# Primary Mental Health Case: Richard Bell

Richard Bell

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**Additional SF/CS Notes:**

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**Richard Bell: Health history**

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**Client Details**

|  |  |
| --- | --- |
| **Name** | Richard Bell  |
| **Date of Birth** | 18/08/1955 |
| **Address** | 6/14 Peel St, Insert suburb  |
| **Health Insurance** | N/A Medicare – Australian Citizen |
| **Work Injury** **Claim Number:** | N/A |

**Medical / Surgical History**

|  |  |
| --- | --- |
| **Presenting Condition /** **Current Presentation** | * Major Depressive disorder in context of bereavement six months ago and 40 year history of being diagnosed with Major Depressive disorder with multiple admissions for depressive episodes and suicide attempts/suicidal ideation
* Referred by GP to the community mental health centre
 |
| **History of** **Presenting Condition** | * Was first diagnosed with Major Depressive Disorder in his early 20s and has had many admissions, including an extended 10 year stay in a rehabilitation unit.
* He has had ECT in the past
 |
| **Past Medical / Surgical History** | * Lower back injury in 20s- never assessed or treated, now says it doesn’t bother him
* Reports memory difficulties following ECT, not assessed ? impact of alcohol
 |
| **Allergies** | Nil  |
| **Medications** | Venlafaxine 75mg mane  |
| **Tobacco** | Nil  |
| **Alcohol** | Significant alcohol use disorder for almost 10 years from early 40s to early 50s |
| **Illicit Drug Use** | Nil |

**Family**

|  |  |
| --- | --- |
| **Living Arrangements** | Has just moved in to his own department of housing unit |
| **Relationship Status** | Widower  |
| **Children** | Stepdaughter Fiona |
| **Mother** | Died by suicide when he was 23 |
| **Father** | He never knew his father or anything about him  |
| **Siblings** | Only child |
| **Responsibilities** | Managing his tenancy and community living requirements at home  |

**Psycho-Social**

|  |  |
| --- | --- |
| **Affect** | Flat, low mood, sadness about loss of wife. Limited eye contact. Says he doesn’t like talking. Silences during conversation.  |
| **Activity** | Spends most of his day staring out the window at home apart from a short walk to get money and take away foodAble to clean his unit, clothes and complete his self-care. Has never cooked or done shopping before. |
| **Relationships** | No friends or relationship  |

**Employment**

|  |  |
| --- | --- |
| Occupation | Worked in his 20s as a labourer has not worked since.  |
| Employer | Nil |
| Work duties | Nil. |

**Orders / Plan**

* OT consult and develop plan
* Assess progress at next home visit

**Richard Bell: Simulated Patient Briefing**

**Summary**

* Richard was first given a diagnosis of major depressive disorder at age 23 years old
* He has been referred by his GP to see a Psychiatrist at the Sunnybrook hospital outpatient clinic at the community mental health centre
* Richard’s GP is concerned that he is again experiencing depression and suicidal thoughts in the context of a recent bereavement and moving to his own accommodation

**Context/Presenting condition**

* Richard was assessed by a psychiatrist at the community mental health centre. The psychiatrist recommended that Richard recommence an antidepressant. Richard has been taking the antidepressant venlafaxine, 75 mg per day for 6 weeks.
* Richard had been experiencing thoughts of ending his life, as he felt hopeless about his future and a burden to his step daughter. He did not have any plans of how he would attempt suicide or make any attempts
* Richard still feels depressed and says he is grieving, but he is no longer experiencing suicidal ideation. He now reports some hope for the future
* He doesn’t want to see a counsellor or psychologist as he doesn’t find talking helps him
* He has also been feeling the desire to start drinking alcohol again, but has not acted on this

**Medical history**

* Richard has had more than 10 long stays in hospital for depression in the past and significant long term suicidal ideation.
* Richard had a long stay of 10 years in an old institutional style mental health rehabilitation unit in his 20s after he was first diagnosed and did not leave until he was 33 years old. Due to this long admission, he still has some effects of institutionalization. For example, there are many community living skills that he feels he did not learn such as cooking, shopping and driving
* During his long hospital admission he made absconded often and made several attempts at suicide by swimming out into the ocean. He had planned to swim until he ran out of energy and then stop. On several occasions, he was in the water for several hours and had extremely serious sunburn and heatstroke. He was rescued by lifesavers on all of these occasions.
* Medications for depression only seem to work temporarily for him and so he has tried many medications to try to be well, but was mostly given ECT when in hospital
* Richard has not experienced symptoms of depression or mental distress from depression for over 10 years
* Richard has lower back pain as the result of a work injury. He says he has just got used to it over the years and it doesn’t bother him anymore
* Cognitive deficit with a memory problem, which he thinks is a side effect ECT
* Significant alcohol use disorder in his early 40s to 50s, during the time he was separated from his wife. He says he drank to forget his feeling of helplessness of being in hospital for so long and his mum dying
* It was a long recovery for Richard to try to stop drinking alcohol of over 15 years. He spent this time living in boarding houses, alcohol rehabilitation centres and support groups. During this time he was homeless for several years sleeping rough and staying in shelters when possible.

