ACI NSW Agency for Clinical Innovation

NSW SSCIS NSW State Spinal Cord Injury Service

PRINCE OF WALES HOSPITAL FOUNDATION

EMOTIONAL WELLBEING TOOLKIT

A Clinician's Guide to

Working with Spinal Cord Injury

NSW State Spinal Cord Injury Service

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This resource has been presented to and reviewed by delegates at the Annual Scientific Meetings of the Australian and New Zealand Spinal Cord Society in 2013 and 2014 and at the Spinal Core Course, Royal North Shore Hospital, Sydney in 2014 and 2015 .

DISCLAIMER

The information in this guide is intended as a general reference guide to help those working with adults with a spinal cord injury (SCI) understand psychosocial issues and screen for suspected psychological difficulties.

The NSW State Spinal Cord Injury Service (SSCIS) Psychosocial Strategy makes this information available on the basis that additional professional advice should be sought when there is concern about the mental health status of a client. While there are recommended assessment tools, this guide in no way takes the place of a full mental health assessment. Due to the general nature of some aspects of the guide, the diverse nature of the SCI population, and the diversity of the situations in which challenging behaviours may arise, this guide may not be appropriate in all situations.

NSW SSCIS Psychosocial Strategy accepts no legal liability arising from any loss (including financial loss, damage, injury or death) suffered by any person acting on or relying on information in the guide or omitted from it. Users should always obtain professional advice relevant to their particular circumstances.

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Foreword

Spinal cord injury is a complex presentation from both a medical and psychological perspective. The NSW State Spinal Cord Injury Service (SSCIS) established the Psychosocial Strategy to advocate for the importance of psychosocial issues for those adjusting to and living with a spinal cord injury.

Psychosocial issues are integral and central to rehabilitation practice. Psychosocial issues are 'everyone's business', not just the domain of social workers, psychologists and psychiatrists.

Every interaction that every staff member has with a client provides an opportunity to either hinder or enhance the client's adjustment to injury. Crises present particular opportunities for staff to positively influence coping ability and mental health, as they provide an opportunity for psychological growth through successful mastery.[1] A relatively minor intervention in a crisis may significantly help someone with a spinal cord injury to adjust or cope.

The Psychosocial Strategy has led to the development of this resource, which is designed to educate and provide guidance to all staff working with people with a spinal cord injury who are experiencing difficulties. The Toolkit is an evidence-based resource containing validated and standardised tools. The intention is for all staff to improve their understanding of psychosocial issues and to understand the critical role they play in assisting their clients in crises and with long-term adjustment; it is not intended that all staff be trained as mental health workers.

Psychosocial issues are 'everyone's business' in the care of people with spinal cord injury.

Overview and Purpose

This Toolkit provides information and tips for understanding and managing psychosocial issues associated with acute and long-term spinal cord injury.

