STATE FORENSIC MENTAL HEALTH SERVICE
WESTERN AUSTRALIA

Clinical Protocol 1
Mental Health Assessment

Nurse Practitioner
Mental Health

October 2009

DISCLAIMER

The information provided in the Clinical Guideline is intended for information purposes only. Clinical Guidelines are designed to improve the quality of health care and decrease the use of unnecessary or harmful interventions. This Clinical Guideline has been developed by clinicians and researchers for use within the State Forensic Mental Health Service. It provides advice regarding care and management of patients presenting with mental illness in the criminal justice setting.

While every reasonable effort has been made to ensure the accuracy of this Clinical Guideline, no guarantee can be given that the information is free from error or omission. The recommendations do not indicate an exclusive course of action or serve as a definitive mode of patient care. Variations, which take into account individual circumstances, clinical judgement and patient choice, may also be appropriate. Users are strongly recommended to confirm by way of independent sources that the information contained within the Clinical Guideline is correct.

The information in this Clinical Guideline is **NOT** a substitute for correct diagnosis, treatment or the provision of advice by an appropriate health professional.

This Clinical Guideline may also include references to the quality of evidence used in its formulation. The Clinical Guideline also includes references to support the recommended care. Providing a reference to another source does not constitute an endorsement or approval of that source or any information, products or services offered through that source.

Acknowledgments

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Mental Health Assessment

The NPMH will provide comprehensive assessment, diagnosis, planning of therapeutic interventions, treatment, evaluation, consultation, education and support with a focus on capacity building with other health professionals whenever possible. Conducting a mental state assessment and taking a history will depend on the circumstances and symptoms of the prisoner. The NPMH will gather sufficient information to gain a clear picture of the patient's problem (Gournay and Rae 2000). There should also be a clear distinction between the mental health assessment of the NPMH and the diagnostic function of psychiatrists (Roberts & Whitehead 2002).

The NPMH will also utilise the HCR 20 risk assessment tool, which will indicate past risk of offending, current clinical status and future predicted risk.

The goals of assessment by NPMH are to:-

- Establish a therapeutic alliance with the patient;
- Collect valid data pertaining to the patients mental state from which a formulation can be made;
- Develop understanding of the patients problems;
- Develop a treatment or management plan in collaboration with the patient;
- Decrease the impact of psychiatric symptoms for the patient.

Pathology and Diagnostics

The NPMH will liaise with the prison GP to review any physical health problems of prisoners.

Complex and detailed physical health assessments are not part of the role of the Nurse Practitioner Mental Health. Where the NPMH identifies symptoms of a physical health problem, a referral to an appropriately qualified health professional such as a psychologist, speech pathologist, dietician, occupational therapist and medical specialist will occur.

It is necessary to exclude physical causes for symptoms as well as screen for factors that may impact on proposed treatment. These tests include full blood count, cholesterol and lipid screens, fasting blood sugar levels, insulin levels, thyroid function tests, liver function tests, renal function screening and serum levels of various medications. The NPMH will order the appropriate tests and where necessary consult with specialist colleagues. When results of investigations are outside the normal range, or raise any other issues of concerns, the NPMH will consult the appropriate health professional for interpretation.

Care will be guided by best practice and available evidence. Guidelines listed below will inform the NPMH's practice whenever possible. However, due to the dynamic and sometimes unclear nature of mental health presentations it is not always possible to access appropriate guidelines. In these circumstances the principles of providing care in accordance with recognised professional standards and within the competencies of the nurse practitioner will apply.
The following table will indicate the tests that the NPMH may request.

Diagnostic Tests

Clinical problem	Investigations	Range/ Result	Significance / Action
Alcoholism	Glutamyl transaminase (GGT) Aspartate aminotransferase (AST) Alanine aminotransferase (ALT) Mean Corpuscular Volume (MCV) (Average volume of a red blood cell)	0-60 u/l 5-55 u/l 5-55 u/l 77-88 u/l	↑ in alcohol abuse, cirrhosis, liver disease Look for AST proportionally higher than ALT ↑ In alcohol dependence secondary to anaemia.
Delirium	Blood cultures Electrolytes- Esp. K and Na Glucose (fasting blood sugar) Drug levels: Lithium carbonate Sodium valproate Carbemazepine	Positive K (3.5-5.0 mmol/l) Na (134-145 mmol/l) 3-5.4 mmol/l (<5.7) 0.5-1.2 mol/l 280-700 mmol/l 17-51 mmol/l	Indicates infection which could be the cause of delirium - Both↓ ↑associated with arrhythmia's if undiagnosed -Fluid balance ↓ Glucose associated with delirium, anxiety, panic and agitation. ↑ glucose associated with delirium Ataxia, slurred speech, confusion, stupor, seizures. Nausea and vomiting, sedation, drowsiness. Drowsiness, nausea and vomiting, constipation and diarrhoea.
Eating disorder	EUC (k, Ca, Mg, PO4) FBC, LFT Albumin/protein	Ca (2.15-2.55 mmol/l) Mg (.72-.92 mmol/l) PO4 (.6-1.3 mmol/l) Hb (130-170 g/l) WCC (4-10.9/l)	Dehydration and electrolyte imbalance demand immediate attention. Electrolytes- Arrhythmias, hydration. Consult staff specialist and dietician for guidance. Haemoglobin, White cell count Albumin- ↓ in malnutrition ↑ in dehydration. Urea – Dehydration (>10) Creatinine – Renal impairment (>110) Liver abnormalities common in malnutrition.