**Current Symptoms/Function:**

* Richard is feeling low in energy and has lost interest in things he previously enjoyed such as riding his bike and swimming
* He feels sadness and grief, less depressed than when he initially went to see his GP and not experiencing suicidal ideation like he was before he saw the psychiatrist and started antidepressants
* He feels very lonely and isolated living alone

**Presentation: Appearance, Clothing and Props.**

* Richard is tall, with a beard and his clothes are clean
* He is in good shape but says has recently started to put on weight and feels flabby
* He makes limited eye contact, says he doesn’t like sitting down and talking, though says he is happy to talk an go for a walk or do something together, like gardening
* His mood is flat and he starts to get teary when he talks about Erin. He stops talking about her and goes silent until the tears stop before he will start talking again.
* His speech is soft and slow

**Social history**

* Richard is an only child
* He did not know his father or grandparents and he was told that his mother’s family did not want to know her anymore after she became pregnant with him
* His mother was a single mother
* Richard doesn’t know if he has any other family members
* His mother had depression
* During his childhood he would often spend months living with his grandparents when his mother was experiencing symptoms of depression, such as sadness, being irritable, having low mood and energy and was spending most of the day in bed.
* When Richard was 23 years old his mother died by suicide by jumping in front of a train
* He met his wife Erin just before he left hospital. They met at a book exchange where Erin worked and Richard was a regular customer when on leave from the rehabilitation unit. Erin had one daughter Fiona, from a previous relationship, who was 3 when Richard met Erin
* Richard and he took an active role in raising Fiona when she was younger including caring for her at home when Erin was at work
* Erin worked in a book shop and had her own house where they lived as a family
* Erin and later Fiona always did the shopping and cooking and most of the overall home management, such as paying bills.
* When Fiona was 12 years old, Richard and Erin’s relationship broke down due to arguments about Richard’s excessive drinking of alcohol and they separated, but did not get divorced
* Erin and Richard have kept in some limited contact while they were separated and they reunited when Richard was in his mid-50s and had managed to overcome his alcohol use disorder. At this time Erin had been diagnosed with breast cancer and due to impact of this and treatments, was no longer working
* Fiona was living with her at home to care for her. Richard also moved back to Erin’s home and took on a caring role for Erin
* Richard was a carer for Erin in terms of emotional support, companionship and attending all medical appointments
* Fiona has provided practical support of looking after the managing bills, house, cooking, shopping etc.
* When Richard re-established his marriage relationship with Erin and moved home, Fiona had mixed feelings. While she had fond memories of Richard from her childhood, she had felt abandoned by him when he left the home and angry at him for his alcohol use during those years. Richard worked hard at trying to re-establish a relationship with Fiona. For example, he tried to be interested in her life and keep quiet at home so she could do her study for a Bachelor of Education. Richard and Fiona have a relationship that is not very close but they do talk and it is a very important relationship to Richard
* After Erin died six months ago, Fiona asked Richard to move out of the family home.
Fiona wanted her partner to move in and they are planning to start a family, so felt there was not enough space for Richard to stay. Fiona assisted Richard to complete a department of housing application

**Activities of daily living including leisure and work**

Current

* Richard has not worked since his 20s when he hurt his back. He is not interested in re-entering the workforce and feels that no one would hire him anymore due to his age and lack of skills. He is not interested in work as he’s struggling with the day to day enough as it is
* In his mid-30s, he worked as a casual labourer and hurt his back on the job. He was only working for cash in hand so wasn’t able to access any workers compensation. He has been on a disability support pension since this time
* Richard has lost interest in his previous leisure activities and feels he now can’t do lots of things he used to like doing at his home as there aren’t the opportunities at his new accommodation. For example, the house had a pool where he used to swim
* He lives on a busy road and is spending most of his time with a pillow rested on his window frame and staring out at the traffic and people walking by

**Activities of daily living**

* He has been washing his clothes and keeping his place clean
* He is managing his budgeting ok but not saving any money
* He currently doesn’t have a fridge
* He has recently put on weight as he has always had others preparing food for him and has been eating cheap unhealthy takeaway foods everyday
* He only goes out once a day to get his money and to buy takeaway food at a fish and chip shop 5 minutes’ walk from his home