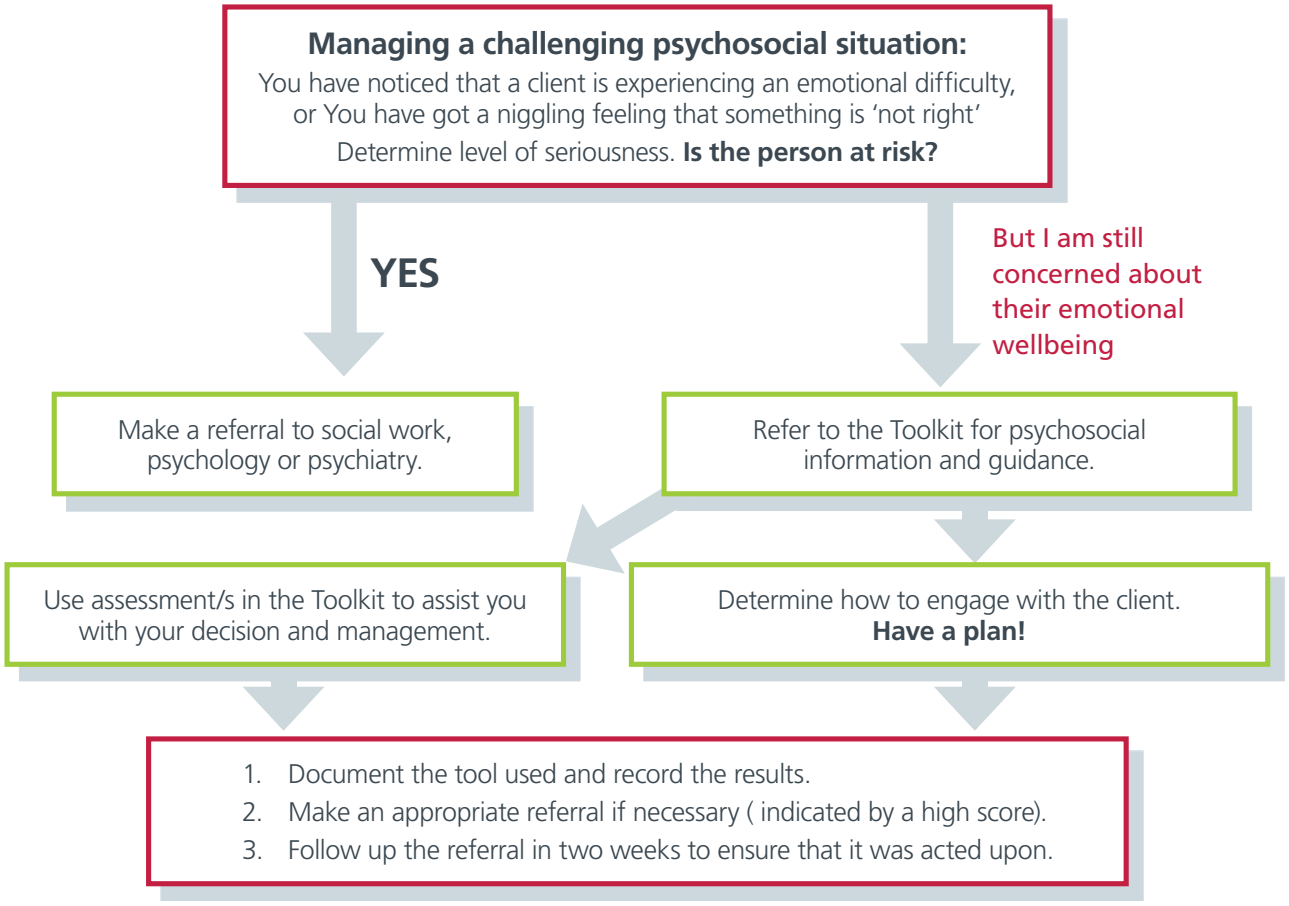
Topics include:

- Grief and trauma
- Common psychological and emotional problems (for example, depression, anxiety, alcohol and other drug use, self-harm and suicidal thoughts) experienced by people who have suffered a spinal cord injury
- Ideas for managing challenging behaviours

Brief standardised screening questions are included in each section to assist you with your assessment and offer you some ideas that might guide your psychosocial practice.

The Toolkit can be used for general information, guidance and ideas or:

- when you are concerned about a client's psychosocial presentation, conversation or ideas
- when you need more information before deciding whether to refer a client to a specialist practitioner



Psychosocial Adjustment and Grieving

Psychosocial adjustment

Psychosocial adjustment to a spinal cord injury considers both the psychological (cognitive, behavioural and emotional) and the social (family, community, cultural, environmental and spiritual) factors.

Many interacting aspects of a person's life effect the adjustment process, including medical, physical, psychological, social, environmental, cultural and community factors.

It is important to distinguish between normal grieving and depression following an acute spinal cord injury.

Reactions to spinal cord injury: normal grieving vs depression

- In the acute phase following a spinal cord injury, an individual attempts to make sense of what has happened to them. They think about how the injury will affect their lives, their view of themselves and their future role within their family, their work and their social network.
- Each individual will respond differently to a spinal cord injury.
- It is normal, expected and appropriate for people to experience a range of emotions, including shock, grief, denial, anxiety, helplessness and immense sadness and anger.
- The intensity, sequence, duration and expression of these emotions will vary – there is no common pattern or correct sequence of emotional responses, no 'right' or 'wrong' and no 'correct time for experiencing any given emotion.
- Major depressive disorder is not a normal, necessary or essential part of the process of adjustment to a spinal cord injury; it indicates that the person is distressed and not coping well.
- The presence of depression is not related to the level or degree of injury.
- The grieving reaction may appear similar to depression but, unlike depression, will dissipate over time as the individual learns to live with his or her injury and impairment.
- Grieving may also present with physical complaints, preoccupation with a former self-image, feelings of guilt, anger or irritability and behavioural changes (such as avoiding social activity).

