NURSE PRACTITIONER CLINICAL PROTOCOL

INTERVIEW, MENTAL STATE EXAMINATION, FORMULATION AND MANAGEMENT PLANNING

For

Mental Health Consultation – Liaison Services

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Sir Charles Gairdner Hospital
North Metropolitan Health Service

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Mack Madahar- NP-Intern, Curtin University of Technology, Bentley, WA- for his updated clinical research and input


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STATEMENT OF INTENT OF THESE CLINICAL PROTOCOLS AND DISCLAIMER

The information provided in these Clinical Protocols is intended for information purposes only. Clinical Protocols are designed to improve the quality of health care and decrease the use of unnecessary or harmful interventions. These Clinical Protocols have been developed by clinicians and researchers for use within Sir Charles Gairdner Hospital. They provide advice regarding the care and management of patients presenting with mental illnesses or mental health issues by the Nurse Practitioner – Mental Health.

While every reasonable effort has been made to ensure the accuracy of these Clinical Protocols, no guarantee can be given that the information is free from error or admission. 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 Protocol is correct.

The information contained in these Clinical Protocols is NOT a substitute for clinical judgement whereby appropriate diagnosis, treatment and advice are taken into account.

These Clinical Protocols may also include references to the quality of evidence used in their formulation. Where this has not been located, the Clinical Protocols include references to support the recommended care. Providing a reference does not constitute an endorsement or approval of that source or any information, products or services through that source.

The Minister for Health, the State of Western Australia, and their Employees and Agents will accept no liability for any act or omission occurring as a consequence of relying on these Protocols in clinical use or as a result of the use of these Protocols.
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MENTAL HEALTH NURSE PRACTITIONER CLINICAL PROTOCOL
FOR
THE ASSESSMENT AND MANAGEMENT OF PATIENTS WITH A MENTAL ILLNESS OR MENTAL HEALTH ISSUES

INTRODUCTION:
These protocols are designed to provide guidance in the assessment of mental state and to facilitate appropriate care of clients with a mental illness or mental health issues associated with a physical illness within the general hospital setting.

Mental health and mental illness are a major public health issue in Australia and have the potential to affect everyone both directly and indirectly. The Australian national Survey of Mental Health and Wellbeing reported that within any 12 month period approximately one in five people will meet the criteria for a mental illness or substance abuse disorder.

Much has been written about the global burden of disease since the mid 1990’s but the contribution of mental illness has astounded many. Although cancer and cardiac disease are the top two illnesses and produce the most fatalities, mental illness is rated at third and contributes the highest non-fatal disability originating in younger individuals. Approximately 40% of disease burden in men and 50% in women can be attributed to mental illness and nine of the top 20 causes of disability burden are mental disorders. When mortality rates are included with disease burden the rate decreases to 14% but McGorry (2005) suggests that this is an underestimate as many of the causes of death are attributed to either ‘injury’ in the case of suicide or to the physical cause in the case of cardiovascular disease. In addition, mortality in mental illness may be preventable. When the emphasis shifts from mortality to that of avoidable deaths the situation is obvious. Mental illness contributes approximately 8.1% of all avoidable life years lost compared with 9% for respiratory diseases, 5.8% for cancers and 4.4% for heart disease. The World Health Organisation (WHO) estimated that in 2000, approximately 1 million people died from suicide and 20 million people attempted suicide. They reported that the suicide rates globally increased by 60% in the last 45 years making the suicide rate equivalent to the death rate from road accidents. However, it has not received the same degree of attention from governments in terms of preventative programs and expenditure and any link with mental illness has been minimised (McGorry, 2005)

One of the major adverse outcomes of mental illness is work impairment, which impacts on the national economy and costs more than successful treatment. Studies conducted by Thomas & Morris (cited in McGorry, 2005) suggested that the cost of lost productivity was 23-fold the cost of treatment by mental health services. Added to this is the cost of reduced performance whilst at work and
the impact on families and carers who may be forced to take time away from normal work roles to care for mentally ill individuals.