**Leisure/interests**

* Richard used to swim laps at Erin’s house where she had a pool
* He used to ride his bike. He left his bike at Erin’s house and is not sure if it’s still there or Fiona has thrown it out to make space for her partners belongings
* He used to like gardening at home, just basics like watering the plants, weeding and mowing
* Richard is not sure what to do with his time now

**Employment**

* Richard left school in year 10
* Richard was a young carer for his mum who had depression
* Richard worked as a casual labourer in his 20s and after hurting his back did not return to work
* Richard had wanted to become a carpenter but didn’t pursue this when he hurt his back

**Transport**

* Richard can catch public transport and likes walking
* He never had a drivers licence and regrets this

**Home**

* Richard has moved to a new housing department unit on his own. This is the first time he has lived on his own

**Behaviour, affect and mannerisms**

* Low mood, but reports this has improved since taking an antidepressant and having time to live with the loss of his wife, but says he still misses her every day and feels regret at the years they didn’t spend together due to his drinking

**General Ideas**

* Richard doesn’t like to sit and talk, but feels he has been doing this a lot lately with the doctors. With Erin, they used do things together and not spend time just talking which he really liked e.g. read paper, watch TV, walk, bike
* Richard would like to learn to use the internet so he can stay in touch with Fiona, as she’s too busy to talk or meet up with now her partner has moved in and she’s started working as a teacher
* He is interested, but not sure about a new men’s shed that he received a flyer about from his GP that is opening up in his area
* He is not sure how he will manage living on his own in his own place
* He used to like doing work around the house, odd jobs, building things, gardening but now lives in a small flat and has lost that

**Concerns**

* His friends are those he used to drink alcohol with socially and he has decided not to associate with them anymore as part of his strategy to try to abstain from alcohol, but he has no other friends
* He is worried about his memory and sometimes forgets his appointments with his GP

**Expectations**

* To try to keep in touch with Fiona and find other people to talk to
* To learn to use the internet and how to email
* To try to do something rather than sitting around all day
* To learn how to cook and what food to buy

**Key stakeholders**

* Fiona
* GP
* Psychiatrist at Community mental health centre

**Richard Bell: Ward Doctor Briefing**

Name: Dr Sonia Simon

Position: General Practitioner

Contact: [Contact number]

Appointments:

 [Insert date] [Insert time]

[Insert date] [Insert time]

**2. Summary/Overview**

* You are the GP of Richard Bell.
* You first met Richard as the husband and carer for his wife, Erin. You were Erin’s GP for 15 years and provided GP services to Erin while she had breast cancer. Richard used to attend all appointments with Erin.
* Four years ago you asked Richard if he had his own support or GP and he said “no”. You did encourage him to have his own GP.
* Five months ago, not long after Erin died, he did come to see you. Based on your assessment, at this time Richard was experiencing distress and grief in the context of the death of his wife only one month prior.
* You attempted to make 2 further appointments with him which he did not attend. He said it was due to his memory. Your opinion is that his memory was functioning better prior to him becoming depressed, but it is also possible that it was Erin who was assisting Richard with remembering things, for example appointment times.
* Richard came to see you on one further occasion 2 months ago. At this appointment, you were concerned about his mental state. He presented with significant depression and suicidal ideation. He was feeling down and worried about becoming depressed like he had been in the past and ending up in hospital. That was the first time that you had heard about his history of major depression and hospitalisation. You don’t think that Erin knew about this either as she never mentioned it. You referred him to see a Psychiatrist at the local hospital outpatient clinic at the community as a priority referral for urgent assessment. You have not seen Richard since then or had feedback from the psychiatrist yet.
* You are being contacted by a second-year occupational therapy student who is assisting Richard to function in the community.
* You are very busy usually and would not have time to talk, but your receptionist has put the call through to your mobile where you are waiting by the side of a busy road for a mobile mechanic to come and change your car tyre. So you have time to talk but it is busy with traffic in the background.

**3. Learning objectives**

* Establish rapport and communicate effectively with health professionals from other disciplines
* Obtain concise and useful treatment information

**4. Student (clinician) task (including briefing for trainee)**

* Conduct a telephone interview to build an assessment of Richard’s functioning and self-management in the community
* To see if Dr Simon has any information about Richard’s prior functioning when he was living with Erin
* You have already tried to phone Dr Simon several times but she has had back to back appointments
* As Dr Simon is waiting for a mechanic she has time to talk but it is noisy on the road where she is talking on her mobile
* You turn the sound up on your phone and check with Dr Simon to see if she can hear you clearly

**5. Setting**

* Busy highway at an emergency call bay where Dr Simon is waiting for a mechanic.