'The important distinction between mourning and depression is that people who are experiencing a grief reaction will be focused on loss, such as the paralysis and the accompanying secondary emotional reactions.

For example, the individual with SCI would bemoan the high dependence that comes with SCI and consequent altered quality of life. In reactive depression, the focus is self-critical, with feelings such as worthlessness, hopelessness, helplessness, and withdrawal from others.'[2]

Tips for dealing with a client with a spinal cord injury

It is helpful to …	It is unwise to …
✓ listen, empathise, give comfort and support	✗ think that you need to have any of the answers
✓ encourage a sense of hope	✗ rush to fill the silences
✓ let your client know it is okay to talk about painful things	✗ give advice
✓ help your client to make sense of their experiences and reassure them that what they are feeling is normal	✗ say 'don't worry', 'time is a great healer' and so on
✓ support your client to develop an understanding of their injury or illness and the process of rehabilitation	✗ avoid difficult conversations with your clients in case they become sad, distressed, angry or cry
✓ encourage your client to do things that they might enjoy	✗ assume that the person is always like this
✓ promote self-care activities	✗ assume that distress is a sign of character weakness, mental illness
✓ improve privacy for your client where possible	✗ end the conversation just because they are tearful
✓ keep the concerns of the client and their family at the centre of your care	✗ try to become a grief counsellor; refer the person to a mental health professional if necessary
✓ encourage your client to use their supports and acknowledge their personal resources	
✓ encourage opportunities for your client to contribute to decision-making and problem-solving	

Monitoring Mood and Anxiety

Tool 1: Patient Health Questionnaire-2 (PHQ-2) for Depression

If you feel concerned that your client's mood is low, they are communicating less and they don't seem to be able to enjoy anything, use the following questions from the PHQ-2[3] to test your concerns.

'Over the last 2 weeks how often have you been bothered by any of the following problems?'

	Not at all	Several days	More than half the days	Nearly every day
Having little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

Scores of ≥3 indicate increased risk of depression and should be investigated further by a mental health professional.

You should:

1. Document your use of the Depression (PHQ-2) and record the score.
2. If the score is 3 or higher, refer to a GP or mental health professional for further assessment.
3. Follow up the referral in two weeks.

It is often difficult to help someone who may be experiencing depression.

Tips:

It is helpful to …	It is unwise to …
✓ talk about how they are feeling	✗ rush your client
✓ be present while you attend to your client, maintain eye contact and remain relaxed	✗ present information too quickly
✓ listen to what they are saying without being judgemental	✗ overwhelm them with too much information
✓ be optimistic and reassuring	✗ pressure them to snap out of it, or cheer up
✓ allow a little extra time	✗ stay away and avoid them
✓ provide information in small chunks to avoid overwhelming	
✓ talk slowly when asking questions	
✓ acknowledge that they seem a bit 'flat'	
✓ check that you have understood what they have said	

Tool 2: Generalised Anxiety Disorder (GAD) Dcale for Anxiety

Some anxiety is expected following a spinal cord injury because the client is dealing with change and a lot of new situations and experiences. For some, the anxious feelings become overwhelming. An anxiety disorder is a serious condition, which disrupts the ability to cope from day to day. Anxiety reactions include:

- feeling tired constantly
- feelings of panic and tension
- difficulty explaining concerns or problems
- difficulty following your response
- getting angry or easily frustrated
- wanting to finish the discussion before the issue is solved.

If you are concerned about your client's level of anxiety you might ask the following questions from the GAD Scale.[4]

'Over the last 2 weeks, how often have you been bothered by any of the following problems?'

	Not at all	Several days	More than half the days	Nearly every day
Do you feel nervous, anxious, or on edge?	0	1	2	3
Have you found yourself not being able to stop or control worrying?	0	1	2	3

Scores of ≥3 indicate increased risk of depression and should be investigated further by a mental health professional.

You should:

1. Document your use of the GAD Scale and record the score obtained.
2. If the score is three or higher, refer to a GP or mental health professional for further assessment.
3. Follow up the referral in two weeks.

