Clinical Protocol 2
Client Exhibiting Psychotic Symptoms

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

Sir Charles Gardiner August, (2007) Sir Charles Gairdner Hospital North Metropolitan Health Service


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Management
Psychotic symptoms can present with varying features, and can be caused by a variety of conditions. The most common condition being schizophrenia, but other pathology such as delirium, neurological conditions, cardiac insufficiency and intoxication, can also be present. During assessment the following points should be carefully considered.

Hallucinations- Is the client experiencing auditory hallucinations? Is there evidence of it or does the client admit they have been hearing voices? Are the hallucinations dangerous in the context that the client is acting on the commands of the voices, such as believing they have to harm themselves or others?

Delusions- Is there evidence of delusions? If so, is the client acting on them, and is this placing them or others in danger? (This could be a factor to determine if involuntary admission of the client into an acute unit is required). Are they oriented to time place and person? If impaired this could mean there is organic aetiology to the behaviour.

Physical state of the client- The physical presentation of the client must also be taken into account, including general appearance, clothing, cleanliness and general demeanour.

Treatment options- Treatment options are made with consideration of the safety of the client and the community. This decision should be made in respect to the WA Mental Health Act (1996), using least restrictive options of care.

Treatment options include:-
  i) Treat in the Crisis Care Unit, with follow up as required
  ii) Transfer to a mental health inpatient facility for treatment (Frankland Centre)
  iii) Treat within normal prison unit but with follow up and support

First episode and early psychosis- Early psychosis’ refers to the prodromal period before the onset of overt psychotic symptoms and the first few years of a psychotic illness. There are many psychiatric and organic illnesses, which can cause psychosis. The main aim of the assessment is early identification and management of psychosis, with final diagnosis a later priority.
Early psychosis or prodromal symptoms in a young person need to be considered:

- declining work or academic performance;
- suspiciousness;
- eccentric behaviour;
- decreased motivation;
- withdrawal from family and friends;
- reduced interest in social activities;
- transient psychotic phenomena;
- depressed mood;
- irritability;
- poor sleep;
- poor concentration.

**Key points for management of psychotic symptoms:**

- Early recognition/treatment of psychosis is crucial and results in better long-term outcomes.
- Thorough physical examination and investigation are necessary to exclude organic causes.
- Empathic, reassuring and competent first assessment is a great building block for ongoing cooperative treatment.
- Involve patients in a specialised early psychosis intervention program.
- The newer (atypical) antipsychotics are the medications of choice in early psychosis (e.g. Risperidone or Olanzapine).
- Family have a vital role in supporting the patient and facilitating treatment.

Source; Centre for Mental Health, Mental Health for Emergency Departments – A Reference Guide (Amended May 2002)
DRUG TREATMENTS AND FORMULARIES FOR NPMH PRESCRIPTION

Introduction

The identified formulary is to be approved and signed by the Area Drug Committee, and any further amendments need to be endorsed by both the Area Drug Committee and the Clinical Executive of the Area Health Service.

The NPMH may only prescribe drugs from the following groups of medications for persons over 18 and between 65 years according to clinical judgement and guidance by the prescribing guidelines for benzodiazepines, antipsychotics and anticholinergics and antidepressants within the dose ranges indicated for specific conditions such as side effects, agitation, psychosis, or mood disturbance.

The formulary has been developed with consideration to support initiation of safe and effective treatment by a Nurse Practitioner Mental Health; having regard to alerts, a patient’s usual medication regimen, tolerance, age and sensitivity.

Rationale for Treatment

- The rationale for prescribing any drug must be based upon its potential benefits outweighing any adverse effects likely to occur. Before commencing treatment potentially dangerous side effects and interactions with other drugs/foods and hazards of prescribing to certain groups of patients (especially pregnant women, breast feeding mothers and those who are a suicide risk), cost and the patient’s likelihood of compliance with treatment should be considered.

- To minimise the adverse consequences of drug use, the practitioner should familiarise her/his self with the actions and side effects of a small number of compounds in each therapeutic group. The aim should be to give the drug at the lowest dose for shortest time possible to achieve the desired therapeutic effect.