ECG **CXR**		A baseline ECG is recommended at the commencement of antipsychotic drug treatment. Additional ECG monitoring is required depending on risk factors
Glucose	3-5.4 mmol/l	Monitor fasting blood glucose when commencing or changing antipsychotic medication and then 3-6 monthly. For patients diagnosed with diabetes, HbA1c should be measured 3-6 months to monitor glycaemic control
Psychosis with inconsistent features	Drug induced psychosis. Urine drug screen (THC, amphetamines, cocaine). Consider HIV, syphilis screen	Can take several days for results. Can be arranged for a later date. Both can manifest with symptoms of psychosis and depression
Anxiety and mood disturbance.	Thyroid function test (TFT) Free T4 (9-19) TSH (0.40-4.00)-	Abnormalities can be associated with depression, anxiety, mania and psychosis.

(Kaplan and Saddock 1998; Beumont, Lowinger and Russell 1995; Sharp and Freeman 1993)

Risk Assessment

Patient management of risk of violence or aggression involves liaison with other team members / clinicians in devising an agreed plan of management Issues to consider when assessing risk and developing a plan:

- Supports that are available to the client;
- Any change in the level of functioning in general;
- Has the individual become more impulsive, distressed and desperate;
- Any drug and alcohol issues involved;
- Type of behaviour that deems the patient at risk;
- Is the patient motivated to avoid it?

(Maphosa, Slade and Thornicroft, 2000, pg 45).

Historical Clinical Risk 20 assessment tool

The Historical Clinical Risk 20 (HCR-20) is a risk assessment tool that is used within the SFMHS and focuses on violence risk assessment, clinical practice and predicated future risk (Webster, Douglas, Eaves, and Hart, 1997). The 'HCR-20' was named for the measures of 10 historical items 5 current clinical and 5 future predicted risk indicators, representing a blend of historical/static variables (those that are not subject to change over time) and dynamic variables (those that do change over time). The Historical scale focuses on past, mainly static risk factors, the C on current aspects of mental status and attitudes, and the Risk on future situational features that relate to the likelihood that an individual's level of risk can be managed.

The HCR-20 is a valid measure of violence for use with male offenders, forensic psychiatric patients, and civil psychiatric patients. Although most of the studies on the HCR-20 have been with men, currently there is support for the use of the instrument with women offenders and psychiatric patients. Studies have shown that higher scores on the HCR-20 relate to a greater incidence and frequency of violence than lower scores.

Studies within civil psychiatric, forensic psychiatric, general population inmates, mentally disordered inmates, and young offenders, conducted in Canada, Sweden, the Netherlands, Scotland, Germany, England and the United States, have found that HCR-20 scores relate to violence (Douglas, Webster, Hart, Eaves, & Ogloff, 2002; Ogloff & Davis, 2005).

The purpose of a risk assessment, and the role of most mental health professionals who work with clients or patients at risk for violence, is to better manage the individual's level of risk. A companion manual was published to accompany the HCR-20 to assist in consistency of rating; the scores are then formulated into a management plan. This is reviewed 3 monthly within the SFMHS (Douglas et al., 2002).

