# Primary Mental Health Case: Beth Baker

Beth Baker

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| Activities & Props | Description of on- and off-campus activities and props required |  |  |
| Referral form | For distribution to students | Address & date |  |

**Additional SF/CS Notes:**

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**Beth Baker: Health history**

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**Client Details**

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| --- | --- |
| **Name** | Elizabeth Baker |
| **Date of Birth** | 08/07/1982 |
| **Address** | 7/219 Caldwell Street  Insert suburb |
| **Health Insurance** | Nil |
| **Work Injury**  **Claim Number:** | Nil |

**Medical / Surgical History**

|  |  |
| --- | --- |
| **Presenting Condition /**  **Current Presentation** | * Diagnosed with bipolar disorder (Type 1) 10 years ago, when she was aged 23yo. Case managed as an outpatient by community treatment team   Current Symptoms:   * Marked irritability about relatively minor issues * Overly optimistic about own skills and abilities * Slightly pressured speech * Easily distracted with poor concentration * Poor impulse control |
| **History of**  **Presenting Condition** | Two episodes of depression in late teens /early 20s, and diagnosed with bipolar disorder at 23 years old following first episode of mania. Came to police attention this episode after causing damage to a street full of cars (she jumped on them while ‘having fun’). Police conveyed her to ED, and there followed a three week inpatient psychiatric admission. Has regained some insight into her mental state, and is engaging in daily visits from her treating team. |
| **Past Medical / Surgical History** | * Classic migraines since puberty. Fortnightly occurrence. Takes painkillers during episodes but not on long term preventative medication. * Seasonal hay fever and uticaria. Controlled by antihistamines. |
| **Allergies** | Nil known |
| **Medications** | Lithium & Seropax |
| **Tobacco** | Smokes roll your owns cigarettes – Approximately 20 per day |
| **Alcohol** | Regular use of alcohol since late teens, generally in a binge pattern. Two previous ED admissions due to acute intoxication (8 years ago, and 2 years ago) |
| **Illicit Drug Use** | Smokes marijuana on a social basis. Reports she would more often if she could afford to. |

**Family**

|  |  |
| --- | --- |
| **Living Arrangements** | Lives alone in public housing bedsit. Australian citizen. |
| **Relationship Status** | Single, previously in several long term relationships |
| **Children** | Nil |
| **Mother** | Louisa (56) – long history of being ‘nervous’ but no formal diagnosis |
| **Father** | Alex (65) – in good health |
| **Siblings** | Two Brother - James (37) and William (35). One sister - Kelly (30). Eight nieces and nephews, ranging from 10 years old to newborn. |
| **Responsibilities** | Personal self-care, domestic duties, shopping and financial management. |

**Psycho-Social**

|  |  |
| --- | --- |
| **Affect** | Very intense eye contact, and frequently makes physical contact with the person she’s talking to. Emotionally warm and animated, but fidgeting and often shifting position. Expresses some irritation at times, but this quickly resolves. |
| **Activity** | Independent in all personal activities of daily living. Completing domestic tasks sporadically – she has the skills to do them but cannot always maintain concentration. Dependent on others for help with community activities such as shopping and banking, which she currently finds overwhelming. Often requires help to make ends meet, as she frequently runs out of money prior to her next pay. |
| **Relationships** | Used to have extensive social network, but this has reduced following her recent admission. Keen to re-connect with friends and possibly find a new partner going forward. |

**Employment**

|  |  |
| --- | --- |
| Occupation | Not currently employed |
| Employer | Not currently employed |
| Work duties | Not currently employed |

**Orders / Plan**

OT to consult and formulate a client centred plan to support:

* Improved sleep hygiene and balanced patterns of activity/rest
* Consistent completion of domestic activities of daily living
* Regained independence in community activities such as banking and shopping
* Increase social inclusion in the local community and contact with social network.
* Re-commence attendance at voluntary arts project
* Explore possibilities for employment in the arts sector
* Improve money management skills in the longer term
* Improve her understand of her bipolar disorder and formulate a wellness and recovery plan
* Improved security in her current accommodation

**Beth Baker: Simulated Patient Briefing**

**Summary**

* Beth was diagnosed with bipolar disorder (Type 1) ten years ago, and has experienced episodes of both low mood (depression) and elevated mood (mania) throughout the past decade.
* She was recently admitted to the inpatient psychiatric unit at the local hospital during an episode of mania. On this occasion Beth was brought to the emergency department by the police. Beth was discharged two weeks ago, and is now being supported by the community mental health team.

