read, the existing literature on the comparison of these two methods, across a number of decisional tasks, suggests that statistical formulas consistently perform as well or better than clinical judgments" (pg 65). There is some evidence to suggest that actuarial methods are better for predicting violence over a longer period of time and that clinical assessment is equivalent for periods of one year or less (Mossman 1994). Borum (1996) goes on to say that; "Even if actuarial methods were consistently superior, these methods can only be applied when appropriate equations exist, have been adequately validated, and are applicable to the question and population at issue" (page 66). The model is more difficult to apply to assessments of targeted violence because the base rates are extremely low and the research base is so far lacking. Essentially this means that risk assessment models for general offenders are not appropriate for assessing the threat associated with targeted violence.

There is at this time no reliable tool or actuarial measure available to assess specific threats. This however doesn't mean it is impossible to assess threats and intervene when a threat is identified. The FBI, US Secret Service and Association of Threat Assessment Professionals (ATAP) all conclude that a threat assessment process based on structured professional judgment is an effective means of achieving this. Structured professional judgment is a collective term used to describe any risk assessment method where the assessor follows a format designed to elicit information that will enable him or her to make an informed decision regarding risk. Structured professional judgment (SPJ) is a model of decision-making that underlies many of the successful risk assessment measures (Douglas et al 2003). This is the approach taken to risk assessment of potentially violent forensic mental health patients in New South Wales. The process is thoroughly outlined by Allnutt and O'Driscoll (2008) for the New South Wales justice health service. The specifics of this approach differ somewhat from the threat assessment model outlined by the US Secret Service, the concept however is very similar. The differences relate to those factors and characteristics that are likely to determine the presence of a specific threat as opposed to those which are relevant for long-term prediction of violence.

Environmental Analysis

Borum et al (1999) argues that the field of risk assessment has made tremendous advances in the past 20 years, yet assessments of targeted violence continue to pose a significant challenge to law enforcement, mental health, and other professionals. These specific and critical assessments require an innovative approach. The threat assessment model, developed and refined by the U.S. Secret Service and (ATAP), provides a useful framework for conducting assessments and proposing management of individuals identified as having the potential for targeted violence.

The Los Angeles Police Department stakes its claim as the first to implement a dedicated threat assessment team. The Threat Management Unit as it is known was formed in 1991. This was in response to a number of high-profile stalking cases. However the process of threat assessment has been best articulated by the US Secret Service. For many decades the US Secret Service had used the process of threat assessment to address the risk posed to government officials and other VIPs by individuals known to

have made threats against them. In recent times the United Kingdom (UK) has developed the Fixated Threat Assessment Centre (FTAC). The unit was set up following a National Health Service research program based at Chase Farm Hospital in Enfield, north London. Researchers examined thousands of cases of prominent people being stalked. It liaised with the FBI, the US Secret Service, the Capitol Hill Police, which protects Congressmen and Senators, and the Swedish and Norwegian secret services.

The US response gained full momentum in 1999, when Dylan Klebold and Eric Harris killed 15 people at Columbine high school. Ensuing from this, the US Secret Service and the Department of Education initiated, in June 1999, a study of the thinking, planning and other pre-attack behaviors engaged in by attackers who carried out school shootings. The resulting findings and the ongoing refinement of the process defines current best practice in terms of threat assessment. Although the entire body of literature is small, the majority of what does exist refers to the US Secret Service framework as a foundation for all threat assessment applications. In summary the report made a number of key findings: Included in these were that perpetrators didn't suddenly act in totally unpredictable ways. They were planned attacks that in many cases had been pre-empted by clear warnings. These warnings were clear and unambiguous in some cases. In addition, prior to taking action most attackers engaged in some behavior that caused concern or indicated a need for help. Some were already engaged with mental health providers, or had a prior history of mental health problems.

In essence the threat assessment process evaluates the threat and the circumstances surrounding it, to determine any facts or evidence that indicate the threat is likely to be carried out. Assessment is not concerned solely with people who have made a threat, but more specifically with those who pose a threat. As stated by Cornell (2006) "anyone can make a threat, but relatively few will engage in the planning and preparation necessary to carry out the threat. Threat assessment attempts to identify persons who pose a threat, which means that they have the intent and means to carry out the threat. Moreover, the assessment does not conclude when a person is determined to pose a threat; rather, the assessment aims to determine how serious the threat is and what should be done to prevent its being carried out" (pg 75).

Threat assessment or profiling?

It is important to note that threat assessment is not profiling. There is no evidence to suggest that psychological profiling can prevent targeted violence. This view is supported by both the FBI's criminal profiling unit and the US Secret Service (O'Toole 2000; Fein et al 2002). The reason for this is that traditional profiling is a retrospective process. In contrast the sort of profiling necessary to prevent targeted violence would be prospective. With such a low base rate, checklists or profiles based on individuals known to have previously carried out a threat would lead to an unacceptable rate of 'false positive' identifications. That is a large number of people who fit the profile but do not pose a threat would be identified. This doesn't further our ability to identify and manage a serious threat.