***Specifically for the simulated person***

**6. Affect/behaviours**

* You are to the point
* You are opinionated
* You are a bit distracted looking for the mechanic’s car in the traffic
* You are really annoyed that you haven’t been able to fix the car tyre yourself
* You are also surprised that your receptionist has put this call through to your mobile, but anyway, it’s not like you have anything better to do and you don’t mind having an update on Richard, given all he’s just been through with Erin and how he was last time you saw him

**7. Opening lines/questions/prompts**

* “Yes, sorry I haven’t been able to talk your calls. It’s been really busy and I haven’t had a spare spot in the diary. It’s only that I am on my way back from a house call and I have a flat tyre - that I’ve been waiting for hours to get fixed - that I do in fact have some time to talk. So shoot, what would you like to know?”
* How is he doing now anyway? So, is he in hospital? Is he taking medication? I expect I’ll receive a transfer of care summary from the Psychiatrist if any follow up is required from me?
* You give credit to him for what he did for Erin and Fiona. When Erin wasn’t well and Fiona was a wild young person (Erin’s words), he kept stability at home and never missed an appointment with Erin

**8. GPs ideas, concerns and expectations of the interaction**

**Ideas**

**Concerns**

* Richard’s neglected his health for many years now. “I understand from Erin that he was homeless for many years when he was on the booze. I mean just look at his teeth”
* You’ve been telling him for years to see his own GP. It hasn’t been appropriate for you to assist him during his appointments with Erin.

**Expectations**

* you would be happy for Richard to keep coming to see you for ongoing GP appointments but wonder if he does have problems remembering appointments and if that could be assessed by the mental health team

**Ideas**

* He picked up a flyer that I had in the waiting area for the new men’s shed in our suburb. He brought it in to the appointment that he first attended on his own. You are not sure if he attended this or not.

**9. Patient’s history of the problem**

* you were away of Richard’s problems with alcohol but not about his depression

**10. Patient’s past medical history**

* You noticed issues that he hadn’t had examined such as his cognitive functioning which he and Erin had complained about.
* You know that he had a lower back injury many years ago but are not sure if he has ever had this assessed. You have suggested follow up for this before e.g. pain clinic but he was not your patient then

**11. Patient’s family history**

* You don’t know anything about Richard’s family of origin, but you are family GP to Erin and Fiona
* Fiona hasn’t attended your practice for a very long time. She had attended with her mum for childhood illnesses and misadventures in the past e.g. chicken pox, broken toe that got caught in their swing set at home

**12. Patient’s social information (work, lifestyle, habits)**

* You have not known of Richard working
* He is a non-smoker
* He has always looked after his personal hygiene
* He has always been in pretty good shape and he and Erin used to exercise together e.g. swimming and biking
* In the last couple of appointments, his personal hygiene was ok but he had put on weight around his gut. Thankfully not a beer belly as he said he was still off the booze.
* I didn’t realise that Erin was cooking right up to the end. He said he has no idea how to cook.

**13. Considerations in playing this role including wardrobe, makeup and challenges:**

* Talking loudly over the traffic
* Asking students to speak up so you can hear them on the busy road
* Suddenly saying have to go here’s the mechanic FINALLY!!!!!!

**Richard Bell: Psychiatrist Briefing Notes**

Name: Dr Cameron Clive

Position: Psychiatrist

Contact: [Contact number]

Appointments:

 [Insert date] [Insert time]

[Insert date] [Insert time]

**2. Summary/Overview**

* You have seen Richard once per week for the past 6 weeks
* He has had a good response to his antidepressant
* He is no longer expressing suicidal ideation and his mood is significantly improved
* You are going to refer him back to his GP for ongoing management but would like to refer him for community mental health occupational therapy follow up at this point and before he returns to the care of his GP
* Your appointments are short. Richard is a man of few words. That’s ok you can talk enough for both of you. That’s why you went in to Psychiatry in the first place. You love to talk all day and the students have trouble ending the phone call.

**3. Learning objectives**

* Establish rapport and communicate effectively with health professionals from other disciplines
* Obtain concise and useful treatment information

**4. Student (clinician) task (including briefing for trainee)**

* Contact Richard’s psychiatrist to gather information on his referral, current treatment and recommendations

**5. Setting**

* Psychiatrist’s office. On speaker phone as he is typing up a paper for a journal article on mental health law. Dr Clive can speak to you and type at the same time.

***Specifically for the simulated person***

**6. Affect/behaviours**

* You are happy as your journal article has just been accepted in the Australasian Psychiatry journal, but you have to send back some minor revisions by this afternoon. So you tell the students you are going to put them on speaker phone and type at the same time – no problem.
* You love talking to students and sharing your knowledge. You ask them if they know what venlafaxine is, what major depression and suicidal ideation is and explain to them anything they don’t understand
* You see Richard as having resilience; built up over his life experiences, from history of a young carer, losing his mother, his own challenges with alcohol use disorder and then caring again for his wife, losing his wife and now facing another challenge of trying to make it in his own place at 60 years old. You wonder if the students know what alcohol use disorder is?