**Context/Presenting condition**

* Diagnosed with bipolar disorder at the age of 23, after experiencing her first episode of mania. Prior to her diagnosis, Beth had also experienced two episodes of depression.
* Came to the attention of police when she jumped on parked cars along both sides of a suburban street, causing considerable damage (dented roofs and smashed windows). When asked why she was behaving this way, she said she was just having fun and she would buy everyone a replacement car. Police took her to the local emergency department, and she was admitted to an inpatient psychiatric unit from there.
* Beth remained in hospital for three weeks until her mood stabilised. While she is still experiencing elevated mood, she has regained some insight into her mental state and wants to recover. The community team is currently visiting her on a daily basis, to monitor medication/mental state and support her re-engagement with daily activities.

**Medical history**

* Beth has experienced classic migraines since puberty, and experienced them on a fortnightly basis. These migraines leave her incapacitated for around 24 hours as she must lie in a darkened and quiet room to gain relief.
* Beth experiences seasonal hay fever and uticaria (hives), but both are well controlled with antihistamines
* Beth has regularly used alcohol since her late teens, saying it makes it ‘easier to talk to people’ and makes her generally feel better. She tends to drink in a binge pattern, and has had two emergency department admissions in the past due to acute intoxication (one eight years ago, and one two years ago).
* Beth has been on Lithium long term to stabilize her mood, but tends to stop medication at times of both lowered and elevated mood. During her current relapse, she ceased her medication approximately one month prior to admission, because she was feeling ‘really, really good’. Her Lithium was re-started during her recent admission, and she is also currently taking Seropax (a benzodiazepine) to address her symptoms of mania. This last medication is being reduced and the plan is to cease it within the next month, as this is only used in the acute phase of her illness

**Current Symptoms/Function:**

* Beth’s symptoms of mania have abated since her admission, but they remain present in a mild to moderate form. These symptoms include:
  + Feeling irritable about relatively minor problems or obstacles
  + Unrealistic beliefs about her skills and abilities (overly optimistic)
  + Slightly pressured speech, and tendency to interrupt others
  + Easily distracted and poor concentration
  + Impulsive and can’t always recognize minor risks or potential issues
* Beth’s sleep has improved, but she is still only managing 5 hours per night on average. This is less than she needs, so fatigue is also impacting on her mental state

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

* Female in her early – mid 30s
* Average height / weight
* Brightly coloured clothes and lots of jewellery (?coloured hair)
* Strong make up

**Social history**

* Youngest of four children. Older brothers (James & William) and older sister (Kelly). Mother and father still live on the farm in the Wimmera where Beth grew up, approximately five hours from Melbourne.
* Father, Alex, still works full time on family farm, and is in good health
* Mother, Louisa, has long history of being ‘nervous’ (although no formal diagnosis), and spends all of her time at the farm.
* James works with his father, Alex , and is set to take over the farm in the coming year when Alex retires.
* William is the local vet in their hometown, and married with three children
* Kelly is married to another local farmer, and has five young children.
* Beth reports always feeling like an ‘outsider’ and a ‘rebel’, and described a lot of tension between herself and her father when they were growing up. She got along better with her mother, but says ‘mum always had issues of her own’.
* James and William have ‘disowned’ Beth as they consider her to be ‘an embarrassment to the family’. However, she regularly communicates with Kelly via Skype and has stayed with her sister and her family during trips home.
* Beth has been in several long term relationships, but is currently single. She reports feeling happy being single, and has no wish to marry or have children in the longer term.
* Beth has a strong interest in art, particularly visual mediums such as screen printing and other forms of textiles. She originally came to the city to study fashion and design, and has worked (mostly on a freelance basis) in the arts community since graduating. Beth very much enjoys her work, although it doesn’t give her the financial stability she would like.
* Beth has come to the attention of police in each of her four manic episodes to date, due to her erratic behaviour during these times. Charges have been bought against her in the past for criminal damage, fraud (via use of stolen credit cards), public drunkenness and affray. However, in each case, the courts have chosen to dismiss charges when told of her mental ill health.