Tips:

It is helpful to …	It is unwise to …
✓ allow the person to take their time	✗ rush them
✓ use a calm and reassuring tone of voice	✗ interrupt with your assumptions about their problem (this can compound their anxiety or make them angry)
✓ acknowledge that it may be difficult for them to talk about their concerns	✗ use a tone of voice that suggests you are bored or irritated if they are unable to explain the situation
✓ listen carefully and ask questions to let them know that you want to work with them to resolve the situation	✗ show frustration if they are unable to make a decision

Tool 3: Primary Care Screen for Post-traumatic Stress Disorder

Many people become distressed after a traumatic event but most recover on their own. A few people remain distressed and anxious, and avoid reminders of the trauma. They may find it difficult to relax, have upsetting dreams or flashbacks of the incident, experience emotional numbing and a sense of helplessness. This may indicate that they have post-traumatic stress disorder (PTSD).

The following screen can be applied if you are concerned that an individual has PTSD.[5]

'In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

	Yes	No
Had nightmares or thoughts about it when you didn't want to?	1	0
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	1	0
Were constantly on guard, watchful, or easily startled?	1	0
Felt numb or detached from others, activities, or your surroundings?	1	0

Scores ≥ 3 indicate increased risk of PTSD and should be investigated further by a mental health professional.

You should:

1. Document your use of the PTSD Primary Care Screen and record the score obtained.
2. If the score is ≥ 3 or higher, refer to a GP or mental health professional for further assessment.
3. Follow up the referral in two weeks.

Tips:

It is helpful to …

- encourage your client to discuss their feelings with people who understand
- allow your client to talk; talking is a natural healing process and will assist with acceptance
- remind your client that they are safe now and that the event is over
- encourage relaxation: listening to music, meditation and progressive muscle relaxation or breathing exercises
- suggest your client writes about their feelings if they are unable to talk about them
- remind them that it is normal to feel rotten after an extremely stressful event, but suggest they remember their strengths because 'even though it is tough, you can deal with it'
- encourage your client to cut back on tea, coffee, chocolate, soft drinks and cigarettes, as these substances will increase feelings of anxiety
- discourage the use of drugs or alcohol as a way of coping as they can lead to more problems in the long term
- identify sources of support and facilitate support from others (such as partners, family, friends, work colleagues, peers); helpful social support is critical for improving one's ability to cope after a trauma

Tool 4: Pain Basic Data Set (short form)

Pain is a major problem affecting at least 65% of people with a spinal cord injury. Pain may have a serious impact on quality of life; affecting sleep, reducing a person's ability to look after themselves and causing low mood. Some types of pain, often called 'nerve pain', does not mean that there is anything being damaged, rather it is a symptom of change in the central nervous system.

Refer to The Spinal Cord Injury Pain Book. This is an excellent resource for pain management strategies in spinal cord injury.[6]

If you are concerned about the pain levels your client is reporting, the following questions may be useful to establish whether a referral or further investigation is necessary.[7]

Have you had any pain during the past week including today?

	Interference Nil ← → Extreme						
In general, how much has pain interfered with your day-to-day activities in the last week?	0	1	2	3	4	5	6
In general, how much has pain interfered with your overall mood in the past week?	0	1	2	3	4	5	6
In general, how much has pain interfered with your ability to get a good night's sleep?	0	1	2	3	4	5	6

You should:

1. Document your use of the Pain Basic Data Set, and record the score obtained.
2. Any report of interference with day-to-day activities, mood or sleep is significant and should be investigated further by an appropriate health professional.
3. Follow up the referral in two weeks.

Tips:

It is helpful to …
✓ encourage maintenance of regular activity despite the pain (talk to the doctor and physio about what is appropriate)
✓ help your client to break their activities into manageable chunks and plan for regular rest breaks
✓ encourage your client to plan ahead and prioritise activities so that they do what is most important and include enjoyable activities
✓ help your client to understand the benefit of establishing a regular pattern of pain medication use, rather than waiting until pain levels become high
✓ encourage planning for dealing with days when the pain is worse; share this information with family and carers so that they can help
✓ encourage your client to speak with a mental health professional about mindfulness; this is a simple and very effective strategy with proven benefits for neuropathic pain
✓ encourage avoidance of drugs or alcohol to cope with pain as this may lead to more problems in the long term, such as increased tolerance or dependence on substances

A multidisciplinary assessment is recommended to obtain a thorough understanding of the client's pain.