It should also be noted that people with serious mental illness have an elevated risk of death from all causes of death with cardiovascular disease topping the list ahead of suicide. Not only is the incidence of physical illness increased in mental illness but they are often diagnosed late and treated inadequately (McGorry, 2005; Vos & Mathers, 2000; Mathers et al, 2001; Phelan, 2001; Petersen, 2003). This pattern of premature death and substandard care has been found to be common in the disadvantaged and often marginalised mentally ill, within the community.

The Australian National Survey of Mental Health and Well-being showed that within a 12 month period approximately one in five people will meet the criteria for a mental disorder with a prevalence of 27% in the 18-24 age range. Approximately, 75% of mental disorders begin before the age of 25 and two thirds of the disease burden in the 15-24 age group is due to mental illness (Vos & Begg, 1999). Other studies (cited in McGorry, 2005) suggest that the incidence of mental illness may be much higher and severely impair lifetime achievement and pose an economic and social burden on our society.

The incidence of psychiatric illness amongst medically ill patients has been estimated to vary from 30% to 65% according to a number of studies (cited in Robinson, 1999). It seems reasonable to assume that these patients incur greater health costs and have a less optimistic prognosis for both their physical illness and their mental illness, often due to both conditions contributing significantly to the other. The presence of mental illness impacts markedly to compliance with medical regimes and reduction of risk factors such as smoking, poor diet and exercise. Medical illnesses may cause additional stress in vulnerable mentally ill patients thus triggering an acute reaction and the treatment of many medical illnesses may provoke mental illness (e.g. Steroid induced psychosis) or worsen some pre-existing mental illnesses (e.g. Beta-blockers). This gives credence to the argument for psychiatric services which provide assessment and treatment for patients admitted to general hospitals and to this end many large general hospitals now have Psychiatric Consultation-Liaison teams which provide this service. Such services provide an opportunity for interface between medical specialities and psychiatry and the diagnosis of mental illnesses which in many cases may have been overlooked.

The increased scope of practice of the Mental Health Nurse Practitioner will improve the effectiveness and efficiency of the diagnosis of mental illnesses and provide specialised mental health care to the Western Australian public. In addition, it will permit greater autonomy to the Nurse Practitioner when managing patients with mental illnesses or mental health issues associated with their medical illness.
**Disease Aetiology**

Although the exact cause of most mental illnesses is not known it is progressively becoming more evident that many mental illnesses are caused by a combination of genetic, biological, psychological and environmental factors.

Some mental illnesses are known to run in families, which suggests that the illness may be passed on from parents to child through genes making such children more susceptible to developing the illness. Experts believe that genetic causes of mental illness occur due to defects in multiple genes – not just a single gene as with other disorders. Individuals with defective genes when exposed to other factors such as environmental stressors are more likely to develop the disorder. Some mental illnesses are closely linked to biological causes such as an abnormal balance of neuro-transmitter chemicals in the brain. These chemicals are responsible for normal functioning in the brain and if not working properly, normal communication between nerve cells in the brain may severely impaired. In addition, injuries to certain parts of the brain are linked to the development of mental illness. Psychological trauma especially in childhood has also been shown to be linked to the development of mental illness in adulthood. In addition, stressors such as death and divorce and substance abuse can trigger mental illness in a person who may be at risk for developing mental illness (MedicineNet, 2005; Askey, 2002; Brockington, 2004; Marmot, 2005; Davies, 1997)

**Patient Population:**

The population of patients to whom these protocols pertain to will include all patients admitted to the general wards at Sir Charles Gairdner Hospital for medical reasons that have a mental illness or mental health issue associated with their medical condition. This includes patients who have behaviours, which render their management difficult either for themselves or for those health professionals caring for them.