**7. Opening lines/questions/prompts**

* “Occupational Therapy students. Oh that’s grand. Occupational Therapists have so much to offer in mental health. Listen I think you can really help Richard with the pickle he’s in”
* “You’re on speaker phone. I’ve got a deadline to send in my journal article today. It’s an opinion piece on mental health law. Have you learnt about that yet? Mental Health law?”
* “Stop me if there is anything you don’t know”

**8. Psychiatrist’s ideas, concerns and expectations of the interaction**

**Ideas**

* He won’t see a psychologist or counsellor, but he’s not a talker so you don’t think that would be helpful
* He wouldn’t like art therapy or any of that either
* But he needs healing and to process his feelings and grief somehow, he used to do gardening and exercise, something practical like that would be good

**Concerns**

* You’re also a bit concerned about how he’s managing at home. He doesn’t have a fridge or money for a fridge- what can be done about that?
* And how is his safety with cooking? His GP is worried about his memory. He may have cognitive deficits from his long history of alcohol use, but it’s not the time for formal assessment now until his mental state is stabilised. As his mood is improving, he has been coming to appointments by bus regularly now. He had missed a couple of appointments with his GP, who thought it might be his memory, however I suspect that may have had more to do with his depressive episode. However, we do need to know that he is safe and functioning at home. What would he do in an emergency? Does he know what to do?

**Expectations**

* An occupational therapist is ideally placed to assess how he is functioning and support him in this transition to living independently.
* It would also be good for the OT to recommend any ongoing services that would be useful.

**9. Patient’s history of the problem**

* you don’t have his file to hand at the moment as you’re still typing up your article, but you have put a thorough history of all you know in the referral

**10. Patient’s past medical history**

* When you refer him back to the GP after the OTs get back to you with their assessment and recommendations and he comes to see you a couple more times, you are going to request the GP review his lower back pain/old injury and also do a physical health screen, particularly with his new medication and ceasing his exercise routine

**11. Patient’s family history**

* His mother had depression and died by suicide. Again you have included all this info in the referral.
* You wonder if the students have read the referral form. You just want to make sure they have done their information gathering on the referral, as they are asking for information you have already meticulously spelled out on the referral form. It’s all part of learning the craft of psychiatry after all.

**12. Patient’s social information (work, lifestyle, habits)**

* You think that this is where the OT comes in. You want them to report back to you on this.

**13. Considerations in playing this role including wardrobe, makeup and challenges:**

* Jovial
* Challenging to the students only from the perspective of wanting them to learn how it’s done
* Multi-tasking typing and talking and asking students questions when they were planning to ask the questions
* If the students ask for more information (From American Psychiatric Association DSM 5):
	+ Major depressive episode:

Depression (major depressive disorder) is a common and serious medical illness that negatively affects how you feel, the way you think and how you act. Fortunately, it is also treatable. Depression causes feelings of sadness and/or a loss of interest in activities once enjoyed. It can lead to a variety of emotional and physical problems and can decrease a person’s ability to function at work and at home.

Depression symptoms can vary from mild to severe and can include:

* Feeling sad or having a depressed mood
* Loss of interest or pleasure in activities once enjoyed
* Changes in appetite — weight loss or gain unrelated to dieting
* Trouble sleeping or sleeping too much
* Loss of energy or increased fatigue
* Increase in restless activity (e.g., hand-wringing or pacing) or slowed movements and speech
* Feeling worthless or guilty
* Difficulty thinking, concentrating or making decisions
* Thoughts of death or suicide
	+ Alcohol Use Disorder:

To be diagnosed with an AUD, individuals must meet certain criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Under DSM–5, the [current version](http://pubs.niaaa.nih.gov/publications/dsmfactsheet/dsmfact.htm) of the DSM, anyone meeting any two of the 11 criteria during the same 12-month period receives a diagnosis of AUD. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.

To assess whether you or loved one may have an AUD, here are some questions to ask.  In the past year, have you:

* Had times when you ended up drinking more, or longer than you intended?
* More than once wanted to cut down or stop drinking, or tried to, but couldn’t?
* Spent a lot of time drinking? Or being sick or getting over the aftereffects?
* Experienced craving — a strong need, or urge, to drink?
* Found that drinking — or being sick from drinking — often interfered with taking care of your home or family? Or caused job troubles? Or school problems?
* Continued to drink even though it was causing trouble with your family or friends?
* Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?
* More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?
* Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?
* Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?
* Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, irritability, anxiety, depression, restlessness, nausea, or sweating? Or sensed things that were not there?
	+ Anti-depressant:

Medication: Brain chemistry may contribute to an individual’s depression and may factor into their treatment. For this reason, antidepressants might be prescribed to help modify one’s brain chemistry. These medications are not sedatives, “uppers” or tranquilizers. They are not habit-forming. Generally antidepressant medications have no stimulating effect on people not experiencing depression.