- Prescribe anti-psychotic medication only for specific clinical symptoms.
SOME PRINCIPLES OF DRUG TREATMENTS

The NPMH will only prescribe medications as listed within the formulary guidelines in this document and does not include IVI. It does include antipsychotic, antidepressant, anticholinergic and benzodiazepines. Any treatments required outside of the formulary guidelines would be referred to a medical practitioner.

Target symptoms should be clearly identified prior to antipsychotic treatment and carefully monitored over the course of the treatment. Medication intervention for poorly defined behavioural eccentricities often provides limited clinical benefit and unnecessarily exposes the patient to medication risks.

Whenever possible patients should receive:

- Physical examination
- Mental state examination.
- A urine screen for drugs of abuse.
- Blood tests: full blood count (FBC) electrolytes, glucose, and liver, renal, and thyroid function should be considered.
- Pregnancy – pregnancy test to rule out pregnancy test for any woman in reproductive age
- Other diagnostic tests that should be considered if it is the patient’s first presentation and/or commencing medication include pregnancy tests and electrocardiogram (ECGs when cardiac disease or cultural diversity is a factor)
- The presence of movement disorders-particularly pre-existing tardive dyskinesia-should be assessed as they may influence the selection of an antipsychotic.
FORMULARY

The NPMH may only prescribe drugs from the following groups of medication and prescription will be according to clinical judgement and within the dose ranges indicated for specific conditions and in an emergency situation.

The dose column indicates up to a maximum daily range (usually in divided doses) that has been identified specifically for the NPMH. The formulary has been developed with consideration to support initiation of safe and effective treatment by a NPMH; having regard to alerts, a patient’s usual medication regimen, tolerance, age and sensitivity.

OVERARCHING PRINCIPLES

The Nurse Practitioner must have regular supervision with the designated supervising Psychiatrist with particular attention to prescribing of medication and taking into account the context of the prison setting.

All prescribing will be according to evidence based practice in accordance with listed guidelines, particularly Western Australian Drugs & Therapeutics Committee guidelines.

In any cases where prescribing may be compromised by co-morbid psychiatric diagnosis, polypharmacy or requirement for higher than recommended dosage, consultation must occur with the supervising psychiatrist before prescribing.

ANTICHLONERGICS

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Dose Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benztropine</td>
<td>Oral/IM/</td>
<td>Dose: take daily dose at bedtime or in divided doses; increase dose as needed by 0.5 mg every 5-6 days to max 6 mg/day. 0.5-1 mg daily.</td>
</tr>
<tr>
<td>Benzhexol</td>
<td>Oral</td>
<td>2 - 5mg BD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Max-15mg /24hrs</td>
</tr>
</tbody>
</table>
## ANTIPSYCHOTICS - ORAL

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Dose Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td>Oral 0.5, 1.5mg, 5mg tablets available</td>
<td>1-5mg daily moderate 5 –15mg daily Severe Max 30mg daily prn for 3 days then review with psychiatrist</td>
</tr>
<tr>
<td>Risperidone</td>
<td>Oral Tablets, wafers Syrup 0.5mg, 1mg 2mg, 3mg</td>
<td>2 – 6mg/ day Max 6mg daily</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>Oral Wafer 2.5mg, 5mg, 7.5mg, 10mg</td>
<td>2.5 – 20mg/ day Max 20mg daily</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>Oral 10mg, 25mg, 100mg</td>
<td>25mg – 500mg daily in 3 divided doses Max 800mg daily prn for 3 days if required, then will need review by psychiatrist</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>Oral</td>
<td>10-15mg/ day Max 30mg daily</td>
</tr>
<tr>
<td>Amisulpride</td>
<td>Oral</td>
<td>50-800mg in divided doses mg/day Max 1200mg daily</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>oral</td>
<td>Titrate in daily divided doses Max 750mg –schizophrenia 800mg acute mania</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>oral</td>
<td>400mg – 800mg daily</td>
</tr>
<tr>
<td></td>
<td>Extended Release</td>
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</tbody>
</table>
## ANTIPSYCHOTICS - INTRAMUSCULAR