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

Current

**Activities of daily living**

* Beth is independently completing all personal activities of daily living, and is particularly interested in maintaining her appearance and grooming.
* Beth’s participation in domestic activities of daily living is variable, as she completes all required tasks some days, but none at all on other days.
* Beth is struggling to participate in community activities of daily living, as she is irritated by having to deal with other people and finds shopping, banking etc. quite overwhelming and tiring at present.

**Leisure/interests**

* Beth is keenly interested in all forms of the arts, and spends her weekends visiting galleries, and catching gigs and performances
* She also enjoys getting out into nature, and bushwalks on trails around the city outskirts whenever she has the chance
* Beth is keenly interested in current affairs, and has passionate views about refugees and migration

**Employment**

* Beth is currently unemployed, and claiming Disability Support Pension.
* She had been participating in a voluntary arts project with new arrivals to Australia up until one month ago, but stopped attending when her mental state deteriorated

**Transport**

* Beth does not own a car on ideological grounds, and is mobile using public transport and her bicycle only.

**Home**

* Beth lives in a bedsit apartment in an inner suburb of Melbourne. The apartment is part of large, older house, and there are several other co-tenants. She has access to a small kitchenette in her room, but no air conditioning or heating. There is a shared bathroom down the hall.
* Her apartment is full to the brim with her belongings, with just a single small path from the door to her bed and the kitchenette, through boxes and piles. Despite the clutter, it is a very colourful and clean space, and Beth has often expressed happiness about having ‘a place of her own’.

**Behaviour, affect and mannerisms**

* Very intense eye contact, and often reaches out to touch the person she’s talking to (i.e. hand on hand, pat on shoulder)
* Rapid speech but able to stop long enough for some interaction in conversation. Starts speaking before others have spoken and doesn’t always listen to questions – tends to go off on tangents.
* Emotionally warm and animated
* Fidgety and shifts position regularly, paces/sways a little when standing

**General Ideas**

* Beth recognizes that she’s been ‘unwell’ recently and wants to get better. However, she has some ambivalence about her recovery, as she believes her mania makes her more creative and productive.
* She would like to get back into the workforce to gain more financial resources, as financial security is very important to her. Beth would also like to be more skilled in managing her money, and put some safeguards in place so she doesn’t ‘lose it’ when becomes unwell.
* Beth feels somewhat isolated at present, as she lost track of (and alienated) many friends and acquaintances during her recent episode of mania. She would like to make more friends and ‘get out in my community’ more. She recognizes that without local family, she doesn’t have easy access to support in the community

**Concerns**

* Beth is worried about possible legal consequences from her most recent contact with the police
* She doesn’t feel confident about finding the sort of work she is most passionate about, but is unsure of what else she would like to do.
* Lives alone in a small housing department bedsit. Beth feels a little unsettled in her current accommodation, as several new tenants have arrived that have serious substance use issues. This leaves her feeling unsafe (particularly at night), but she doesn’t want to have to leave ‘her place’.
* She says she thought she would ‘outgrow’ her mania by now, and doesn’t understand why she keeps having episodes

**Expectations**

* To reconnect with friends and community connections to decrease feelings of isolation
* To find employment in the creative arts field
* To learn more about what ‘triggers’ her episodes of both depression and mania, and try to put in some preventative measures
* To feel safe and secure in her accommodation

**Key Stakeholders**

Abby Richards– Case Manager (OT)

Kelly Smith – Sister

Dr. Nisha Singh – GP (Has known Beth for a long time)

Zelda Jamieson – Project worker at Arts Project (Has already contacted Beth and asked her to return)

**Beth Baker: Arts Project Manager Briefing**

**1. Title**

Name: Zelda Jamieson

Position: Arts Project Worker

Contact: [Contact number]

Appointments:

[Insert date] [Insert time]

[Insert date] [Insert time]

**2. Summary/Overview**

You are a project worker at a community arts project for new arrivals to Australia. You know Beth from her previous voluntary work at the project, and you are very keen for her to return.

You are being interviewed today by second-year Occupational Therapy students who have been asked to develop an intervention plan for Beth Baker. Beth is 33 years old, and has recently returned to living in the community after an acute admission for mania (in the context of Type 1 bipolar disorder).

The nature of the interview today is for the students to gain a perspective of how Beth used to participate as a volunteer worker, and assess what would need to be put in place to enable this to re-commence.