In contrast to 'profiling', threat assessment "utilises available information about warning signs, risk factors, stabilising influences, and potential precipitating events to arrive at a categorical description of risk for a particular point in time. (Mohandie & Hatcher 1999). This may include but is not limited to individual characteristics and psychological traits. The process itself is base on a number of principles. The US Secret Service identifies six of these (see table 1).

The application of these principles has been addressed in a number of different ways. The ownership of threat assessments in the United States has essentially taken one of two forms: one is an enquiry undertaken by school authorities, the other is an investigation initiated by law enforcement. In either case, a thorough collation of relevant information is essential. A number of sources may be required to establish this information. Information from school records and interviews with individuals from the school such as teachers or other students may reveal important information and interviewing student's parents or guardians. Interviewing the student concerned may be required although may not be essential and in some cases may be counter-productive. The potential target may reveal information that informs the assessor of the motivation for the threat and possibly the veracity of the threat. Historical information will help to build a picture of previous criminal activity. Mental health records may provide vital information regarding the individual's mental state, current treatment or the need for treatment in the future. (Information about individual's mental state and mental health history is of particular importance.

The final report and findings of the safe school initiative found that approximately 78% of students involved in school killings had a history of depression, suicidal ideation and/or suicide attempts. Likewise a comparative analysis of mass murders in the US found that 63% of adolescent perpetrators were experiencing depressive symptoms at the time and 67% of adult perpetrators were psychotic or had symptoms suggestive of psychosis (Meloy et al 2004). The UK's FTAC has also found some striking patterns, of 24 recent incidents of targeted violence five involved deaths (two of them were mass murders), while another eight led to serious injuries. About half of the assailants were clearly psychotic; most of the rest were either drunk (four) or politically motivated. However, it was the mentally disordered who were responsible for most of the fatal incidents and serious injuries, and most had given warnings

Table 1. Threat assessment principles (US Secret service)	
1	Targeted violence is the end result of an understandable, and oftentimes discernible, process of thinking and behaviour.
2	Targeted violence stems from an interaction among the person, the situation, the setting, and the target.
3.	An investigative, sceptical, inquisitive mindset is critical to successful threat assessment.
4	Effective threat assessment is based on facts, rather than characteristics or traits: it is important that each threat assessment is an independent analysis of the facts and behaviours of the individual at specific time and in the specific setting the threat was made.
5	An 'integrated systems approach' should guide assessment investigations: this recognises the importance of interagency co-operation in the assessment and management of serious threats.
6	The central question of a threat assessment is whether a student poses a threat, not whether the student has made a threat: Individuals utter threats for many reasons, only some of which involve intention or capacity to commit a violent act. However, a person can present a grave threat without articulating it. The distinction between *making* and *posing* a threat is important: Some persons who make threats ultimately pose threats. Many persons who make threats do not pose threats. Some persons who pose threats never make threats. (Fein et al 1995)

Table 2. Clinical assessment features	
1	Nihilistic: Many perpetrators of mass killings had demonstrated or voiced a nihilistic view of the world. Nihilism essentially being the rejection of social norms, in particular conventions such as morality and human value. Dylan Klebold and Eric Harris saw life as fleeting, shallow and ultimately meaningless. (Block 2007).
2	Paranoia: Perpetrators tend to have a paranoid view of others or society as a whole. Paranoid ideation is less likely to be specifically focused as opposed to a view that large groups or society as a whole is against the individual. Sueng Hui Cho ultimately formed the belief that anyone in society who was better off than him, existed simply to taunt and undermine him.
3	A pathological interest in weapons and violence: Many mass killers have identified or were known to have an unusual interest in weapons and/or violence. Martin Bryant for example purchased and practised with a number of weapons including the military grade automatic rifles used in the Port Arthur massacre.

Table 3. Associated features	
1	Fantasies: The threat posed by mass killers is one that develops over time. It is not impulsive and is often fuelled by violent fantasies related to the event and aftermath.
2	Plans: Incidents of targeted violence have a common feature of being planned, often with meticulous attention to detail. The columbine shootings were planned over a period of at least 12 months (Block 2007). The more detailed and plausible the plan, the higher the risk is likely to be. The existence of such plans should be queried in any threat assessment investigation.
3	Warnings: The available case studies suggest that the majority of school shooters gave clear warnings of their intentions Fein et al (2002). These were communicated through a variety of means and to a variety of individuals other than any intended targets. These on numerous occasions were mental health professionals and school counsellors.
4	History of mental health problems: As has been outlined the vast majority of perpetrators of targeted violence had a diagnosis of mental illness or would have attracted such a diagnosis. Or, in the case of school age perpetrators, many had clear indicators of psychopathology.

which had gone unrecognized (Rose 2007).