Psychosis

Tool 5: Psychotic Disorders Mini Screen

Are you worried about odd behaviour changes? If your client is confused, avoids people, or has developed delusional or strange ideas not shared by others, they may be experiencing a psychosis. It is important that a mental health professional such as a psychiatrist follows this up.

Refer to a medical officer if your client exhibits, or reports, any of the following symptoms, as they may indicate a psychotic disorder:

- stopped talking to family and friends
- has become afraid or suspicious for no reason
- poor sleep or is often awake much of the night
- developed strange ideas
- hearing voices no one else can hear
- believes they have special powers
- difficulty concentrating
- saying or writing things that don't make sense
- using alcohol or other drugs

If you are concerned about someone's behaviour you might ask the following questions.[8]

	Yes	No
Have you ever believed that people are spying on you, or that someone is plotting against you, or trying to hurt you?	1	0
Have you ever believed that people are reading your mind or can hear your thoughts, or that you can actually read someone's mind or hear what another person is thinking?	1	0

Scores ≥ 1 indicate increased risk of psychosis and should be investigated by a mental health professional.

You should:

1. Document your use of the Psychotic Disorders Mini Screen, and record the score obtained.
2. If the score is 1 or greater or two, refer to a GP or mental health professional for further assessment.
3. Follow up the referral in two weeks.

Tool 6: AUDIT–C for alcohol use

If you are concerned about alcohol consumption[9] ask the client to answer the questions in terms of 'standard drinks'. For example, one standard drink equals 100 ml sparkling or still wine, 425 ml (schooner) of light beer, 285 ml (middy) regular beer and 30 ml (nip) spirits.

.

100ml of @12% alcohol content **wine**

375ml of @2.7% alcohol (light) **beer**

375ml of @4.9% alcohol (heavy) **beer**

30ml of @40% alcohol **spirit**

	Score				
	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
How many standard drinks do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have six or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Scores ≥ 6-7 indicate an increased risk of harm and should be investigated further by a relevant health professional.

You should:

1. Document your use of the AUDIT–C and record the score obtained.
2. If the score is ≥6, refer to a GP or mental health professional for further assessment.
3. Follow up the referral in two weeks.

Tool 7: MINI Screen for Illicit Substance Use

If you are concerned about your client's behaviour, you might ask the following questions and/or use the following tool to guide a further referral:

- What are your prescribed medications?
- Are there times when you take more of these medications than prescribed? If so, how many do you take and can you tell me what was happening for you at the time?
- How frequently are you taking these additional meds?
- Do you use anything else on top of these medications?

You can also use the MINI Screen for Illicit Substance Use 8, by asking the following questions:

1. Explain that you are going to read them a list of street drugs or medicines.
2. In the past 12 months, did you take any of these drugs more than once, to get high, to feel better, or to change your mood? **YES/NO**

Circle each drug taken:

Stimulants	Amphetamines, 'speed', crystal meth, 'crack', Dexedrine, Ritalin, diet pills
Cocaine	Snorting, IV, freebase, crack, 'speedball'
Narcotics	Heroin, morphine, Dilaudid, opium, Demerol, methadone, codeine, Percodan, Darvon, OxyContin
Hallucinogens	LSD – 'acid', mescaline, peyote, PCP ('angel dust', 'peace pill'), psilocybin, STP, 'mushrooms', 'ecstasy', MDA, or MDMA, ketamine or "special k"
Inhalants	'Glue', ethyl chloride – 'rush', nitrous oxide – 'laughing gas', amyl or butyl nitrate," poppers"
Marijuana	Hashish – 'hash', THC – 'pot', 'grass', 'weed', 'reefer'
Tranquilizers	Quaalude, Seconal (reds), Valium, Xanax, Librium, Ativan, Dalmane, Halcion,

Scoring:

- Add up the number to which they respond Yes
- Score ≥ 1 indicates need for further investigation by a relevant health professional.

You should:

1. Document your use of the Illicit Drug Use: Mini Screen and record the score obtained.
2. If the score is one or higher, refer to a GP or mental health professional for further assessment.
3. Follow up the referral in two weeks.