**3. Learning objectives**

* Establish rapport and effectively elicit required information from a community worker
* Communicate with the community worker in an appropriately professional manner

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

* Conduct a telephone interview with the purpose of finding out how Beth used to participate as a volunteer worker, and assess what would need to be put in place to enable this to re-commence.

**5. Setting**

* You are at a community centre, and have just left a very successful session with new arrivals to Australia. You are phoning from your office, and keep being interrupted by people wanting to speak to you and ask where materials are.

***Specifically for the simulated person***

**6. Affect/behaviours**

* You are a gregarious, outgoing person who is very keen to talk about the program you lead
* You’re extremely keen to get Beth back into her volunteer role, and can’t think of any barriers which might get in the way
* You are a little irritated by the gradual return suggested by the caller, and get a little defensive on Beth’s behalf (as you believe the service may be holder her back).

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

* “We can’t wait to have Beth back – she’s the life and soul of our group”
* “Why can’t she just come back to her old hours right from the start – she’s a grown woman you know, she can look after herself”
* “Whatever’s happening for Beth, I can handle it”

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

**Ideas**

* Wants Beth to return to her previous volunteer hours (3 days a week for 2 hours a day) immediately
* Doesn’t see any barriers to Beth’s return to the role – doesn’t have a lot of information about her current state and isn’t aware she was in hospital for some time
* Feels sceptical about the usefulness of mental health services, and expresses the opinion that they hold people back from achieving what they want from life
* Very keen to take Beth ‘under her wing’ as she knows how to work with creative people and believes she has a lot of skill in this area

**Concerns**

* Worried that Beth is being ‘held back’ inappropriately from returning by other people’s concerns
* Beth has told her she is on medication, and Zelda is concerned that will dampen her creativity and lead her to be overly sedated
* Unsure what to tell the participants in the group, who have missed Beth and are asking about her
* Doesn’t want to give up Beth’s place as a volunteer to someone else, if she takes a long time to ‘get back up to speed’.

**Expectations**

* Expects Beth to step back into her role immediately, and participate at her previous level from the start
* Believes Beth will be very keen to continue in her volunteer role indefinitely, as she seems to get so much from it.

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

Beth came to the attention of police when she jumped on parked cars along both sides of a suburban street, causing considerable damage (dented roofs and smashed windows). When asked why she was behaving this way, she said she was just having fun and she would buy everyone a replacement car. Police took her to the local emergency department, and she was admitted to an inpatient psychiatric unit from there. Beth remained in hospital for three weeks until her mood stabilised. While she is still experiencing elevated mood, she has regained some insight into her mental state and wants to recover. The community team is currently visiting her on a daily basis, to monitor medication/mental state and support her re-engagement with daily activities.

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

* Beth has mental health issues, but Zelda questions how much of this is just due to her creative temperament
* Zelda has no other knowledge of Beth’s medical history

**11. Patient’s family history**

* Zelda has no knowledge of Beth’s family history

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

* Zelda was seeking Beth several times a week when she was volunteering, but hasn’t seen her face to face for over three months. She is aware that she has also been isolated from other staff at the community centre, but assumes she’s been in contact with her family and other friends.
* Believes that Beth has a lot of creative talent, but hasn’t considered that she may wish to have paid employment in the area.
* Would like to involve Beth in more of the activities of the community centre, but only on a voluntary basis.

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

* Very exuberant and talkative, particularly when discussing the great outcomes from her arts project. Zelda doesn’t always pick up when others are trying to ask her a question or re-enter the conversation.

**Beth Baker: Case Manager Briefing Notes**

**1. Title**

Name: Abby Richards

Position: Case Manager

Contact: [Contact number]

Appointments:

[Insert date] [Insert time]

[Insert date] [Insert time]

**2. Summary/Overview**

You are a case manager, and you are also a qualified occupational therapist. As you are not employed in a discipline specific role, you p to an occupational therapist for specialist assessment and support.

You are being interviewed today by second-year Occupational Therapy students who have been asked to develop an intervention plan for one of your patients Elizabeth (Beth) Baker. Beth is 33 years old, and has recently returned to living in the community after an acute admission for mania (in the context of Type 1 bipolar disorder).

The nature of the interview today is for the students to get a handover about Beth’s recovery to date, and your perspective on the provisional intervention plan.