Implications for clinical assessment

The need for threat assessment processes has become clear to law enforcement agencies around the world. What should also be clear from the preceding discussion is that potential perpetrators of targeted violence frequently come into contact with clinical services. Clinical assessment may provide early opportunities to intervene with at risk individuals. Clinicians however should remain mindful of the indicators of threat, their professional responsibilities and potential pitfalls in the assessment process. As has been outlined, reliance on traditional clinical assessment of risk for violence, or actuarial measures would be unreliable in this context. There are however a number of distinguishing features that a clinical assessment might reveal. Having reviewed the literature extensively this paper will propose three high level clinical features and a number of other features whose combined presence would cumulatively add load to the seriousness of the threat (see table 2). It is proposed here that these three factors, in the presence of a threat to kill others would be enough to raise serious concern. They are not causal in nature and they do not necessarily identify a high risk individual however they are factors which tend to occur in concert for perpetrators of targeted violence. These are the high level clinical features. There are also a number of associated features worthy of mention and that if identified in the presence of the high level risk factors, would contribute to a higher level of threat assessment (see Table 3 Associated features). These associated factors should be considered amongst others in the threat assessment process. They, in combination with the three high level risk factors would cause a clinician to have extreme concerns about the individual.

Implications for Mental Health Liaison Nursing

The above discussion highlights the need for mental health clinicians to have some understanding of threat assessment and threat versus risk. The prevalence of mental health issues, psychopathology such as paranoia and nihilism, and the likelihood of communication with mental health professionals sees those professionals as a likely initial contact and potentially a key referral source. Mental health liaison nurses will be in a position to potentially assess and liaise with police, school counsellors and other key stakeholders in the process of threat assessment.

The identification of potential at risk people by mental health liaison nurses may occur and the appropriate ongoing referral for the management of this risk will need to be formulated. Potential ethical issues of release of confidential information outside of the traditional health setting will require debate and resolution. Mental health liaison nurses will need to have greater roles within police services, and education departments to provide their expertise in the assessment and management of this potential risk.

Conclusion

The incidence of violence in schools has a long history. Australia has been relatively fortunate to have recorded a low rate of such incidents. There are however individuals in our society who have the potential to carry out serious acts of violence against others. The NSW Police Force; Targeted Violence Initiative seeks to use available models of threat assessment to identify high risk individuals and support Local Area Police Commands, schools and others to intervene where possible. This paper has specifically explored the threat assessment model and discussed the rational for its use. In addition, important clinical factors have been highlighted and their implications for clinical assessment discussed. This is significant because previous events suggest that mental health clinicians may well have contact with at risk individuals in the course of their clinical work.

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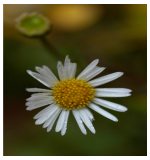
A literature review of the atypical antipsychotics in the management of delirium: implications for mental health liaison practice



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Abstract

Interventions for delirium have traditionally been separated into two distinct areas, non-pharmacological and pharmacological treatments. The aim of this study was to review recent research literature on the effectiveness of the atypical antipsychotics in the management of delirium. An electronic database search through Medline, CINAHL, PsychINFO and Google scholar was conducted using the key words; behaviour management, challenging behaviours, delirium, risperidone, olanzapine, quetiapine, aripiprazole, ziprasidone, atypical, and antipsychotics. Results from systematic reviews and meta-analyses of atypicals used in delirium management were also included. A total of 10 clinical trial papers and nine review papers were found that meet inclusion criteria for the study. There is enough evidence within the literature to support the use of the atypicals over the typicals, but discerning between the atypical antipsychotics is limited. Until prospective randomised control trials are completed with all the atypicals in the one study using standardised measures, clinicians will need to rely on expert level consensus evidence to inform their practice.

Key words: delirium, antipsychotics, confusional state, atypicals

Background

Acute confusional state or delirium is associated with cognitive impairment, suicidal behaviour, other challenging behaviours, and is of significant concern to the nursing profession (Takahashi et al., 1995). The impact of delirium on patients and their nursing care is well documented (Foreman, 1999; Breitbart 2002). Foreman (1999) reports that delirious patients experience more falls, adverse reactions to medications and pressure ulcers, whilst requiring greater nursing surveillance and a longer than normal length of stay. Breitbart (2002), in a study of caregivers and nurses (using the delirium experience questionnaire), found that 76% of caregivers and 73% of nursing staff reported severe distress associated with caring for patients with delirium.

Delirium's prevalence in the general hospital is reported to range from 10% (Lonergan et al 2007) to 30% (Harding 2004) of an inpatient hospital population. In the elderly patient group, delirium is reported to be as high as 15% for patients on admission, with 10%-40% being diagnosed during a hospital admission (Hanley 2004). Delirium is described as an organic psychiatric syndrome of acute onset, which results in fluctuating levels of consciousness and compromised cognitive functioning (Neil, 2003). The aetiology of delirium is multi-factorial, and given the multisystem complexities of the disorder, management and treatments remain symptomatic in nature. The following are suggested by the American Psychiatric Association (1999) as some of the systems involved in its cause: *1) The central nervous system*: head trauma, seizures, postictal states, vascular disease and degenerative disease; 2) *Metabolic disorder*: renal failure, hepatic failure, anaemia, hypoxia, hypoglycaemia, thiamine deficiency, endocrinopathy, fluid or electrolyte imbalance, acid-base imbalance; 3) *Cardiopulmonary disorder*: myocardial infarction, congestive heart failure, cardiac arrhythmia, shock, respiratory failure; 4) *Systemic illness*: substance intoxication or withdrawal, infection, neoplasm's, severe trauma, sensory deprivation, temperature deregulation and post operative state. To further

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understand how the disorder presents itself in the clinical setting, Samuels and Evers (2002) have developed four types of delirium states based on patient behaviour: hyperactive states, where psychomotor activity is increased and agitation is prominent; hypoactive states, where psychomotor activity is decreased and often misdiagnosed as depression; mixed states, where both hyperactive and hypoactive states exist; and normal states, where psychomotor activity is normal.

