Mental Health Nursing Case Study: First Episode Psychosis and Recovery-Oriented Care

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Standards: NMBA RN Standards (2016) | National Framework for Recovery-Oriented Mental Health Services (2013)

Jurisdiction: Victoria, Australia

SECTION 1

1. Introduction

Mental health nursing in Australia is underpinned by a commitment to person-centred, recovery-oriented practice that respects the dignity, rights, and autonomy of every individual who accesses mental health services (National Mental Health Commission, 2023). The shift from custodial, biomedical models of care to recovery-oriented frameworks has fundamentally reshaped how Australian mental health nurses conceptualise their role — from managing symptoms to supporting individuals in building meaningful, self-directed lives despite the ongoing presence of mental illness (Department of Health and Aged Care, 2022). This case study examines the nursing care of Mr Liam Carter (fictitious), a 24-year-old male presenting with first episode psychosis (FEP), exploring comprehensive mental state examination, risk assessment, priority nursing interventions, and recovery-oriented discharge planning aligned with the Victorian *Mental Health and Wellbeing Act 2022* and the NMBA Registered Nurse Standards for Practice (2016).

SECTION 2

2. Clinical Presentation and Background

Mr Liam Carter is a 24-year-old male engineering student who was brought to the inpatient mental health unit by his parents following a two-week period of social withdrawal, deteriorating self-care,

and increasingly disorganised behaviour. His parents reported that he had ceased attending university approximately three months prior, had stopped engaging with friends and family, and had become preoccupied with the belief that university staff were monitoring his movements via his mobile phone. He had not slept consistently in four days. Mr Carter consented to voluntary admission, stating: *"I don't feel safe at home but I don't really know why I'm here."*

His past medical history was unremarkable, with no prior contact with mental health services. A maternal aunt had a documented diagnosis of schizophrenia. Mr Carter reported occasional cannabis use approximately six months prior, which he had since ceased. He denied use of alcohol or other substances. He was not taking any prescribed medications at the time of admission. Collateral history from his parents confirmed a three-to-four month prodromal period of declining academic performance, social isolation, and progressive disorganisation of thought — changes they had attributed to academic stress until his behaviour became more overtly unusual.

SECTION 3

3. Mental Status Examination (MSE)

A structured Mental Status Examination (MSE) was completed on admission in a calm, private setting to minimise distress, consistent with the principles of person-centred assessment described by Hungerford et al. (2023). Findings are summarised in Table 1.

MSE Domain	Finding	Clinical Relevance
Appearance	Unkempt; wearing multiple layers of clothing despite warm ambient temperature; poor eye contact; body odour noted	Suggests self-care deficit and possible responding to internal stimuli
Behaviour	Agitated and guarded; intermittently glanced towards corner of room; turned phone face-down when nurse entered	Behaviour consistent with responding to auditory hallucinations and paranoid ideation
Speech	Normal rate and volume; poverty of content; occasional tangential responses; episodes of thought blocking	Disorganised thought form typical of psychotic episode
Mood / Affect	Subjective mood: "frightened"; objective affect: constricted, fearful; no euphoria or depression identified	Fear response expected in FEP; rules out manic or depressive episode as primary presentation
Thought Content	Paranoid delusions (surveillance by university staff via phone); ideas of reference (news reader "speaking directly to him")	Fixed, false beliefs not amenable to logical challenge — primary psychotic features
Perceptions	Auditory hallucinations confirmed: voices commenting in third person and occasional command hallucinations ("don't trust them")	Command hallucinations increase risk; require close monitoring and safety planning
Cognition	Orientated to person, place, and time; concentration markedly impaired; serial 7s failed at first subtraction	Cognitive disruption secondary to psychosis; baseline MMSE/ MoCA documented
Insight / Judgement	Limited insight: acknowledges "something is wrong" but rejects illness attribution; judgement impaired (planned to remove SIM card to "stop the monitoring")	Limited insight is a common feature of FEP and has implications for medication adherence and engagement

FEP = first episode psychosis; MMSE = Mini-Mental State Examination; MoCA = Montreal Cognitive Assessment.

SECTION 4

4. Risk Assessment

Comprehensive risk assessment is a foundational obligation of mental health nursing practice and must be conducted in a structured, systematic manner at every point of contact (Meadows et al., 2022). The assessment for Mr Carter was conducted using a biopsychosocial framework, incorporating the HoNOS (Health of the Nation Outcome Scales) as the standardised clinical instrument used within the unit, consistent with AIHW (2023) recommendations for routine outcome measurement in Australian mental health services.