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Dose Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone Consta long acting injection</td>
<td>IMI</td>
<td>25-50mg (2 weekly)</td>
</tr>
<tr>
<td>Zuclopenthixol Decanoate</td>
<td>IMI</td>
<td>100-400mg 2-4 weekly</td>
</tr>
<tr>
<td>Flupenthixol Decanoate</td>
<td>IMI</td>
<td>20-40mg 2-4 weekly Max 100mg every 2 weeks</td>
</tr>
</tbody>
</table>

PRN Prescribing.  
This should be done following consultation with a consultant psychiatrist. NMHP may prescribe 3 days only prn of chlorpromazine or haloperidol and then review with psychiatrist.

## ANTIDEPRESSANTS

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Dose Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram</td>
<td>Oral</td>
<td>20-40mg / daily Max 60mg daily</td>
</tr>
<tr>
<td>Sertraline</td>
<td>Oral</td>
<td>50-150mg daily Max 200mg daily</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>Oral</td>
<td>75-225mg daily Max 225mg</td>
</tr>
</tbody>
</table>
## BENZODIAZEPINES

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Dose Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diazepam</td>
<td>Oral</td>
<td>2 – 20mg / daily</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Usually 2.5mg tds</td>
</tr>
<tr>
<td>Temazepam</td>
<td>Oral</td>
<td>10 – 20mg / nocte</td>
</tr>
</tbody>
</table>

## MOOD STABILISERS

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Dose Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithium Carbonate</td>
<td>Oral</td>
<td>2 – 20mg / daily</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Usually 2.5mg tds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To be prescribed only by psychiatrist. NPMH to provide monitoring and titration of dosage in response to serum levels.</td>
</tr>
<tr>
<td>Sodium Valporate</td>
<td>Oral</td>
<td>10 – 20mg / nocte</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To be prescribed only by psychiatrist. NPMH to provide monitoring and titration of dosage in response to serum levels.</td>
</tr>
</tbody>
</table>
Assessment reveals patient experiencing extra pyramidal, dystonia or parkinsonian symptoms due to psychotropic medication.

Yes

Prescribe appropriate anticholinergic as a stat dose. Observe response.

Symptoms resolved

Yes, refer to psychiatrist for review

No

Consider other causes for the symptoms and refer to medical officer for physical examination.

Discuss/ refer clinical findings with Consultant Psychiatrist for further recommendations for treatment.
DECISION PROCESS FOR COMMENCING ANTIPSYCHOTIC MEDICATION

Mental state assessment reveals patient meets criteria for a psychotic illness, after organic cause excluded

Patient requires admission under the Mental Health Act 1996

As authorised practitioner make appropriate referral to psychiatric facility and facilitate safe transportation

no

Review medication history. Check for other drug interactions and adverse effects. Discuss clinical picture with consultant psychiatrist. Reinstitute previous medication if good response and no side effects, review after 7 days with psychiatrist.

Monitor FBC, LFT, U&E’s BP weight and body mass index, waist hip ratio

If good response continue therapy and review 2 weekly with consultant psychiatrist or unless needed sooner

If poor previous response or new patient

Choose antipsychotic (refer to antipsychotic guideline, version 3, 2006) Use dose as indicated

If poor response dose after 2-4 weeks increase dose up to maximum if needed and review in further 2-4 in weeks

MHNP to review response in 7 days in conjunction with consultant psychiatrist. Would need at least 2-4 weeks for accurate response before considering changing. If tolerated continue therapy with review minimum 2 weekly

Consider alternative atypical antipsychotic following review with consultant psychiatrist and follow same process

If to be released from prison MHNP to supply 1 week of medication
DEVELOPMENTAL PROCESS FOR COMMENCING ANTIDEPRESSANT MEDICATION

- Mental state assessment which includes risk of suicide reveals patient meets criteria for depression.
  - No: Consider alternative therapy.
  - Yes: Make appropriate referral to psychiatric facility as an authorised practitioner and facilitate safe transportation.