Traumatic Brain Injury and Post-traumatic Amnesia

Traumatic brain injury

It is common for individuals with a spinal cord injury to also have sustained a traumatic brain injury (TBI). In most cases, this injury is mild but some people sustain a moderate to severe brain injury.

The short- and long-term effects of a traumatic brain injury will depend on the location in the brain and extent of the damage. Each person is different: their pre-injury personality, intelligence, education and other life factors will affect their recovery and long-term prognosis.

Some of the common short-term effects following a traumatic brain injury include:

Physical	Behavioural/Emotional	Cognitive
Balance problems	Anxiety	Difficulty concentrating
Blurred or double vision	Depression	Difficulty remembering
Dizziness	Difficulty falling asleep	Feeling 'in a fog' or 'dazed'
Headache	Drowsiness	Feeling 'slowed down'
Nausea	Fatigue	
Seeing stars or lights	Irritability	
Sensitivity to light or noise	Lethargy	
Tinnitus	Sleeping more than usual	
Vomiting		

Adapted from Willer and Leddy (2006)[10]

Post-traumatic amnesia

Post-traumatic amnesia (PTA)[11] means a loss of memory and an inability to create new memories following a head injury. The length of time someone is in post-traumatic amnesia is defined as the 'length of the time from moment of injury until continuous memory returns'. This includes any period of unconsciousness, confusion and disorientation. There is considerable evidence to suggest that longer periods of post-traumatic amnesia are associated with problems in cognition, motor ability, functional deficits and poorer prognosis.

Post-traumatic amnesia is characterised by one or more of the following symptoms

- Confusion, disorientatation and behavioural disturbances
- Reversed sleep/wake cycle
- Restlessness, thrashing, needing to wander
- Aggression and/or agitation
- Combative, for example, pulling at tubes
- Moaning, calling out, 'childlike' behaviour
- Disinhibited or inappropriate social behaviour
- Fear and paranoia
- Over-sensitivity to light
- Fatigue
- Decreased attention and/or concentration
- Fixation on a single topic
- Lack of continuous memory, for example day-to-day memory

Management of the clients in post-traumatic amnesia:

- Ensure a consistent team approach to create and maintain a non-stimulating, quiet and supportive environment.
- Create a familiar environment using objects and photos.
- Where possible, provide them with a single room that is safe and secure.
- Provide a quiet and calm environment.
- Reduce external stimuli: limit TV, radios, bright lights, loud noise and clutter.
- Create a consistent environment with routine and structure.
- Monitor visitors: restrict them to one or two at a time and for short periods.
- Do not allow the patient to become over-stimulated.

Understanding Suicide Ideas and Self-harm

Many people become distressed following a spinal cord injury, and thoughts of suicide are common as the individual attempts to process the reality of their injury. Individuals may think, or openly talk, of death or suicide (such as 'I'd rather be dead, I should have died in the accident, I have no life now, I can't cope like this I want to die'). While this can be extremely distressing for carers and staff, very few clients in the acute or rehab phase go on to suicide.

People considering suicide usually feel isolated and alone. They may feel that nobody can help them or understand their emotional pain. When they are unable to see any other way of dealing with their situation, suicide may seem like their only option. People considering suicide often give clues about their thoughts and feelings, such as talking about feeling hopeless, helpless or worthless. This may mean that they are thinking along the lines of: 'There's not much point going on', 'I might as well give up now', 'I've had enough' [5].

Tips:

It is important to …
✓ Be aware of suicidal thoughts
✓ take threats of self-harm seriously
✓ be aware of your organisation's protocol on managing threats of self-harm or suicide and the NSW Health Framework for suicide risk assessment and management for NSW Health staff[12]
✓ follow up a suspected suicide risk by asking if your client is feeling suicidal

The risk will not be increased by a professional asking about the possibility of suicide.