The pharmacological management has favoured the 'atypical' antipsychotics and their potential benefits in delirium management over the older traditional antipsychotics such as haloperidol (Peritogiannis et al 2009). Haloperidol has been the standard treatment for delirium for many years but has been associated with significant extrapyramidal side effects (EPS) and its use is therefore a concern in some populations (Tune 2002). Intravenous haloperidol has been associated with ventricular arrhythmias and prolongation of the QTc interval. ECG monitoring is recommended because of this risk, as it appears unpredictable (Broadhurst, 2003). Reports of haloperidol show its relationship to an increase in delirium duration in ICU patients (Pisani et al 2009). The introduction of the atypical antipsychotics has changed the landscape of pharmacological treatment for delirium. A review by Miyaji et al (2007) shows the incidence of adverse events being significantly lower for oral risperidone (6.5%) versus haloperidol (30.5%). Miyaji et al (2007) also report the incidence of death during delirium being significantly higher for intravenous or intramuscular haloperidol than risperidone patients. These findings suggest that an effective alternative to haloperidol as a first line treatment in delirium is available. The use of a benzodiazepine as a monotherapy is recommended for use with alcohol or sedative/hypnotic withdrawal induced deliriums (Lonergan et al 2007). For patients who do not tolerate antipsychotics well, it has been recommended that a combination therapy of antipsychotic and benzodiazepine is used (American Psychiatric Association, 1999). The predominant adverse events related to benzodiazepine use are respiratory depression and postural hypotension. The high prevalence of delirium in the elderly population and the risk of respiratory depression are reasons for the cautionary use of benzodiazepines in this group (Therapeutic Guidelines Psychotropic, 2003). A more recent Cochrane review (Lonergan et al 2007), found no adequately controlled trials to support the use of benzodiazepines in delirium, and recommended against use in non alcohol withdrawal delirium. Benzodiazepines have also been associated with causing delirium (Lonergan et al 2007). The use of antipsychotics has largely been associated with the hyperactive and mixed states as described by Samuels and Evers (2002). The atypical psychopharmacological treatments may avoid some of the difficulties in using 'typical' antipsychotics such as haloperidol and the risks associated with the use of benzodiazepines.

Aim

The aim of this study was to review research literature on the atypical antipsychotic pharmacological management of delirium in general hospital settings.

Method

A literature review of Medline, CINAHL, PsychINFO and Google Scholar was conducted using the key words; delirium, risperidone, olanzapine, quetiapine, aripiprazole, ziprasidone, atypical, and antipsychotics. The reference lists of retrieved articles were perused to identify influential authors and seminal papers. Further contact with researchers in the area was conducted to determine any further studies. The inclusion criteria for the review were: published clinical trials of the atypicals in the 5 year period from February 2005 to February 2010, where interventions are described and outcomes clearly articulated; and results from systematic reviews and meta-analyses of atypicals used in delirium management. Given the volume of trials and the number of literature reviews recently published, the 5 year time frame for clinical trials was made to ensure the most recent trials were captured in this review that may not have been captured in any previously published review papers. The only exclusion criteria were studies of a case report nature. The studies used have been arranged by author, method, instrument used, efficacy and side effects reported.

Results-clinical trial studies

A total of 10 clinical trial studies were found that evaluated the atypical antipsychotics in the study period. The atypicals that were studied in the clinical trials were risperidone, quetiapine, aripiprazole and perosprione (see table 1 for study details). Risperidone was studied in n=5 trials, with three of the studies producing statistically significant results on the delirium rating measures. Kim et al. (2005) found no statistically significant difference between the study drug (risperidone) and the comparator (haloperidol), in respect of efficacy; however the response rate for the haloperidol group was 8.5 days compared to 4.8 days for the risperidone group. Although they report this as not being statistically significant; this may be of clinical and financial significance, when considering the context of a reduced length of illness. Toda et al's (2005) small sample size (n=10) prevented researchers from being able to produce significant differences in delirium rating scale (DRS) scores, but report some improvements in the patients treated. Prakanrattana and Prapaitrakool (2007) studied risperidone in n=126 adults post cardiopulmonary bypass surgery. A focus on the prevention of delirium, with patients receiving 1mg of risperidone versus placebo, showed a statistically significant in post operative delirium incidence (11% for risperidone versus 31% for placebo group). A study (n=16) con-