Table 1. The HCR-20 Violence Risk Assessment Scheme

Sub-scales	Risk items
Historical	Generally static risk factors
H1	Previous violence
H2	Young age at first violent incident
H3	Relationship instability
H4	Employment problems
H5	Substance use problems
H6	Major mental illness
H7	Psychopathy
H8	Early maladjustment
H9	Personality disorder
H10	Prior supervision failure
Clinical	Dynamic risk factors subject to change
C1	Lack of insight
C2	Negative attitudes
C3	Active symptoms of major mental illness
C4	Impulsivity
C5	Unresponsive to treatment
Risk Management	Dynamic risk management factors subject to change
R1	Plans lack feasibility
R2	Exposure to destabilisers
R3	Lack of personal support
R4	Noncompliance with remediation attempts
R5	Stress

Best Practice Evidence

The following coding system is used to specify the quality of the supporting evidence for the protocol for mental state assessment:

- **[A] Randomised clinical trial.** A study of an intervention in which the subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are blind to the assignments.
- **[B] Clinical trial.** A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet the standards for a randomised clinical trial.
- **[C] Cohort or longitudinal study.** A study in which subjects are prospectively followed over time without any specific intervention.
- **[D] Case – control study.** A study in which a group of patients and a group of control subjects are identified in the present and information about the subjects is pursued retrospectively or backwards in time.
- **[E] Review with secondary data analysis.** A structured analytic review of existing data. Eg. A meta-analysis or a decision analysis.
- **[F] Review.** A qualitative review and discussion of previously published literature without a qualitative synthesis of the data.
- **[G] Other.** Textbooks, expert opinion, case reports and other reports not included above.

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Mental health assessment process

Process	Action	References	Level of evidence-guidance
Mental State Assessment	• Appearance and behaviour – general appearance and dress. Self-care and cleanliness. Attitude to situation / manner of relating. motor behaviour • Speech – Rate, Volume, Pitch, Tone, Fluency, Quality of Articulation and Information. • Mood and affect – Mood – depressed, euphoric, suspicious, irritable. Affect – restricted, flattened, blunted, incongruous, perplexed. • Form of thought – Amount of thought and rate of production, continuity of ideas, disturbances in language and/or meaning. • Content of thought – Delusions, Suicidal Thoughts, Obsessions, Phobias, pre-occupations, Anti-social urges. • Perception – Hallucinations, Other perceptual disturbances (de-realisation, de-personalisation, heightened or dulled perception) • Insight – Extent of the patient's awareness of problem and current situation • Cognition – Level of consciousness, memory (immediate, recent, remote), orientation (time, place, person) concentration, abstract thinking.	Davis, 1997. IGDA Workgroup, WPA, 2003. Henshall, 1999. Laws & Rouse, 1996. New Zealand Guidelines Group, 2003. Orygen Research Centre, 2004. Brockington, 2004. Gomez, 1987. American Psychiatric Association, 1995. Muggli, E, 2002. Sompradit et al., 2002.	G G G F A, B, C, D F, G A G E

Patient History, Formulation and Presentation	• Presentation – The mode of referral or admission • Presenting medical illness and current mental health problem • Physical findings – significant findings on physical assessment • History of mental health problem – When did the problem start? Did any events precede the problem? How did it develop? What effect does the problem have on the patient's day-to-day functioning and ability to participate in their recovery? • Past Psychiatric History – A record of previous mental health problems and treatment and services involved previously in their care. • Medications – Current medications including alternative medicines. Recent changes to medications. Side – effects to current and past medications. Allergies. Compliance with medications. • Personal background – Family and personal history. • Alcohol and Other Drugs – type of alcohol / drugs and pattern of use. Amount and frequency of use. Psychological and social impact of drug use. • Sexual Health – Lifestyle and risk factors. Previous history of abuse, sexually transmitted diseases, sexual dysfunction and / or sexual orientation. • Medical History – Previous and current physical illnesses. • Forensic History – Previous and current offences and convictions. Bail or Parole Conditions. Pending legal matters. • Formulation – summary of presenting psychiatric signs and symptoms, historical data and significant physical illnesses.	Davis, 1997. IGDA Workgroup, WPA, 2003. Henshall, 1999. Laws & Rouse, 1996. New Zealand Guidelines Group, 2003. Orygen Research Centre, 2004. Brockington, 2004. Gomez, 1987.	G G G F A, B, C, D F, G A G

	• Management – Liaison with other health care team members to discuss risk factors and further information needed, investigations required and consultations with other services needed to plan comprehensive care. A psycho-social framework should be utilised to address such factors such as: - Psychiatric and / or physical phenomena - Functional performance - Relationships with family and significant others and the wider social environment - Interpersonal communication - Social resources		

Collaborative History and referral data	Wherever possible additional information should be sought. Liaison with the patient's • General practitioner • Case manager • Community mental health nurse • Psychiatrist • Family members or significant others To ensure clarification of the patient's history and reduce duplication of investigation and treatment.	Davis, 1997. IGDA Workgroup, WPA, 2003. Henshall, 1999. Laws & Rouse, 1996. New Zealand Guidelines Group, 2003.	G G G F A, B, C, D F, G
Risk Assessment	For 1. Self-harm / suicide Using risk assessment tool HCR 20 2. Aggression / harm to others	American Psychiatric Association, 2003. National Collaborating centre for Nursing and Supportive care, 2005.	D, E, F, G D, E, F, G