Tips:

It is helpful to …	It is unwise to …
✓ stay calm	✗ panic
✓ if there are indications that your client may be considering self-harm or suicide, ask directly 'Are you having any thoughts of harming or killing yourself?'	✗ sound shocked by anything they tell you
✓ if you are talking to them on the phone, find out where they are calling from and take down their name, phone number and where they are	✗ dismiss or belittle the problem
✓ indicate your concern and that you are prepared to listen (say 'I am worried about you and I want to help' or 'I'm concerned about what you are saying'). Take your time	✗ joke about suicide
✓ acknowledge their sadness and despair (say 'I can hear that you are very upset')	✗ try to cheer your client up
✓ accept what your client is telling you	✗ assume that the situation will resolve by itself
✓ let them know that you will need to let another professional know about what they have said to you in order to get them help	✗ keep it secret
✓ let them know you are unable to keep it a secret	
✓ if you are in anyway unsure about how to handle this, refer to a senior staff member/ colleague (say 'I'm not sure if I am the best person to help you any further. I think that (name of colleague) will be better able to help with your situation. If it's all right with you, I'll organise for them to see you/speak with you')	
✓ contact the 'on call' or liaison psychiatrist (inpatient facility) or the local community mental centre or crisis team	
✓ afterwards, debrief with your manager/ senior staff members and document it	
✓ follow your organisation's incident reporting guidelines relating to threats of suicide or other forms of self-harm	

Factors that help protect a client from self-harm or suicide include: strong perceived social supports, family cohesion, belonging to a group, having good coping and problem-solving skills, positive values and beliefs, and the ability to seek and access help.

Tips for Managing Challenging Behaviours

Our interactions with clients with spinal cord injuries occur in a variety of settings, such as acute and rehabilitation hospitals or in the community. No matter where the setting, these interactions can sometimes be very challenging.

Clients experience a wide range of emotions following a spinal cord injury, due to both physical and psychosocial factors, and may sometimes seem uncertain, unhappy and demanding. They may appear unreceptive and unwilling to hear or understand what you say and they may be antagonistic.

Here are some general tips to manage challenging behaviour:

- It is important to remember that all interactions between people are two-way, and each person is influenced by what the other says and how they react.
- Being aware of your own responses to the challenging behaviour is helpful.
- How you speak and what you say when you respond to challenging behaviour is important.
- Understanding the source of difficulty and the emotional reactions can be helpful.
- In difficult situations, knowing how to manage your own, and other people's, reactions will help you achieve positive outcomes.

An acronym **PEARLS** will assist with relationship building:

P	E	A	R	L	S
Partnership	**Empathy**	**Apology**	**Respect**	**Legitimisation**	**Support**
'Let's work together'	'that sounds hard'	'I am sorry for...'	'I appreciate you're...'	'Anyone would be...'	'I'll stick with you'

Socially inappropriate behaviour

It is helpful to …	It is unhelpful to …
✓ remain calm	✗ laugh or giggle
✓ redirect the client's attention to the task you are working on	✗ make jokes or dismissive comments that show you are paying attention to the behaviour
✓ if possible, ignore the behaviour by focusing on the task, not giving eye contact	✗ make derogatory comments that put the client down
✓ if the behaviour makes you uncomfortable, tell them immediately that it is unacceptable say I feel uncomfortable when you say that, please talk about the task	✗ make inappropriate comments yourself as this gives mixed messages
✓ set limits on your interaction by clearly stating that the behaviour is unacceptable (say 'Mr Smith, I don't think that behaviour is appropriate')	
✓ give attention to appropriate behaviour	
✓ talk to your supervisor or manager about what happened	
✓ follow your organisation's incident reporting guidelines	

Intoxication

It is helpful to …	It is unhelpful to …
✓ be patient	✗ ask them if they are drunk or on drugs
✓ listen to their concerns and provide brief information	✗ expect them to be rational
✓ minimise the number of people involved	✗ become angry or upset
✓ get backup if you feel you need it	
✓ assure them that you will talk about it later when everyone has calmed down	

Uncooperative behaviour

It is helpful to …	It is unhelpful to …
✓ listen first to understand your client's perspective and concerns	✗ let the person's attitude and concerns become your problem
✓ ask questions, such as 'What do you think is a fair way to deal with this situation?' or 'How can I help to resolve this problem?'	✗ become flustered
✓ let them know what you are able to do to help	✗ show your frustration in your gestures, voice tone and other signals
✓ if they continue to insist on something that is unreasonable or that you can't deliver, repeat this (gently yet firmly) several times until they hear you	✗ talk over the person
✓ use reasonable language and try to stay calm	✗ raise your voice or shout
✓ agree on an action plan that includes the things you will do and the things they need to do	✗ withhold items
✓ refer the person to your supervisor or manager if you are unable to resolve the problem	