**Patient Contacts:**

Since its inception in 2001-2002, requests for mental health review of patients believed to be suffering from mental illnesses or mental health issues have been at a steady rise. Patient contacts have risen from 165 patient contacts in 2001 to 949 patient contact in 2010. **Addendum 1 illustrates the incremental growth of patient contacts in a tabled form.**

The author believes that the total current levels of patient service have reached its capacity for 1 full-time equivalent staff. If more patients are to be referred to the service, will require additional resources in the form of staff and office space. Such patients are referred directly to the Clinical Nurse Consultant (Psychiatry) by both medical and nursing staff for primarily mental health assessment and then ongoing management of the patient’s mental health problem. Treatments provided cover a wide range of management options including counselling, relaxation training and behavioural therapy. In addition, due to the difficulty in managing some of these patients due to abnormal behaviour, support and education is provided to staff. Currently, if the patient is considered to require either medication or referral to another health professional, the treating team must make referrals on the recommendation of the Clinical Nurse Consultant.
(Psychiatry). Thus if the treating team does not believe that the patient’s mental health problem is a priority the patient does not receive or the appropriate mental health care is delayed significantly. The ability to directly refer patients and commence appropriate mental health treatment would be greatly enhanced by the designation of a Mental Health Nurse Practitioner.

**Expected Outcome of the Protocols:**
Early intervention in mental illnesses is believed to be best practice in management. It is suggested that early access to mental health care will reduce the loss of function and disability which often results as a consequence of serious mental illness.
The assessment of a patient’s mental state will depend on the circumstances and the type of presentation. Sufficient information needs to be elicited to achieve a comprehensive picture of all factors which may have a bearing on the patient’s mental state.

Set formats for the assessment of mental state are intended to be guidelines only and should not be followed rigidly. Interviews to elicit a patient’s mental state should be adapted to the clinical situation whereby the interviewer’s approach should take into account the patient’s presentation and reaction to the interviewer. Flexibility to adapt the approach remains an essential component of the process. Mental State Assessment is therefore not merely eliciting information but also about engaging the patient.

Engagement refers to “the ongoing development of a sense of safety and respect from which patients feel increasingly free to share their problems, while gaining an increased confidence in the clinician’s potential to understand them” (Shea, 1998, pg 10)

**Goals of Assessment:**

- To establish a therapeutic alliance with the patient
- To collect valid data pertaining to the patient’s mental state from which a formulation can be made.
- To develop an understanding of the patient’s problems
- To develop a treatment or management plan in collaboration with the patient if possible
- To decrease the impact of psychiatric symptoms for the patient and reduce suffering
- Support ward staff and provide education and diagnostic assistance and knowledge about specific conditions and drugs
## ASSESSMENT AND INVESTIGATION

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<thead>
<tr>
<th>PROCESS</th>
<th>ACTION</th>
<th>REFERENCES</th>
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<tbody>
<tr>
<td>Mental State Assessment</td>
<td>• Appearance and Behaviour – general appearance and dress. Self-care and cleanliness, Attitude to situation / manner of relating. Motor Behaviour</td>
<td>Davis, 1997;</td>
</tr>
<tr>
<td></td>
<td>• Speech – Rate, Volume, Pitch, Tone, Fluency, Quality of Articulation and Information.</td>
<td>IGDA Workgroup, WPA, 2003;</td>
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<td></td>
<td>• Form of Thought – Amount of thought and rate of production, continuity of ideas, disturbances in language and/or meaning.</td>
<td>Laws &amp; Rouse, 1996</td>
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<td></td>
<td>• Content of Thought – Delusions, Suicidal Thoughts, Obsessions, Phobias, pre-occupations, Anti-social urges.</td>
<td>New Zealand Guidelines Group, 2003</td>
</tr>
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<td></td>
<td>• Perception – Hallucinations, Other perceptual disturbances (de-realisation, de-personalisation, heightened or dulled perception)</td>
<td>Orygen Research Centre, 2004</td>
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<td></td>
<td>• Insight – Extent of the patient’s awareness of problem and current situation</td>
<td>Brockington, 2004</td>
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<td></td>
<td>• Cognition – Level of consciousness, memory (immediate, recent, remote), orientation (time, place, person) concentration, abstract thinking, Folstein MMSE.</td>
<td>Gomez, 1987;</td>
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<td></td>
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<td>American Psychiatric Association, 1995</td>
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<td>Muggli, E, 2002.</td>
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<td>Sompradit et al, 2002</td>
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<td>Brown et al, 2004</td>
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<td>Petersen et al, 2001</td>
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<td>Davis, 1997; IGDA Workgroup, WPA, 2003; Henshall, 1999; Laws &amp; Rouse, 1996</td>
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<td>G</td>
<td>New Zealand Guidelines Group, 2003</td>
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<td>F</td>
<td>Orygen Research Centre, 2004</td>
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<tr>
<td>A, B, C, D</td>
<td>Brockington, 2004</td>
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<tr>
<td>F, G</td>
<td>Gomez, 1987; American Psychiatric Association, 1995; Muggli, E, 2002; Sompradit et al, 2002</td>
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<td>A</td>
<td>Brown et al, 2004</td>
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<tr>
<td>E</td>
<td>Petersen et al, 2001</td>
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</table>
| Presentation, History, Mental State examination and Formulation | • 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  
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| Collaborative History and referral data | 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  