ducted by Ushijima et al (2008) showed improvements in delirium scores, but was unable to show any differences between the risperidone and perospirone groups. Ikezawqa et al (2008), in a study (n=22), reported significant improvement in delirium scores (risperidone) but reported a high 27.3% of patients with mild side effects. Aripiprazole has been trialled in one pre-post design study of n=14 patients with delirium. Using the DRS, n=12 showed a greater than 50% improvement, and n=13 showed improvement using the clinical global impression scores (Straker et al., 2006). Aripiprazole has no clinically sedating profile making it an attractive option for use in delirium; however clinicians may be restricted in its use until well established trials are completed. Perospirone was studied by Takeuchi et al., (2007) in an open labelled trial of n=38 patients. Using doses ranging from 6.5mg to 10mg, perospirone was effective in 86% of patients, showing improvement on DRS scores, with the most common side effect being that of increased fatigue (15.2% of patients). A Ku et al study (2005) of amisulpiride and quetiapine showed signicicant improvements in DRS scores, in a sample of n=40 patients. Although no side effects were reported, no screening tool was used to measure side effects. A Maneeton et al (2007) study (n=17) of quetiapine, showed statistically significant improvement in DRS scores, with mild tremor reported in two patients, although again, no screening tool was used to measure side effects.

Review papers

There were a total of nine review papers published since 2002. Tune (2002) reviewed both the atypicals and typicals, reporting high levels of drug induced side effects with the typical antipsychotic haloperidol compared to the atypicals. Whilst reviewing several case studies, only two major trials of the atypicals were available for review at that time. In concluding, Tune (2002) suggests that there is more evidence for the use of the atypicals (risperidone and olanzapine) in delirium than the typicals, based on reduced amounts of drug induced side effects such as extrapyramidal (EPSE) symptoms. Schwartz & Masand (2002) reviewed case reports and studies of olanzapine, risperidone, quetiapine and ziprasidone. From this review the authors recommend the safe use of the atypicals in delirium, whilst not reporting the use of one atypical over another based on the studies reviewed. Boettger & Breitbart (2005) systematically reviewed 13 studies (one double blinded, retrospective, prospective and open label studies) of the atypicals risperidone, olanzapine and quetiapine in delirium, concluding that they are safe and have a low burden of side effects. Boettger & Breitbart (2005) report limited but early data for the use of risperidone and olanzapine, with growing evidence for the use of quetiapine. A more rigorous review by Lacasse et al (2006) of four prospective randomised controlled trials of n=258 patients was conducted. Lacasse et al (2006) suggest there is adequate evidence to treat delirium with the atypical antipsychotics, but falls short of making first line recommendations for them. Rea et al (2007) offered similar conclusions to earlier review papers arguing that the atypicals provide equal efficacy to the typicals, primarily haloperidol, but have less extrapyramidal side effects. Rea et al (2007) make no single first line treatment recommendation, but report that olanzapine, risperidone and questiapine in low range doses are effective. The first Cochrane review was conducted by Lonergan et al (2007). Three studies satisfied the rigourous selection criteria for the Cochrane review which compared the antipsychotics; haloperidol, olanzapine and risperidone. In low dose, Lonergan et al (2007) suggests there is no difference between these antipsychotics on efficacy or side effects, but in higher doses of haloperidol, more EPSE's are experienced. An Ozbolt et al (2008) review concurs with Lonergan et al's (2007) review with regards the equal efficacy of the atypicals to haloperidol, with a finding of EPSE's within the haloperidol groups being reportedly up to 10%-13% higher. Peritogiannis et al (2009) reviewed a total of 23 studies and reported that the atypicals were well tolerated, but concern was raised over the systematic review of their safety in the included studies. In the 23 studies none of studies included a placebo group, there were small sample sizes, use of different rating scales and a lack of adequate control samples. Concluding that the atypicals were effective and safe in the symptomatic treatment of delirium, but the evidence is limited and inconclusive. Tabet & Howard (2009) in a review paper for the prophylactic use of antipsychotics in delirium, conclude that there is insufficient evidence to recommend the use of the antipsychotics prophylactically until further well designed controlled trials are completed.

Discussion

The atypicals shows promising results in most studies on efficacy and safety versus the typicals. Differentiating between which atypical for delirium in terms of efficacy and safety will remain elusive until well designed randomised controlled trials involving all the atypicals in controlled trials are completed. A major confounding variable in any pharmacological trials in delirium is that of concomitant treatment of the underlying aetiology. Attributing the resolution of the delirium singularly to the effect of an antipsychotic is problematic. The confounding variable of the 'medical treatment' would be difficult to control and unethical. Extrapyramidal side effects and sedation is of concern in this patient population, as they are predominantly elderly and of greater falls risk. The side effects of sedation and parkinsonism with atypicals have been studied by Hien et al, (2005), who found that the atypicals olanzapine and risperidone did not decrease the risk of falls compared to typical antipsychotics in n=2500 aged care facility patients, however, both contributed to falls risk more