Aggressive Behaviour

It is helpful to …	It is unhelpful to …
✓ let your client speak	✗ tell your client to calm down or 'get a grip'
✓ listen carefully to the reasons for their anger	✗ raise your voice
✓ to show you are listening carefully sit or squat to their wheelchair level, use nods, make eye contact, use a soft tone of voice, arms open	✗ interrupt
✓ acknowledge that they are upset or frustrated (say 'You seem to be quite upset')	✗ try to complete their sentences for them
✓ if applicable, apologise for errors made by your office or organisation	✗ promise something that you know you can't deliver
✓ show that you are listening by clearly summarising the complaint in your own words	✗ use the word 'but'
✓ assure them that you are interested in helping them to resolve the issue	✗ Ignore them
✓ ask questions (say 'Can you tell me a bit more about what happened?')	✗ Use punishment

Confusion and dementia

Confusion is related to loss of orientation (knowing where the person is, who they are, the time, the date) and is often accompanied by memory loss, and other cognitive changes.

It is helpful to …	It is unhelpful to …
✓ listen carefully with sincerity and understanding	✗ is confused
✓ reflect their emotion	✗ correct them
✓ speak softly and slowly (be mindful of hearing difficulties)	✗ patronise them as if talking to a child
✓ practice patience if the person is repeating themselves	✗ get angry and speak with a loud voice
✓ provide reassurance for as long as needed	✗ appear frustrated and agitated if they are struggling to make a decision
✓ be clear and simple with your instructions, and give them time to respond	
✓ ensure that the environment is quiet, reducing background noise and distractions	
✓ if they are struggling to comprehend you, find a family member or carer to assist	
✓ consider if they are more acutely confused than usual and may have behavioural changes it might be a delirium which is a serious medical illness, contact their GP to review their health immediately or go to the Emergency Dept of your local hospital	

Looking After Yourself

Looking after people with a spinal cord injury can be challenging and exhausting. Here are some tips to help you cope and increase your resilience:

- Keep things in perspective and maintain an optimistic outlook.
- Take care of your physical, social and personal needs.
- Strive to have good social networks and relationships that support you.
- Talk and debrief with colleagues, your team and your managers.
- Learn from your past successes and mistakes, and be flexible.
- Accept that change is a part of living.
- Accept self-responsibility; develop realistic goals for yourself.
- Broaden your horizons and be prepared for self-discovery.
- Make careful and considered decisions and act on them.

Access and use

- The Employee Assistance Program (EAP) is a valuable, free and confidential support service that assists all health employees with any organisational and/or personal issues.

  http://intranet.nslhd.health.nsw.gov.au/corpsupport/workforce/Pages/eap.aspx

- Better Access to Psychiatrist, Psychologist & General Practitioners through the Medicare Benefits Schedule (Better Access) is an initiative that provides Medicare rebates to anyone who wishes to access local allied mental health services provided by qualified GPs, eligible psychologists, social workers and occupational therapists.

  http://health.gov.au/internet/main/publishing.nsf/content/mental-ba-fact-pat

Your Contacts

- Consultant liaison psychiatrist _____
- Local counselling service _____
- Drugs and alcohol service _____
- AA/Al-Anon _____
- Local general practitioner _____
- Psychiatrist _____
- Psychologist _____
- Social worker _____
- Local community mental health crisis team _____
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Organisations

NSW Agency for Clinical Innovation (ACI)
http://www.aci.health.nsw.gov.au/networks/spinal-cord-injury
The following resources can be found on the website:

- Guide for health professionals on the psychosocial care of adults with a spinal cord injury
- Directory of information and support
- Psychological adjustment after spinal cord injury.

Mental health

- SANE Helpline on 1800 18 SANE (1800 18 7263), 9–5 weekdays, email helpline@sane.org
- Mental Health First Aid – www.mhfa.com.au
- Beyond Blue – beyondblue.org.au
- The Mood Gym – moodgym.anu.edu.au
- The Black Dog Institute – blackdoginstitute.org.au
- MindSpot – https://mindspot.org.au/

NSW State Spinal Cord Injury Service

- Psychosocial Strategy Coordinator
  Annalisa Dezarnaulds
  Ph: (02) 9382 5645
  Email: annalisa.dezarnaulds@health.nsw.gov.au

Never hesitate to speak to a psychosocial representative on your team.

Resources

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