**3. Learning objectives**

* Establish rapport and effectively elicit required information from the health professional
* Communicate with the case manager in an appropriately professional manner

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

* Conduct a telephone interview with the purpose of obtaining a handover about Beth Baker’s recovery to date, and feedback about the proposed intervention plan

**5. Setting**

* You are on ‘duty’ and have just returned from an intake assessment which ended in the patient becoming verbally (but not physically) aggressive. You still feel a little shaken by earlier events

***Specifically for the simulated person***

**6. Affect/behaviours**

* A little disorganised and flustered – need questions repeated a couple of times
* Happy that Beth will be seen by occupational therapy, and you disclose that you are also an occupational therapist
* Distracted towards the end by a colleague coming into your office and asking for you to return to the intake room

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

* “Thanks for calling. So you want to speak about Rosie…. oh no, sorry…. umm Beth, is that right?”
* “I know Beth wants to find work, but do you think that’s really the top priority at the moment?”
* “Beth seems really committed to knowing more about her early warning signs and what to do about them this time, which gives me hope”

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

**Ideas**

* Worked with Beth following her last relapse, but found her a bit unreliable in terms of following up on interventions
* Not convinced that Beth is ready to seek employment, and highlights that her accommodation concerns are more of a priority (in your opinion)
* Would also like OT to focus on building her financial skills, and you often have to arrange food parcels or free meals for her at short notice because she has run out of money
* Very keen for Beth to return to her voluntary work with the Arts program, as this was very supportive of her recovery in the past
* Asks which functional assessments have been carried out to formulate the draft intervention plan, and seeking a full report of these for Beth's records
* Knows that Beth is concerned about the possible legal consequences from her most recent contact with the police, but asks students to reassure her that it is all in hand

**Concerns**

* Worried that Beth is very socially isolated at the moment, which exacerbates both her loneliness and vulnerability
* Concerns that the proposed intervention plan may push Beth too far, too fast and doesn’t want to lose the positive momentum she feels has built in recent weeks
* Sees an opportunity for psychoeducation with Beth around her condition, but wants to ensure all workers are providing her with consistent information
* Unsure of Beth’s current alcohol use – thought she may be slightly inebriated when she last saw her, but couldn’t be sure.

**Expectations**

* Beth will have further episodes of both depression and mania in the future, but she will be able to enact a Wellness and Recovery Plan more promptly next time
* Beth will settle back into voluntary work in the short term, with paid employment a longer term goal

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

Beth came to the attention of police when she jumped on parked cars along both sides of a suburban street, causing considerable damage (dented roofs and smashed windows). When asked why she was behaving this way, she said she was just having fun and she would buy everyone a replacement car. Police took her to the local emergency department, and she was admitted to an inpatient psychiatric unit from there. Beth remained in hospital for three weeks until her mood stabilised. While she is still experiencing elevated mood, she has regained some insight into her mental state and wants to recover. The community team is currently visiting her on a daily basis, to monitor medication/mental state and support her re-engagement with daily activities.

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

* Diagnosed with bipolar disorder (Type 1) at the age of 23 (ten years ago)
* Classic migraines since puberty (fortnightly occurrence on average)
* Seasonal hay fever and uticaria – well controlled with antihistamines
* Binge pattern of alcohol use – two previous ED admissions as a result

**11. Patient’s family history**

* Mother had no formal diagnosis, but was always described as ‘nervous**’**

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

* Youngest of four children. Older brothers (James & William) and older sister (Kelly). Mother and father still live on the farm in the Wimmera where Beth grew up, approximately five hours from Melbourne. Regular phone contact with mother and sister, but less so with father and brothers
* Currently unemployed. Work history within creative field, and until recently a volunteer at an arts project with new arrivals to Australia.
* Lost much of her social network in the lead up to her most recent relapse, and has few close contacts at the moment. Spends much of her time out and about, as she feels insecure in her current accommodation. Engages in free arts events and exhibitions on a regular basis.

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

* N/A

**Beth Baker:**  **Sister Briefing Notes**

Name: Kelly Smith

Position: Sister

Contact: [Contact number]

Appointments:

[Insert date] [Insert time]

[Insert date] [Insert time]

**2. Summary/Overview**

You are the younger sister of Beth, and you share two older brothers.

You are being interviewed today by second-year Occupational Therapy students who have been asked to develop an intervention plan for your sister Beth Baker. Beth is 33 years old, and has recently returned to living in the community after an acute admission for mania (in the context of Type 1 bipolar disorder).