Table 1. Details of clinical trials

Author	Method	Instruments	Efficacy	Side effects
Devlin et al (2010)	Double blind randomised control trial N=36 Quetiapine (50mg, 50-200mg range) versus placebo	Intensive care delirium screening tool	Statistically significant improvement, reduced delirium duration, reduced length of stay, and reduced agitation	Somnolence in quetiapine group (22%) versus placebo (11%).
Ikezawqa et al (2008)	Open Label-Risperidone 1.5mg, range 0.5mg to 3mg per day. N=22	Delirium rating scale	Significant improved difference	27.3% of patients reported to have mild side effects
Ushijima et al (2008)	Retrospective study N=16 Perospirone 4-12mg daily Risperidone 1-2mg daily	Delirium rating scale	Significantly improved scores for both groups	None reported
Prakanrattna & Prapaitrakool (2007)	N=126, Randomised double blind, placebo controlled trial. (Risperidone 1mg versus placebo) Post operative delirium	Confusion assessment method	Significant reduction in incidence of delirium in risperidone group 11.% -31.7% in placebo group	None reported
Maneeton et al (2007)	Open Label-Quetiapine N=17 Mean dose 45.7mg, range 25-100mg	Delirium rating scale	Statistically significant positive results	N=2 reported to have mild tremor
Takeuchi et al (2007)	N=38, open label trial of Perospirone (6.5mg to 10mg per day)	Delirium rating scale	86.8% of patients showed improvement on DRS	Fatigue (15.2%), sleepiness (6.1%0, akathesia (3%) and blood pressure decline in 3% of patients

Table 1. Continued

Author	Method	Instruments	Efficacy	Side effects
Straker et al (2006)	N=14, pre post test study of Aripiprazole (5mg - 15mg)	Delirium rating scale	12 > 50% reduction in symptoms, n=13 showed improvement in CGI	None significant
Toda et al 2005	Open Label, n=10 Risperidone mean dose 0.61-1.79mg per day	Delirium rating scale	Sample to small to show any significant differences. (out of !0 patients were regarded as responding well.	N=2 reported excessive sedation
Kim & Jung et al (2005)	N=42, Non randomised trial Risperidone (1.19mg range 0.5-5mg) versus haloperidol (1.67mg range 0.5-2.5mg)	Delirium rating scale-revised–98	No statistically significant difference in DRS-R-98 scores	Sedation in 1 patient for 2 days
Ku et al (2005)	Open prospective randomised trial N=40 Amilsulpiride mean daily dose-156.4mg Quetiapine mean daily dose 113mg	Delirium rating scale Clinical Global Impressions Scale	Significant difference in both groups	None reported, paper note them as being generally well tolerated

than patients who were not on antipsychotics.

Until well-established large randomised control trials are conducted, recommendations for the use of any single atypical antipsychotic remains difficult. The Maudsley prescribing guidelines (Taylor, Paton & Kerwin, 2007) make no single recommendation for any specific antipsychotic, but preview a list of available medications. The Expert Consensus Guideline (2004) series, published by the Journal of Clinical Psychiatry, notes that there was no consensus among the experts on a first line antipsychotic for delirium. Whilst they gave no preferred option, they recommend risperidone (0.75mg-1.75mg/day) as a high second line rating and quetiapine, olanzapine and conventional antipsychotics as second line ratings. Folsom et al., (2004) recommend doses for use in delirium as risperidone 0.5-1mg/day (starting dose) to 1-2mg/day (maintenance dose), and olanzapine 2.5-5mg/day (starting dose) to, 5-10mg/day (maintenance dose).

Implications for mental health liaison practice

Nurse prescribers will have to consider not only the studies of efficacy, but their local jurisdiction recommendations or therapeutic goods administration guidelines for use of the antipsychotics for this disorder. Future studies that consider all the atypicals and possibly haloperidol in the one study, the use of the DRS to measure efficacy and the drug induced extrapyramidal symptom scale to measure safety would be a minimum requirement.

Conclusion

A trend is emerging that atypicals are being preferred over the typicals in the treatment of delirium, with low dose risperidone the most recommended of the atypicals. Until comprehensive randomised controlled trials are conducted, definitive conclusions cannot be made. Mental health liaison practitioners are in positions to recommend and or prescribe the best possible treatment options for their patients; however effective treatment of delirium requires both pharmacological and non-pharmacological interventions for successful management.

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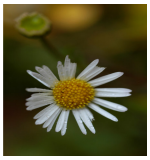
Differentiating the underlying cause of delirium; a brief case study



Kerrie Cooper

Abstract
Delirium in the general hospital setting remains a highly prevalent and significant challenge to clinicians in terms of diagnosis, treatment and overall management. This case study highlights the complexities in the diagnosis of delirium in patient who has a background of mental illness and complex physical health problems.

Key Words: Delirium, nursing, mental illness, physical health

Introduction

General hospital patients are referred to consultation liaison psychiatry services for a range of symptoms including; depressed mood, anxiety, sleep disturbance, confusion, irritability, distress, fear, agitation, hallucinations, ideas of reference, paranoia and behavioural symptoms. These symptoms and behaviours can all be attributable to a number of different mental disorders; however they can also have an organic basis such as delirium (Spiller & Keen, 2006; White, McCann & Jackson, 2007). Delirium reportedly occurs in up to 50% of hospitalised elderly patients, and is associated with significant morbidity and mortality rates. With early identification and appropriate intervention, multiple causative factors are often reversible (Liptzin, 2000; 2006; Stevic -Rust & Maximin, 2000; White et al, 2007). Identification and treatment of any underlying medical condition is a priority (American Psychiatric Association, 1999; Burns et al 2004).This brief case study will discuss the overlap of symptoms in delirium and other mental illnesses, as well as some of the investigations and assessments which are useful in differentiating the underlying cause of delirium. The case is de identified and informed consent was gained from the consumer to present the case in a future publication.