Antidepressants may produce some improvement within the first week or two of use. Full benefits may not be seen for two to three months. If a patient feels little or no improvement after several weeks, his or her psychiatrist can alter the dose of the medication or add or substitute another antidepressant. It is important to let your doctor know if a medication does not work or if you experience side effects.

Psychiatrists usually recommend that patients continue to take medication for six or more months after symptoms have improved. Longer-term maintenance treatment may be suggested to decrease the risk of future episodes for certain people at high risk.

* + Mental health law

Meadows, G., Grigg, M., Singh, B., & MacDermott, F. (2012). Delivering Mental Health Care. In G.

 Meadows, J. Farhall, E. Fossey, M. Grigg, F. McDermott, & B. Singh (Eds.), *Mental Health in*

 *Australia. Collaborative Community Practice* (3rd ed.) (pp. 45-68). Melbourne: Oxford

 University press.

“mental health legislation embodies the balance between autonomy and individual rights, paternalism and community safety” (p.48).

**Richard Bell:**  **Step Daughter Briefing Notes**

**1. Title**

Name: Fiona Pace

Position: Stepdaughter

Contact: [Contact number]

Appointments:

 [Insert date] [Insert time]

[Insert date] [Insert time]

**2. Summary/Overview**

* You are the stepdaughter of Richard Bell.
* You are 30 years old and feel like your life is just getting started
* You are being contacted by a second-year occupational therapy student who is assisting Richard to function in the community

**3. Learning objectives**

* Build rapport with a family member and obtain effective information, while remaining professional and respectful
* Develop client history via secondary sources

**4. Student (clinician) task (including briefing for trainee)**

* Contact Richard’s stepdaughter to gather information on social and any known medical history

**5. Setting**

* On your lunchbreak at your desk in the staff room at your primary school where you have just started working
* You can talk now as the other teachers are having lunch but you were planning to quickly do some work at your desk when the phone rang

***Specifically for the simulated person***

**6. Affect/behaviours**

* You too are hurting since your mum died
* You have finally started work as a teacher after many years of deferring your studies and going part time so you could care for your mum
* You appreciated Richard being there with your mum every day, so you could go out to uni, study and spend time with Patrick (your partner)
* Richard had no idea about looking after a house though, like paying bills, organising anything like cooking or shopping so you did all that and your mum was amazing doing being as active as she could right until the end
* You live in your mum’s house now with your partner Patrick
* Patrick’s moved in now and he’s not much better round the house than Richard was, so you have your hands full
* Patrick’s a full time teacher as well
* You are planning to get married and have a family
* You asked Richard to move out after your mum died because you wanted Patrick to move in and there wasn’t enough space for everybody
* You feel you’ve got your own life to live now and no one is going to tell you what to do. You feel you have already spent 10 years sad about Richard abandoning you and then 10 years sad and caring for your mum

**7. Opening lines/questions/prompts**

* “Hello. Who are you? “
* “Why are you seeing Richard?”
* “What can an occupational therapist do for Richard?”

**8. Stepdaughter’s ideas, concerns and expectations of the interaction**

**Ideas**

**Concerns**

* You asked Richard to send you emails to keep in touch as he is useless at talking on the phone. He just says how are you? How’s the house? How is the garden? Over and over and then says “ok, bye love”. He doesn’t even answer your questions over the phone. You are working all week now and spend your weekends at the sailing club with Patrick, so you haven’t had any time to visit Richard yet
* In fact, you just feel like it’s your time to live now, you are just managing yourself with you busy working life and you don’t want to have to worry about anyone else right now
* If he starts drinking again you’ve told him you’ll never ever talk to him again. You told him that ever since your mum took him back and that’s the only reason you accepted him back as stepdad again, because he stopped the drinking and was good company for mum
* Richard and your mum were happy and did love each other. You think that’s rare and you understand mum taking him back, but you still never forgave him for the drinking and being an embarrassing bum on the streets. You saw him once in the city with alcohol in a paper bag, all stinky and looking like a beggar on the street and it was the shock of your life. You never told him or mum about that. You just walked past like you didn’t know him and you really never wanted to see him again. But he was good with mum when she was sick and he was always a decent stepdad to her when he was home
* I had a stage where I was going out and drinking a lot too. It scared mum. I think maybe the both of us stressed her out so she got sick with worry