The nature of the interview today is for the students to gain a perspective of how Beth has been since her discharge from hospital, and your perspective on the provisional intervention plan.

**3. Learning objectives**

* Establish rapport and effectively elicit required information from a family member
* Communicate with the family member in an appropriately professional manner

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

* Conduct a telephone interview with the purpose of finding out more about Beth Baker’s family supports, and feedback about the proposed intervention plan

**5. Setting**

* You are at home, and need to go and pick up your kids from school soon

***Specifically for the simulated person***

**6. Affect/behaviours**

* You are a private person, and somewhat reticent to discuss your family with strangers
* Glad to hear Beth getting some assistance, but you’ve never heard of occupational therapy before
* Gradually get warmer and more forthcoming as the interview progresses

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

* “I should probably know this, but what’s an occupational therapist?”
* “Dad and the boys are really embarrassed by her – they thinks she’s just go no self-control”
* “I just want her to be happy, and to stay well”

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

**Ideas**

* Thinks it would be a good idea for Beth to find steady work and believes this might help her relationship with her father and brothers
* Would like to see Beth in their home town more often, as she really enjoys her visits
* Feels positive about what occupational therapy could offer, but is realistic about the fact that Beth will also need to play her part and engage
* Wonders if anyone is helping Beth with her ‘police troubles’ and wants to accompany Beth to court if she needs to appear
* Wants to know if there’s anywhere she could get more information about bipolar disorder, and discloses she worries that it could be ‘passed on’ to her children

**Concerns**

* Worried that Beth no longer makes an effort to contact her father or brothers anymore, and as a result very rarely speaks to her mother. This has been very distressing for their mother, and Kelly bears the brunt of this.
* Beth has told her she is currently on Seropax at the moment, and Kelly worries that she might become ‘addicted’ to this
* After becoming more forthcoming towards the end of the interview, expresses concerns about who will have access to the information she has disclosed in the phone call.
* Now that Beth is in her 30s, Kelly is losing hope that she will ever fully recovery and expresses her fear that things will always ‘go in a cycle’.

**Expectations**

* Hopes that Beth will get better, but believes she will continue to have episodes much the same as she always has
* Beth will settle back into her life as it was prior to her latest relapse, with very little change

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

Beth came to the attention of police when she jumped on parked cars along both sides of a suburban street, causing considerable damage (dented roofs and smashed windows). When asked why she was behaving this way, she said she was just having fun and she would buy everyone a replacement car. Police took her to the local emergency department, and she was admitted to an inpatient psychiatric unit from there. Beth remained in hospital for three weeks until her mood stabilised. While she is still experiencing elevated mood, she has regained some insight into her mental state and wants to recover. The community team is currently visiting her on a daily basis, to monitor medication/mental state and support her re-engagement with daily activities.

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

* Beth has had ‘mood problems’ since her late teens, but they good worse when she moved down to Melbourne
* Has migraines just like Kelly, although Beth’s seem to happen more frequently
* Periods when Beth doesn’t take good care of herself (i.e. drinking too much, not eating regularly), which happen both during relapses of her mood problems and at other times

**11. Patient’s family history**

* Mother had no formal diagnosis, but Kelly believes she experiences depression and anxiety
* Family stories of a cousin (of her mother’s generation) that ended up in an ‘asylum’, but Kelly doesn’t have any more details
* Close family during their childhood, but the siblings have drifted apart somewhat as they started families of their own or established careers. This is a source of some sadness for Kelly, but she says Beth doesn’t seem too bothered by it.

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

* Speaks to Kelly by Skype every week. Kelly gave her an old laptop and modem specifically for this purpose, as the thought that she might be less worried about her if she could ‘see her’.
* While the rest of the family is a bit disparaging of her Arts career, Kelly is very proud of Beth’s creative work and says she wishes she had her talent
* Wishes Beth had more regular activities, as she thinks some of the issues Beth has faced have been made worse by boredom.