Clinical history and presentation

A sixty four year old widow, who lives with her daughter was admitted under the gastro-intestinal team for surgical removal of wire gauze, placed in the past as a supportive measure, after it had begun eroding her abdomen. With a history of Hereditary Non-Polyposis Colorectal Cancer (HNPCC), she had previously undergone multiple laminectomies and a Whipples procedure, following which she experienced a trans-ischaemic attack. Past treatment also included hepatectomy for liver cancer and a partial lung lobectomy for lung adenoma. She also presented with diabetes mellitus type II, chronic airways limitations and portal hypertension. Following her surgery the woman had a ten day intensive care admission, before being transferred to the surgical ward. A referral to the consultation liaison psychiatry team requested a review of her reported low mood. The patient also had a history of treatment for anxiety and psychotic depression, for which she had being seeing a private psychiatrist following a brief psychiatric admission. Initial assessment was conducted by the liaison psychiatry clinical nurse consultant, followed by daily review over the following two week period. Joint review was conducted with a consultant psychiatrist on two occasions.

Clinical assessment

During assessment, the patient expressed that staff had been packing her belongings in order to send her away that night. She stated that she believed she was going to gaol and said that police were holding her responsible for an assault she witnessed in the park the previous night. Although she could not identify what she had done wrong, she reported that the nursing staff were angry with her. The patient kept the door of her room closed to avoid overhearing conversations she misinterpreted as being about her. She

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was quite irritable about her daughter, accusing her of assault prior to admission. When seen for routine support by the departmental social worker, she had given instructions to find alternative discharge accommodation, insisting that the home situation was untenable. The patient had multiple extended admissions to the same ward in the past, and she and her daughter were well-known to the social worker. There had been no known indication of any domestic violence in the home. The social worker was advised to put discharge planning on hold until further corroborative assessment had taken place.

At times she got confused and was unsure of her surroundings and reported experiencing 'horrible dreams' at night for many weeks. Her daughter had rung advising she had contacted her mother's private psychiatrist and wanted to arrange a psychiatric admission following discharge. Her reasons for this were recent irritability, thought disorder and delusional thinking which she perceived as relating to a relapse into psychotic depression.

In appearance, there was no evidence of recent self neglect which might be expected in a depressed person (Wilson & Giddens, 2009). On assessment, the woman was co-operative and easily engaged throughout the assessment process. Her speech was normal in rate and tone. She denied being depressed, however her affect was labile and she appeared distressed and fearful, due to persecutory ideation which preoccupied her thoughts. She had difficulty concentrating and was tangential in her speech. There was no other evidence of disorder of thought form. Perceptual disturbance was evident, which included misinterpretation of voices outside her hospital room, where she described horsemen and kangaroos racing past her window sill on previous nights. She was oriented to place and person, but not date or time of day. Her sleep at night was disturbed by her reported 'horrible dreams' and previously described auditory and visual hallucinations. Her appetite was normal. Using the mini mental state examination (MMSE) the patient scored 23/30, indicating of some impairment of cognition (Fayers et al, 2005; Liptzin, 2000).

Physical observations revealed the patient to be febrile and hypertensive, indicating the need for investigation of sepsis. Blood tests were within normal limits, apart from abnormalities in liver function reflective of obstruction, and raised white blood cell count. Her chest X-ray was clear and an abdominal CT revealed liver lesions. MSU, blood cultures and biopsy of liver lesions confirmed infection. Brain CT ruled out metastases and an EEG confirmed very mild hepatic encephalopathy. Her current medications included nortriptyline, diazepam, fentanyl and endone, all of which can be associated with delirium (American Psychiatric Association, 1999; Stevic-Rust & Maximin, 2000). Corroborative history from the daughter indicated endone had led to a previous delirium. BSL's ruled out hypo/hyperglycaemia as a cause of her confusion. Despite having a history of psychotic depression and the presence of sleep disturbance, flattened affect and poor concentration, a diagnosis of delirium was made. There was no evidence indicating the presence of any other relapse signatures of her psychotic depression. Delirium was diagnosed due to the presence of the above physiological aetiologies. (Del Fabbro et al, 2006; Spiller & Keen, 2006).

Clinical management

The patients existing medication regimen was rationalised, with her diazepam being gradually withdrawn. Endone was ceased and pain managed solely with fentanyl. Nortriptyline, although known to cause delirium due to anti-cholinergic effects, was low dose and unchanged to avoid re-emergence of a major depression. Antipsychotic medication was initiated to reduce distress associated with her delusions and hallucinations (Liptzin, 2000; Spiller & Keen, 2006; White et al, 2007). Haloperidol 1.5 mg intravenously was switched to olanzapine 5mg daily, with an additional 5mg as required. Sepsis was treated with antibiotics. Non-pharmacological management of delirium included a low stimulus appropriately lit environment and education of staff and family about delirium, with regular nursing interventions to reorient and reassure her (Burns et al 2004; Del Fabbro et al, 2006; Gleason, 2003).