**Expectations**

* For your own wellbeing you don’t really want to get involved
* You are happy for Richard to contact you via email and don’t find talking to him on the phone useful. For him to keep saying nothing on the phone there is no point
* You feel you don’t have the time or energy to visit him at the moment, you are very busy with your first teaching job and learning the ropes

**9. Patient’s history of the problem**

* You never heard of him being depressed before and your mum or Richard never mentioned anything
* You don’t think he’s depressed or needs a psychiatrist
* You think Richard’s just missing mum and lonely in his own place
* He just needs to get a life, get some friends and find something to do
* He’s never had any friends except the losers at the pub when you were younger
* You’ve never known him to work and you always thought that was a bit sad, but he always said your mum and you were his whole life and it seemed so

**10. Patient’s past medical history**

* You have no idea, that’s his business

**11. Patient’s family history**

* you didn’t know anything about his family at all

**12. Patient’s social information (work, lifestyle, habits)**

* He was just always by mum’s side they did everything together - watched TV, went for walks, went to the doctor. They loved swimming in the pool and riding bikes. Even though mum was tired, weak and in pain, they would still go for a swim most days. I’ve still got his bike here actually.

**13. Considerations in playing this role including wardrobe, makeup and challenges:**

* In a bit of a rush as the students are about to come back after lunchtime
* You haven’t had your lunch yet and are a bit grumpy
* You’re sad too, but all the questions are about Richard
* You really aren’t in a good space to be worrying about him now. You helped him get his own place that he could afford on his pension and that wasn’t easy. Now you just want to get on with your own life.

**Richard Bell: OT Activities & Props**

**Sub groups**

|  |  |  |
| --- | --- | --- |
|  | **Observed tasks in university setting****With patient**  | **Activities in a shopping centre****Without patient** |
| **Group A** | Richard has expressed an interest in mindfulness practice. -ask Richard to read through the mindfulness handout (<http://www.blackdoginstitute.org.au/docs/10.MindfulnessinEverydayLife.pdf>) -guide Richard through the mindfulness minute exercise-discuss how he finds it: Richard says he would be willing to try this and used to sit quietly in a bench in his garden. He would like to try and do mindfulness outdoors in a garden or park. He agrees to practice another mindfulness minute.-practice one minute mindfulness together | Green Care: “using the natural green environment as a context for human occupation” (Fieldhouse & Sempik, 2014 in Creek’s Occupational Therapy in Mental Health.Local Park:* Is there a park bench where Richard could practice mindfulness?
* If not are there any other options for where he could site? e.g. picnic table
* What are the options to access the park e.g. walk, bus, bike tracks?
* Are there any other options for leisure or productive occupations in this park e.g. community gardens/activities?
* Are there times of day that would be best suited to use this park for quiet times e.g. is it used for sporting matches at any times?
* Are any other considerations e.g. are there benches in the shade or would Richard need to bring hat/sunscreen if attending in middle of the day/summer?
 |
| **Group B** | Richard is going to have a fridge and basic kitchen utensils donated to him by his buildings tenants resource. - Richard has identified his favourite food as spaghetti and vegetables and you have a recipe from the Australian Government website – Eat for health:<http://www.eatforhealth.gov.au/eating-well/healthy-recipes/fast-vegie-spaghetti>* Ask Richard to read through the recipe
* Plan with Richard how he would go shopping for the ingredients e.g. to fruit shop, to a large supermarket
* Ask Richard to write a shopping list
* Richard is concerned about how much it will cost and about going shopping at all, he doesn’t want to go shopping with you until he knows how much this is all going to cost and whether he can afford to pay
* He agrees for you to go and check the costs first
* Discuss with Richard about how this meal could be frozen in smaller portions
 | Local Supermarket* What are the opening hours?
* Is home delivery available?
* What are the options for travel e.g. walk, bus?
* Locate and record the price for these ingredients:

**500g spaghetti or other pasta2 teaspoons vegetable oil1 small onion, thinly sliced1 small carrot, thinly sliced1 small celery, thinly sliced½ capsicum, seeded and cut into small dice1 small zucchini, cut into small dice570g tomato based pasta sauce¼ cup grated Parmesan cheese*** Can they be easily found in the one shop?
* What strategies/options are available if you have trouble locating items e.g. are staff able to assist, is there a store map available in a handout or on the trolleys?
* Are there cheaper ways to buy the items e.g. on sale, in bulk, cheaper brands?
* Write the total cost of the items for Richard for your next appointment
 |
| **Group C** | Richard has taken up your suggestion of using a diary to help remember his appointments and start planning his day. The first thing he wants to plan is to start exercise with swimming once a week. -observe Richard planning his next week-book in a time with him for your next appointment - book in the next appointment he has with his Psychiatrist Dr Clive- book in a time to go swimming after your appointment. Richard has booked this after your appointment, as he doesn’t want to attend the local pool until he knows the cost, opening times etc. You have offered to check this out for him first.  | Local pool* What are the opening hours?
* How much does it cost to attend?
* Is membership available? Does this make it cheaper to attend?
* Are there any discounts for those on a DSP?
* Are there any times you can’t attend for lap swimming e.g. children’s swimming lessons book out lanes afternoons?
* Are there change rooms available?
* Are there any rules e.g. must wear a swimming cap or flip flops?
 |
| **More options** | Plan a goal to ride bike to next Psychiatrist appointment | Local Bike Track  |
|  | Richard wants to email his stepdaughter. He said he has never used email and doesn’t really get it. Explain to him how he could use email.  | Local library – find out about access for members to internet, need to be member first, any courses on internet/email use available etc. ?  |