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

Slightly slower pace of speech, as may be found in people from rural communities

**Beth Baker: OT Activities & Props**

**Sub groups**

|  |  |  |
| --- | --- | --- |
|  | **Observed tasks in university setting**  **With patient** | **Activities in a shopping centre**  **Without patient** |
| **Group A** | Formulating a shopping list / meal plan for next 5 days | Visit local supermarket with shopping list |
| **Group B** | Sorting out bills, prioritizing which bills need to be paid first, budgeting for the payment of these bills, and planning to go to Post Office to pay the bills | Visit a busy Post Office to pay the bills at lunch hour / busy time |
| **Group C** | Discussion with client about how to manage shortfall in budget with regard to food, e.g., checking on line for food parcels, vouchers or free meals via soup kitchen etc. | Go to local free food agencies |

**Group A**

|  |  |
| --- | --- |
| **On campus requirements**  Beth has just $70.00 left until her next payment (in five days’ time), and needs to do her shopping. She needs to think about what she has to buy, and whether she’ll be able to afford it on her budget.   * Kitchen setting (to prompt her thinking about making a list) * Catalogues for local shops / vouchers from magazines or leaflets * Pen and paper, or mobile phone to make list | **Off campus requirements**  Visit to a local supermarket with shopping list to complete an environmental assessment. Aspects to consider include:   * How much social interaction will Beth need to negotiate to buy her items? * What aspects of the environment will enable her to remain on task and what could be potentially distracting? * How will Beth transport her items once purchased? |

**Group B**

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| **On campus requirements**  Beth has been putting off paying a series of utility bills, but they are all now past due and she is receiving final notices. While she has access to online banking (via the old second hand laptop and dongle modem), she prefers to pay her bills in person at the post office. She needs to prioritise which bills need to be paid first, budget to ensure they can be paid and plan to get to the post office.   * Several overdue utility bills * Bank book / bank statement showing current balance | **Off campus requirements**  Visit to the local post office at a busy time (i.e. lunch time) with bills to complete an environmental assessment. Aspects to consider include:   * What will Beth have to prepare to bring to the branch to complete her bill payments? * What aspects of the environment will enable her to remain on task and what could be potentially distracting or distressing? * What are the advantages / disadvantages of paying in person for Beth, in comparison to online banking? * What could you do as an OT to support Beth use financial services (both branch and online)? |

**Group C**

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| **On campus requirements**  Beth often runs out of money prior to her next payment, and doesn’t always have enough left for food. She is discussing this ongoing issue, and trying to problem solve how she can manage it better in future.   * Leaflets / information about food services (i.e. food bank, parcels, vouchers, free meals) * Tools for budgeting (i.e. planners etc.) * Pen and paper | **Off campus requirements**  Visit to local free food agencies, to assess their accessibility. Aspects to consider include:   * Is Beth eligible for their service, and if so what information does she need to provide to access it? * What aspects of the environment will enable her to remain on task and what could be potentially distracting or distressing? * Assuming Beth requires some assistance, how would she deal with making the necessary arrangements or waiting? * What could you do as an OT to support Beth improve her budgeting and financial management? |

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| **Occupational Therapy**  **Referral Form** | **Surname:** Baker    **Given Name:** Elizabeth **DOB:** 08/07/1982 **Sex:** F  **Address:**  7/219 Caldwell Street, Insert suburb |

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| **Referred from** | Sarah Brown (Inpatient OT) | | **Referred to** | Abby Richards (Case Manager) |
| **Interpreter Required:**  Yes  No  **Language:** | | | | |
| **Diagnosis:** Bipolar Disorder (Type I), migraines, seasonal hayfever and uticaria | | | | |
| **Social Situation:** Lives alone in a public housing bedsit. Stable accommodation, but has some security  **Occupational Therapy Referral Form** | | | | |
| concerns due to the behaviour of some fellow tenants. | | | | |
| **Home Assessment Completed:** Yes  No  Required | | | | |
| **Equipment Provided:** Not applicable | | | | |
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| **Current Occupational Performance** | | | | |
| **PADLS:** Independent and completing regularly | | | | |
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| **DADLS:** Completing sporadically – has the skills but cannot always maintain concentration. | | | | |
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| **Mobility/Transfers (Including Aid):** Independent with no mobility aids | | | | |
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| **Referral Goals** | | | | |
| 1. Improve sleep hygiene and balanced patterns of activity / rest | | | | |
| 1. Improve performance of DADL’s (including money management) | | | | |
| 1. Improve performance of CADL’s (including banking and shopping) | | | | |
| 1. Explore possibilities for employment and other productive activities | | | | |
| 1. Improve social network and inclusion in the local community | | | | |
| **Therapist:**  *S. Brown* | | **Date:** *date* | **Consent Obtained:**  Yes  No | |