> **Risk Summary — Mr Liam Carter:**
> **Suicide:** Low-moderate. Passive death wishes present ("Sometimes I think it would be easier to not exist") with no active suicidal ideation, no plan, and no intent. Protective factors include strong family support, future orientation (expressed desire to complete his degree), and engagement with the admitting nurse.
>
> **Self-harm:** No current self-harm behaviour or intent identified.
>
> **Harm to others:** Low. No specific threats to any identifiable person. Command hallucinations are present but Mr Carter reports resisting commands. Risk to be monitored closely with any increase in command hallucination frequency or intensity.
>
> **Vulnerability:** High. Lives alone in student accommodation; limited social network; limited insight; poor self-care; command hallucinations; sleep deprivation. Involuntary treatment order not currently required but threshold criteria remain under review per the *Mental Health and Wellbeing Act 2022* (Vic).

Risk is not static and must be re-evaluated at every nursing handover and following any significant clinical change (Hungerford et al., 2023). The safety plan was co-developed with Mr Carter and his family, incorporating agreed-upon warning signs, coping strategies, and emergency contact details consistent with the principle of least restrictive care (Mental Health and Wellbeing Act 2022 (Vic), s. 11).

FIGURE 1 — CHIME RECOVERY FRAMEWORK (LEAMY ET AL., 2011) APPLIED TO MR CARTER'S CARE

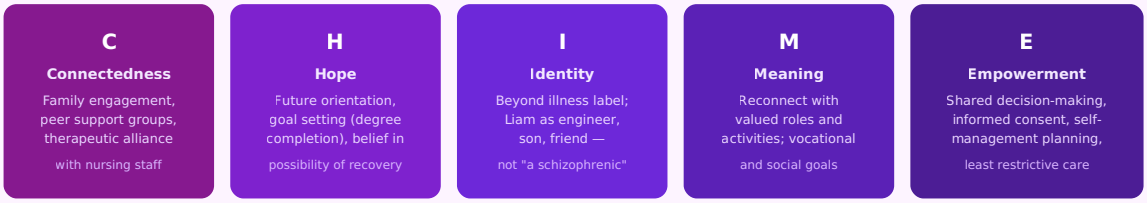

Figure 1: The CHIME Framework (Leamy et al., 2011) applied to recovery-oriented nursing care for Mr Liam Carter. Each domain informs a specific aspect of the nursing care plan, from therapeutic alliance-building to discharge goal-setting. CHIME = Connectedness, Hope, Identity, Meaning, Empowerment.

SECTION 5

5. Priority Nursing Interventions

5.1 Developing a Therapeutic Relationship

The therapeutic nurse-consumer relationship is the foundational intervention in mental health nursing and the primary vehicle through which all other care is delivered (Shattell, Starr and Thomas, 2022). For Mr Carter, who presented with significant paranoia and limited trust, building a therapeutic alliance required deliberate, consistent, and non-threatening communication. The nurse assigned consistency (same nurse across shifts where possible), used open, non-confrontational body language, avoided challenging his delusional beliefs directly, and employed Rogerian core conditions — genuineness, unconditional positive regard, and empathy — to establish a safe relational environment (Hungerford et al., 2023).

Critically, therapeutic communication in the context of psychosis requires the nurse to neither reinforce nor directly challenge delusional content, but instead to acknowledge the consumer's emotional experience: *"It sounds like you have been feeling very frightened — that must be exhausting."* This approach validates distress without colluding with the delusion, preserves the therapeutic alliance, and is consistent with the NMBA Standard 2 — therapeutic and professional relationships (NMBA, 2016).

5.2 Medication Administration and Monitoring

In collaboration with the treating psychiatrist, Mr Carter was commenced on risperidone 2 mg nocte, titrated gradually in accordance with Orygen's first episode psychosis clinical practice guidelines

(Orygen, 2023). Nurses administered oral medication under direct observation and documented administration contemporaneously. Key nursing responsibilities included monitoring for and educating Mr Carter about common side effects — extrapyramidal symptoms (EPS), somnolence, orthostatic hypotension, and metabolic effects including weight gain — and conducting baseline and regular monitoring of blood glucose, fasting lipids, and weight (Orygen, 2023). Given Mr Carter's limited insight and ambivalence about medication, motivational interviewing techniques were integrated into medication education conversations to support adherence without coercion, consistent with the least restrictive practice principles of the *Mental Health and Wellbeing Act 2022* (Vic).