**Group A**

|  |  |
| --- | --- |
| **On campus requirements**Black Dog Mindfulness in everyday life handoutsClock to time one minute | **Off campus requirements**Local park  |

**Group B**

|  |  |
| --- | --- |
| **On campus requirements**Copies of recipe for vegie spaghetti printed out from website or below. Pen and paper for shopping list  | **Off campus requirements**Supermarket Pen and paper for shopping list and to add up costs Access to calculator (could have this in their phones) |

**Group C**

|  |  |
| --- | --- |
| **On campus requirements**DiaryPen | **Off campus requirements**Local Pool |

|  |  |
| --- | --- |
| **Fast vegie spaghetti**11 serves of vegies in this recipe**Ingredients**:500g spaghetti or other pasta2 teaspoons vegetable oil1 small onion, thinly sliced1 small carrot, thinly sliced1 small celery, thinly sliced½ capsicum, seeded and cut into small dice1 small zucchini, cut into small dice570g tomato based pasta sauce¼ cup grated Parmesan cheese | image of finished recipe fast vegie spaghetti |
| **Method**Cook pasta according to packet directions and drain. Heat oil in a saucepan, add onion and cook until soft. Add other vegetables, stirring until well mixed. Lower heat, cover and cook for 5-7 minutes. Add pasta sauce to vegetables and heat through. Remove from heat and serve over pasta. Sprinkle with cheese.Serves 4-6.10 minutes preparation + 10 minutes cooking |

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| --- | --- |
| **Occupational Therapy** 42_as_Interleaved_2_of_5_barcode[1]**Referral Form** | **Surname:** Bell**Given Name:** Richard **DOB:** 18/08/55**Sex: M****Address**: 6/14 Peel St, Insert suburb |

|  |  |  |  |
| --- | --- | --- | --- |
|  **Referred from** | His GP - Dr Sonia Simon | **Referred to**  | Health Enhance Occupational Therapy Mental Health |
| **Interpreter Required:** Yes [ ]  No [x]  **Language:** English |
| * **Diagnosis and current management:**  Major Depressive disorder and suicidal ideation (no specific plans) in context of bereavement six months ago and 40 year history of being diagnosed with Major Depressive disorder with multiple admissions for depressive episodes and suicide attempts/suicidal ideation. Previous suicide attempts were acted on 30 to 40 years ago. His attempts were to swim in the ocean until unable to swim any more due to exhaustion. Was saved by lifesavers.

**Occupational Therapy Referral Form*** Family history – his mother had depression and died by suicide when Richard was 23.
* Currently mood is improving since starting venlafaxine 75 mg mane for 6 weeks and he is no longer expressing suicidal ideation
* Previous alcohol use disorder approx. 8 years ago for over 10 years
* to be referred back to GP for ongoing management and physical health review including dental in next couple of months
 |
| **Social Situation:** Lives alone. Stepdaughter with limited contact.  |
|   |
| **Home Assessment Completed:** Yes [ ]  No [ ]  Required [x]   |
| **Equipment Provided:** Nil |
| **Current Occupational Performance** |
| **PADLS:** Good personal hygiene. Teeth in poor condition due to history of neglect despite looking after his teeth well now. |
| **DADLS:** Long history of institutionalisation and then of others taking care of cooking, shopping, organising budgets and bills. Effect of institutionalisation evident in that he just learnt to look after his own personal hygiene, tidy his living area etc but not community living skills or home management. He is able to catch public transport though. Has caught the bus to this appointment  |
| **Mobility/Transfers (Including Aid):** Nil applicable |
| **Referral Goals:** -Assess ADL/IDADL function. -Skills training to client re cooking and shopping-assess his functional cognition and safety at home when performing domestic tasks -Assess his routine, daily activity and time use -restart exercise  |
| Therapist: Insert | Date: Insert  | Consent Obtained: Yes [x]  No [ ]   |