- Patient requires admission under the Mental Health Act 1996 because of risk to self.
  - No: Review medication history. Check for other drug interactions and adverse effects. Discuss clinical picture with Consultant Psychiatrist. Reinstitute previous medication if good response and no side effects.

- Anti-depressant to be commenced at starting dose. Review weekly and assess risk of self-harm. If any deterioration in mood, refer to consultant psychiatrist for review.
  - If good response: Continue therapy and review minimum of 2 weekly.
  - If partial response after 2 weeks: Discuss with psychiatrist and consider increase dose and review in 2 weeks.
  - If no response: Increase dose or change to different antidepressant.

- Review after 6 weeks with psychiatrist and maintain therapeutic dose for up to 12 months.
  - MHNP to refer to psychiatrist for further specialist intervention.
DECISION PATHWAY FOR PRESCRIBING BENZODIAZEPINE MEDICATION

Patient experiencing excessive, anxiety, worry or agitation that is not attributed to physical cause.

Following assessment is pharmacological intervention required?

Yes

Monitor FBC, LFT, U&E’s, and BP

Use for short term pharmacological relief of severe anxiety symptoms, discuss with consultant psychiatrist

Before prescribing consider- Previous treatment response, risk of deliberate self harm, possible interactions. Refer to any policies on prescribing benzodiazepines in prison

If patient having sleep disturbance/insomnia or severe anxiety and non drug therapies are not effective, refer to process above

No

If patient agreeable and pharmacology not appropriate refer to prison psychological services for CBT or counselling service

Facilitate dose of Diazepam 2-5mg tds and review in 24 hours. If anxiety continuing repeat process and refer to consultant psychiatrist for review

MHNP to prescribe 10-20mg of Temazepam as a stat dose only and then review effect

Any further sleep disturbance refer to consultant psychiatrist for review because of risk of addiction
DECISION PATHWAY FOR MONITORING MOOD STABILISING MEDICATION

Assessment reveals patient meets criteria for a bipolar affective disorder requiring treatment. To discuss with consultant psychiatrist

Patient requires admission under the Mental Health Act 1996

Yes

Make appropriate referral to psychiatric facility and facilitate safe transportation

No

Consultant psychiatrist to prescribe mood stabiliser and NPMH to provide monitoring & titration only.

Lithium monitoring guidelines to be adhered to

Or

Sodium valproate monitoring guidelines to be adhered to

Renal & thyroid function test, ECG at baseline
Regular blood test to establish therapeutic range 0.5 - 1mmol/L.
Be aware of symptoms of toxicity
Regular monitoring of the patient’s clinical state and serum lithium concentrations is necessary. Serum concentrations should be determined once or twice per week during the acute phase, and until the serum level and clinical condition of the patient have been stabilised. Again review any findings with consultant psychiatrist

Review progress after 3 days and then minimum of weekly
Discuss findings with consultant psychiatrist

Renal & thyroid function test, ECG at baseline
Establish therapeutic range-50-100mg mmol/L
Weight
DISCHARGE/REFERRAL PROCESS

Discharge criteria:
- Patients who have completed their treatment.
- Patients whose psychiatric symptomology has resolved and is unlikely to re-occur.

Referring criteria
- Patients whose psychiatric symptomology is likely to reoccur.
- 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 that is beyond the NPMH scope of practice.
- Patients who require long-term psychiatric care, psychotherapy or rehabilitation.
- Patients under 16 years of age and older than 65 years.
- The NPMH will liaise with local mental health services and other relevant community based services for sentenced prisoners with a serious mental illness in the transition between prison and the community.

Referrals will be made to the following services: -
- Other health professionals within the criminal justice service.
- Alcohol and Drug Services within the prison and the Alcohol and Drug Services in WA.
- Aboriginal Mental Health Service.
- Community Mental Health Clinics.
- General Practitioners.
- Private psychiatrists.
- Older-Age Psychiatry (Over 65 years).
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.


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).


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).
REFERENCES