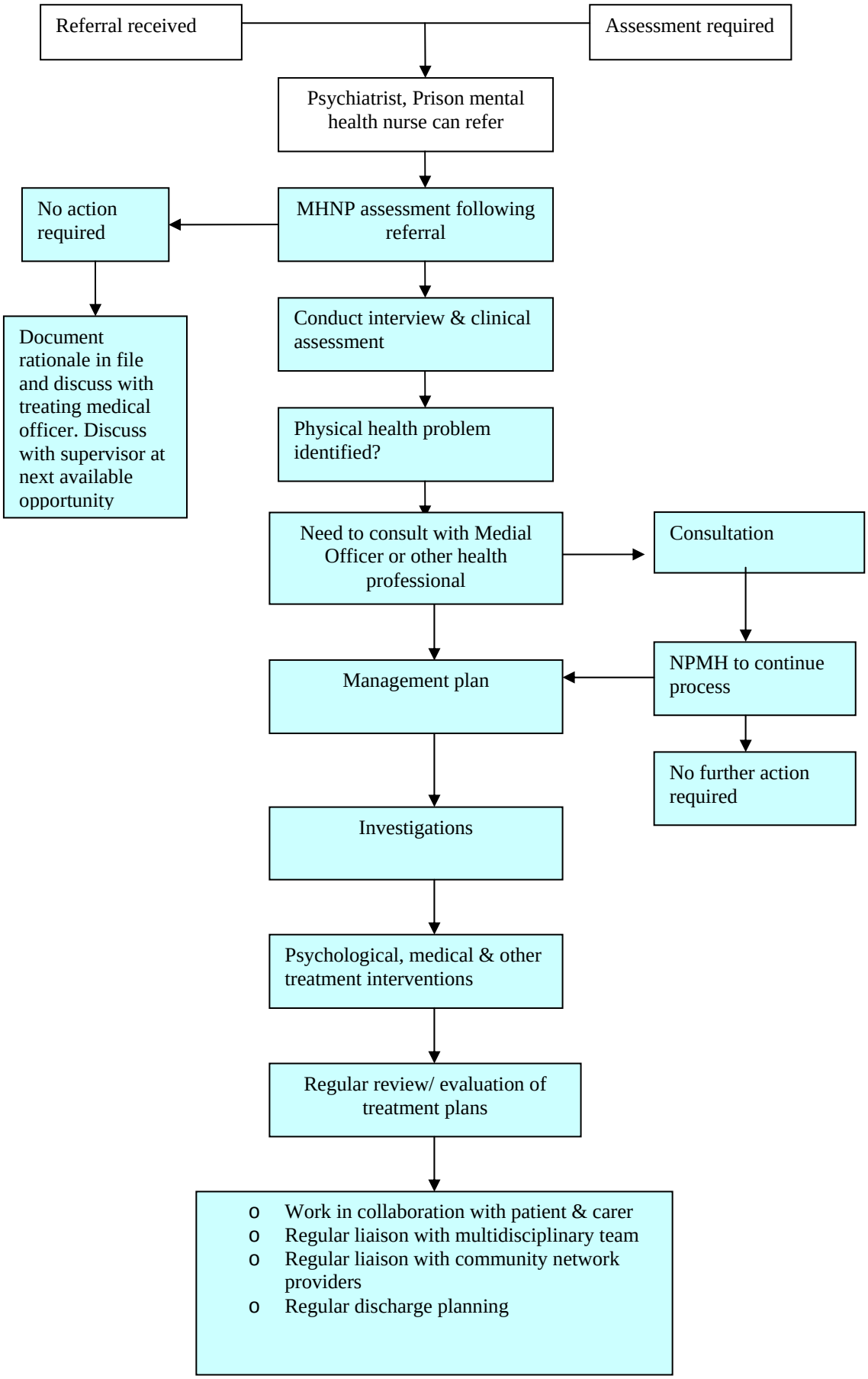
Legal Considerations	Awareness of the legal implications of caring for patients within a criminal justice setting. 1. Duty of care – The premise that all health professionals owe patients and other staff a duty of care is well accepted. It involves both *acts and omissions* meaning that liability can arise from a failure to act as it can from doing it and doing it badly. The justification for medical treatment against the patient's wishes is the common law duty of clinicians to provide whatever care is required to preserve life. The justification of treatment against the patient's will in an emergency is known as the concept of urgent necessity. Health professionals must balance need for emergency treatment against the patient's right for self-autonomy. 2. Capacity to Consent – A competent person has the right to consent or not to consent to examination, investigation and treatment even if their decisions are likely to result in death. The following three factors must be met to achieve competence; - The patient understands the information on the proposed treatment and is able to retain this information and understands the consequences of no treatment. - The patient believes the information - The patient is able to weigh up that information and make a choice. Decisions regarding capacity to refuse treatment should be made with an experienced medical practitioner and must take into account the effect of physical and mental illness, alcohol and other drugs which may have been consumed by the patient. Consideration of the effect of drugs on the patient's capacity should be urgently considered. 3. The WA Mental Health Act (1996) – The WA Mental Health Act provides treatment for patients suffering from a mental illness utilising the concept of the least restrictive treatment option. It places particular emphasis on the maintenance of the patients, dignity and respect and is specifically aimed at mode of referral and admission of patients to and the treatment of patients in authorised	Office of the Chief Psychiatrist (1997). Office of the Chief Psychiatrist (2006).	G G