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.  

NOTE: The need to preserve patient confidentiality should be adhered to at all times unless required to disclose information in the public interest |

| | Davis, 1997;  
| | IGDA Workgroup, WPA, 2003;  
| | Henshall, 1999.  
| | Laws & Rouse, 1996  
| | New Zealand Guidelines Group, 2003  
| | Orygen Research Centre, 2004  
| | Brockington, 2004  
| | Gomez, 1987  
| | Carers Recognition Act, 2004 | G  
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<tr>
<th>Risk Assessment</th>
<th>For</th>
<th>OCP, Communicating with Carers and Families, 2007</th>
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<td>National Collaborating centre for Nursing and Supportive care, 2005</td>
<td>D, E, F, G</td>
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<tr>
<th>Legal Considerations</th>
<th>Awareness of the legal implications of caring for patients within a general hospital setting.</th>
<th>Office of the Chief Psychiatrist (1997)</th>
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<tr>
<td>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.</td>
<td>Office of the Chief Psychiatrist (2006)</td>
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<td>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;</td>
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<td>- The patient understands the information on the</td>
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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 mental health facilities.

3. 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 who determines the assessment and medical management of patients referred to the Mental Health Nurse Practitioner. 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
- CNS Tumour
- Encephalitis
- Wernicke’s Encephalopathy / Korsakoff psychosis
- Non-Epileptic Seizures (Pseudo-seizures).

<table>
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<tr>
<th>Investigations</th>
<th>The performance of investigations on patients presenting with psychiatric symptoms should be specific to the patient and the presentation. The following investigations may be performed; Alcohol use / abuse</th>
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<tr>
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<td>• Glutamyl transaminase (GGT)</td>
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| Delirium                  | Electrolytes (especially K+ and Na)  |
|                         | Glucose (fasting BSL)               |
|                         | Drug levels (if appropriate regarding toxicity) |
|                         | Lithium carbonate                  |
|                         | Sodium valproate                   |
|                         | Carbamazepine                      |
| 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        |
| Other conditions        | Urinalysis MC&S                    |

**Therapeutic Techniques**

The essential component of mental health nursing is the nurse – patient relationship (interpersonal relationship between the patient and the nurse. This human contact is often the essence of what patients appreciate from the health professional. Techniques include:

- Listening skills

*Cutcliffe, 2002*

*Peplau, 1994*

*Calvert & Palmer, 2003; Newell, 2000*
<table>
<thead>
<tr>
<th>Techniques</th>
<th>References</th>
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<tbody>
<tr>
<td>Cognitive Behavioural Therapy</td>
<td>Wales, 1998</td>
</tr>
<tr>
<td>Solution Focused Brief Therapy</td>
<td>Chychula &amp; Sciamanna, 2002</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
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<tr>
<td>Anger Management techniques</td>
<td>Swaffer &amp; Hollin, 2000</td>
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<tr>
<td>Anxiety management techniques</td>
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<td>Psycho education</td>
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<td>Relaxation techniques</td>
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<td>Interpersonal Therapy</td>
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<td>Grief Counselling</td>
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Treatment of patients whose symptoms are likely to respond to the above techniques will take place
ASSESSMENT PROCESS PATHWAY

Patient referred from Medical Team in General Hospital

NP Assessment

No Action Required

Yes

Conduct Interview and Clinical Assessment

Ensure physical examination & investigations completed

Need to consult with psychiatrist, medical officer or other health professional?