Discussion

A review of medical and psychiatric history as well as current physical and mental state are necessary before a diagnosis of depression or delirium can be made (Spiller & Keen, 2006; Stevic-Rust & Maximin, 2000). Features of delirium include impairment of cognition and attention, as well as behavioural, emotional and sleep disturbances (White et al, 2007; Wilson & Giddens, 2009). Identified risk factors associated with delirium include being elderly, polypharmacy, medical illness and recent surgery all of which were contributing factors in this case (Spiller & Keen, 2006; White et al, 2007). Without an objective assessment of cognitive function, delirium can often go unrecognised (Del Fabbro et al, 2006; White et al, 2007). High risk patients can be screened using the Mini Mental State Examination (MMSE) (Fayers et al, 2005; Liptzin, 2000). There are a number of specific assessment tools for delirium, including the Confusion Assessment Method (CAM) and the delirium rating scale (Del Fabbro et al, 2006; Ely et al, 2001; Liptzin, 2000).

Attributing symptoms to relapse of preexisting mental illness, could potentially lead to treating teams ignoring the relevant underlying physiological aetiologies of delirium (Gleason, 2003). Hypotheses regarding the pathophysiology of delirium suggest that abnormalities in neurotransmitters interfere with higher cortical function. Involvement of serotonin, noradrenalin and dopamine have been identified,

though cholinergic deficiency is primarily indicated (Liptzin, 2000; Lonergan & Luxenberg, 2009; White et al, 2007). Clinicians need to give consideration to pharmacological agents which interfere with neurotransmitter function or substrates involved in drug metabolism, as there is a known association with delirium (American Psychiatric Association, 1999; Brown, 2000; Burns et al 2004). Consideration of and changes to tricyclic antidepressant, benzodiazepine and opiates were undertaken in this case because of potential central nervous system effects.

Ongoing symptom management occurs simultaneously with investigation of the causes of delirium (Spiller & Keen, 2006; Stevic-Rust & Maximin, 2000). Antipsychotic medications are most often used for the treatment of agitation and psychotic symptoms in delirium. Haloperidol, which has less anticholinergic effects than the other typical antipsychotics, was used initially whilst intravenous access was available. When given in low dose and when given intravenously, haloperidol is reportedly less likely to cause extra-pyramidal side-effects (EPSEs) (American Psychiatric Association, 1999; Lonergan & Luxenberg, 2009).Once the cannula was removed this was changed to an oral dose of olanzapine. The atypical antipsychotics such as olanzapine, which are associated with fewer EPSEs are being frequently used in delirium (Lonergan & Luxenberg, 2009; White et al, 2007).

Non-pharmacological interventions which reduce stimulus, disorientation and confusion are also recommended in delirium (Lonergan & Luxenberg, 2009; White et al, 2007). Providing education about delirium to care-givers can avoid potential exacerbation of patient distress (Burns et al 2004; Del Fabbro et al, 2006). Patients with delirium are often aware of their experience despite their cognitive impairment (Burns et al, 2004). Gaining an understanding of a patient's experience of delirium ensures that nursing interventions such as reassurance and reorientation can be tailored to help reduce distress (Dodds et al, 2001). Being aware of the woman's delusions enabled nursing staff to avoid having conversations outside her door which might be misinterpreted, and to regularly provide reassurance that she had not done anything wrong and they were not angry with her. A daily mental status examination will determine the ongoing need for antipsychotic medication which should be titrated once symptoms subside (Gleason, 2003). Because delirium fluctuates and is often worse at night, assessment for evidence of improvement in sleep disturbance is dependent on nursing staff observations (Burns et al 2004; Del Fabbro et al, 2006). Repeating MMSE intermittently through the course of recovery gives an indication of improvement of cognitive impairment which contributed to disorientation, confusion and poor concentration (Fayers et al, 2005; Liptzin, 2000). The decision making capacity of patients experiencing a delirium is often impaired (Burns et al, 2004). In this case, the social worker was asked to defer investigating alternative accommodation requirements as this request was perceived to based on delusional beliefs.

As the delirium resolved, the patient became less distressed by paranoid ideas about the nursing staff. She no longer conveyed any paranoid ideation about her daughter and was keen to return to the family home. No objective evidence of a relapse of psychotic depression was apparent following the resolution of the delirium

Conclusion

Multi-factorial causes of delirium are accentuated in this brief case study. Early investigation of the underlying cause and diagnosis of delirium was essential to the therapeutic outcome in this patient. This prevented the 'red herring' of her historical depressive illness distracting the clinical team from appropriate management. Protracted course and variable presentation of symptoms demonstrates the need for ongoing assessment and investigations. Pharmacological and non-pharmacological symptom management continues to be appropriate and effective during the changing course of the illness.

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