	mental health facilities. The Occupational Health and Safety Legislation of WA –This act is aimed at promoting the health, safety and welfare of employees and overrides all legal statutes and regulations. All staff need to consider their own safety as a priority and not subject themselves to undue risk. No staff member should feel they must restrain a patient who is absconding from the hospital prior to receiving appropriate care in the absence of a coordinated response team. Restraining a patient without adequate resources or a planned response places the safety of the patient and other staff members in jeopardy.		

Medical Assessment	Medical assessment is a multi-disciplinary and ultimately it is the treating medical team /prison GP who determines the assessment and medical management of patients referred to the Nurse Practitioner Mental Health. The purpose of such an assessment is aimed at identifying the role of any underlying medical illness, which may explain the patient's symptoms, and to identify any medical factors, which may render the admission to a specialised mental health facility inappropriate. Indicators which suggest organic pathology and which require further medical investigation include: • Clouding of consciousness • Disorientation • Late onset of behavioural symptoms • Abnormal vital signs • Visual hallucinations and illusions. Common underlying causes for psychiatric symptomatology include: • Medications • Drug and alcohol intoxication and withdrawal • Metabolic and endocrine disorders (eg. Thyroid disease) • Cardiac disease. • Delirium	Lukens TW et al., 2006. Robinson, 1999. Phelan, 2001.	A, B C, D G F, G

	• CNS Tumour • Encephalitis • Wernicke's Encephalopathy / Korsakoff psychosis • Non-Epileptic Seizures (Pseudo-seizures).		
Investigations	The performance of investigations on patients presenting with psychiatric symptoms should be specific to the patient and the presentation. The following investigations will be performed; Alcohol use / abuse • Glutamyl transaminase (GGT) • Aspartate aminotransferase (AST) • Alanine aminotransferase (ALT) • Mean Corpuscular Volume (MCV) Delirium • Electrolytes (especially K+ and Na) • Glucose (fasting BSL) • Drug levels Lithium carbonate Sodium valproate Carbemazepine Eating Disorder • Electrolytes (especially K+, Ca, Mg, PO4) • FBC, LFT, Albumin/ protein • ECG • CXR • Glucose (fasting BSL) Psychosis • Urine drug screen • CT scan if 1st presentation Anxiety or Mood disturbance • Thyroid function test • Serum antidepressant levels Organic conditions • Urinalysis	Lukens TW et al., 2006. Robinson, 1999. Phelan, 2001.	A, B C, D G F, G

Assessment Process Pathway



GUIDELINES LIST

The NPMH will be guided by the following practice parameters and guidelines. If other appropriate guidelines become available they will also be used to guide assessment and treatment.

Clinical practice guidelines for the treatment of schizophrenia and related disorders. (RANZCP, 2005).

Eating disorders. Core interventions in the management and treatment of anorexia nervosa, bulimia nervosa and related disorders. (NICE, 2004).

Eating disorders. Summary of identification and management. (NICE, 2004).

Psychiatric Nursing Clinical Guide, assessment tools and diagnoses. (Varcarolis, 2000).

Self-harm. The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. (NICE, 2004).

Schizophrenia. core interventions in the treatment and management of schizophrenia in primary and secondary care. (NICE, 2002).

Schizophrenia. algorithms and pathways to care. (NICE, 2002).

Violence. The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. (NICE, 2005).

Clinical practice guidelines for management of post traumatic stress disorder (NICE, 2002).

Clinical practice guidelines for management of anxiety (NICE, 2002).

Clinical practice guidelines for management of depression (NICE, 2002).

Clinical practice guidelines for management of bipolar disorder (NICE, 2002).

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