5.3 Observation, Safety Monitoring, and Environmental Safety

Given the presence of command hallucinations and a low-moderate suicide risk, Mr Carter was placed on Level 2 nursing observations (30-minute checks) on admission, with the plan to de-escalate to hourly observations as clinical status improved. The inpatient environment was reviewed for ligature risks and access to potential implements of self-harm. Mr Carter was oriented to the unit, introduced to the multidisciplinary team, and the rationale for observations was explained in plain language and documented in the care record (ACSQHC, 2023). Sleep monitoring was prioritised given the four-day sleep deprivation, with a non-pharmacological sleep hygiene protocol initiated, supplemented by low-dose pharmacotherapy as prescribed.

5.4 Consumer and Carer Education and Engagement

With Mr Carter's consent, his parents were engaged as active partners in his care. A structured family meeting was convened with the social worker and nurse facilitating, providing psychoeducation about FEP, the likely treatment pathway, realistic recovery expectations, and strategies for supporting their son without inadvertently reinforcing psychotic experiences. The Orygen booklet *Early Psychosis: A Guide for Families* was provided (Orygen, 2023). Mr Carter himself was provided with accessible consumer information about psychosis, his prescribed medication, and his rights as a voluntary consumer under the *Mental Health and Wellbeing Act 2022* (Vic), including the right to access an independent mental health advocate.

SECTION 6

6. Recovery-Oriented Practice and Discharge Planning

Australia's National Framework for Recovery-Oriented Mental Health Services (COAG Health Council, 2017) defines recovery not as the absence of symptoms but as a deeply personal journey

towards a self-defined, meaningful life. For Mr Carter, recovery-oriented nursing practice meant consistently positioning him as the expert on his own experience, using language that centred his identity beyond his illness ("engineering student navigating a mental health challenge" rather than "a schizophrenic patient"), and co-designing the discharge plan around his own stated goals.

The CHIME framework (Leamy et al., 2011) — Connectedness, Hope, Identity, Meaning, Empowerment — provided the conceptual structure for care planning beyond symptom stabilisation (Figure 1). Discharge planning commenced on day three of admission and included: referral to the Orygen headspace Early Psychosis Program for ongoing community-based recovery support; a comprehensive medication management plan including written instructions and a follow-up psychiatry appointment within one week; a WRAP (Wellness Recovery Action Plan) co-authored with Mr Carter; a return-to-study plan in liaison with the university's disability and inclusion service; and a safety plan reviewed and signed by Mr Carter and his parents. Connection to an NDIS early intervention pathway was also discussed, with referral to the hospital's NDIS navigator for assessment.

> **Key Recovery Principles Operationalised in Mr Carter's Care:**
> Person-first language used consistently | Voluntary status maintained throughout | Goals set by Mr Carter, not for him | Family engaged with consent and in supportive (not surveillance) role | Discharge plan co-produced with consumer and family | Transition to least restrictive community support (Orygen Early Psychosis Program)

SECTION 7

7. Legal and Ethical Considerations

Mr Carter's care was governed by the *Mental Health and Wellbeing Act 2022* (Vic), which establishes legally enforceable principles including least restrictive practice, supported decision-making, and the right of the consumer to participate in all decisions about their treatment (s.11). As a voluntary consumer, Mr Carter retained the right to refuse treatment, a tension that required ongoing skilled nursing negotiation rather than coercion. The Act also confers rights on nominated support persons (his parents, by consent), including the right to be notified of treatment decisions where the consumer agrees. The ethical obligations of beneficence (acting in Mr Carter's best interests), non-maleficence (avoiding harm through unnecessary restriction), and autonomy (respecting his right to make decisions) were balanced through ongoing, documented clinical reasoning (NMBA, 2016).

SECTION 8

8. Conclusion

This case study has demonstrated the application of evidence-based, recovery-oriented mental health nursing practice to the care of Mr Liam Carter, a 24-year-old male presenting with first episode psychosis. Through comprehensive mental state examination, structured risk assessment, and a therapeutic relationship grounded in Rogerian principles, priority nursing interventions were identified and implemented in accordance with the NMBA Standards for Practice (2016), the *Mental Health and Wellbeing Act 2022* (Vic), and the National Framework for Recovery-Oriented Mental Health Services (COAG Health Council, 2017). The integration of the CHIME recovery framework into discharge planning ensured that care extended beyond symptom stabilisation to encompass the consumer's self-defined recovery journey. This case illustrates that distinction-level mental health nursing practice demands not only clinical competence but a fundamentally different relational posture — one that positions the consumer as the primary agent of their own recovery.

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