No

Problem formulation and management plan

Yes

Consultation

Investigations

Psychological, medical and other treatment interventions

Regular review / evaluation of treatment plan

Document rationale in patient file and discuss with treating medical team

No further action

NP to continue process?
DISCHARGE/REFERRAL CRITERIA:
Discharge Criteria:
• Patients who have completed their treatment with the above techniques
• Patients whose psychiatric symptomatology has resolved and which is unlikely to re-occur.

Referral Criteria:
• Patients whose psychiatric symptomatology is unlikely to respond to the above techniques.
• Patients who are displaying no current insight into their condition and are refusing psychiatric treatment.
• Patients who require additional treatment or the services of another health professional which is beyond the scope of practice of the Mental Health Nurse practitioner.
• Patients who require long-term psychiatric care, psychotherapy or rehabilitation.
• Patients under 16 years of age and older than 65 years.

The Mental Health Nurse practitioner will facilitate referrals to departments within SCGH and to other mental health services and facilities within the North Metropolitan Health Services.
Referrals will be made to the following services;
• Other health professionals of the Consultation-Liaison Psychiatric Service at SCGH.
• Social Work both within SCGH and other Services within NMHS.
• Alcohol and Drug Services within the Hospital and the Alcohol and Drug Services in WA.
• Aboriginal Mental Health Service.
• Community mental Health Clinics
• General practitioners
• Private psychiatrists
• Private Psychology and Counselling Services
• Older-Age Psychiatry (Over 65 years)
• Child and Adolescent Psychiatry (Under 16 years).
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 are 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.


[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.

REVIEW:
This clinical protocol will become effective after approval and will be reviewed every 3 years or more often if significant research / evidence-based information is available which is likely to lead to a change in practice.

IMPLEMENTATION PLAN:
As the Mental Health assessment of patients is an ongoing process the implementation of this clinical protocol will take place subsequent to the designation of the Mental Health Nurse Practitioner at Sir Charles Gairdner Hospital. The promotion of changes in practice and the enhancement of referrals will be commenced approximately 6 weeks of designation.

EVALUATION PLAN:
The use of this protocol will be reviewed annually and evaluated using the Clinical Governance framework. Reports will be provided to the crucial key line manager (Nursing Co-Director of Corporate Nursing, Education and research) and the Director General of Health, as part of the process outlined by the Office of the Chief Nursing Officer (Department of Health Western Australia).
**Clinical Performance and Evaluation:**
The number of mental health referrals, assessments and disposals (eg. Treated by NP or referred to another health professional) will be monitored over a 12 month period. These statistics will be maintained on a regular basis utilising the PSOLIS database for mental health patients.

**Professional Development and Management:**
The Mental Health Nurse Practitioner will be responsible for own individual professional development within the designated area, the provision of education to professional colleagues and own ongoing Performance Management. The development of Policies, Guidelines and standards within the hospital and across the health sector will also be noted.

**Clinical Risk:**
The identification and minimisation of clinical risks are an important aspect of clinical safety. Practice guidelines and standards and the use of risk assessment tools will be utilised by the Mental Health Nurse Practitioner and probable risks which include clinical incidents and adverse events will be identified and reported as part of the NP review and reporting to the Department of Health.

**Consumer Value:**
Consumer Satisfaction will be determined via satisfaction surveys of selected customer groups including selected patients, carers and referring sources. Consumer input into protocols and/or patient information will also be noted.
REFERENCES:


Cutcliffe, J. (2002). The beguiling effects of nurse-prescribing in mental
health nursing: re-examining the debate. *Journal of psychiatric and Mental Health Nursing*, 9(3), 369-375.


Somprakit, P, Lertakyamanee J, Satraratanamai C, Wanicksamban S,


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**Addendum 1**

**COMPARISON WITH OTHER YEARS OF PATIENT CONTACTS: Table Form**

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Addendum 1

Graph Form