Mental Health Nurse Practitioner

Model of Care

The Context

Forensicare provides specialist mental health services to people in the care of the Victorian justice system. These services are provided at the Melbourne Assessment Prison, the Dame Phyllis Frost Centre, Thomas Embling Hospital (TEH), and the community (including Magistrates’ Courts).

There are 4400 beds across the 14 male and female prisons in Victoria. The 286-bed Melbourne Assessment Prison (MAP) is the State reception prison. At the MAP, Forensicare clinicians provide a reception mental health assessment program, outpatient services and after hours crisis intervention. Forensicare also provides the clinical services for the 16-bed Acute Assessment Unit (AAU) for prisoners thought to be mentally ill and/or at risk. The growing number of prisoners in Victoria coupled with reducing numbers of beds for Security Patients at Thomas Embling Hospital have placed increased pressure on the demand for Outpatients services and valuable AAU beds. Melbourne Assessment Prison is the only acute psychiatric assessment and treatment facility amongst the 12 male prisons in the state.

From 1 July 2009 to 31 January 2010:

- 3276 reception mental health assessments were undertaken by nurses (100% of receptions to MAP)
- 166 prisoners were admitted to the AAU
- 1649 occasions of outpatient service were attended by nurses
- 1120 prisoners were seen in the outpatient’s clinic by nurses
- 158 crisis calls were attended by psychiatric nurses
- An average of 3.3 prisoners were confined to be managed in observation cells each night due to suicide and self-harm risk. This equates to approximately 600 separate nights of seclusion.

In Victoria, Mullen et al. (Department of Health and Aging, 2003), reported that 8% of male prisoners had a psychotic illness. Furthermore, rates of the major mental illness, such as schizophrenia and depression are between three and five times higher in offender populations than in the general community.
The launch of the ‘Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019’ clearly identifies that the prison population presents with extremely poor health status and complex health needs and that the prevalence of major mental illness is three to five times higher in the prison population compared to the general population (50 per cent higher for severe depression). The Strategy aims to strengthen prison capacity to provide early intervention and treatment, address the fragmentation of service provision and expand access to transition programs. Some key outcomes identified in the Strategy for prisoners include: access to high quality specialist mental health care, improved continuity of care, reduction in need for crisis intervention, reduction in suicide rate and reduction in recidivism.

The literature also identifies the processes that are required for an effective mental health service in a prison and the key role of nurses. These processes include:

- Systematic screening for mental illness at time of reception to identify mental illness as soon as possible to commence treatment planning.
- Ongoing assessment, monitoring and screening of prisoners through mental health outpatient clinics. There should be follow up of prisoners after the reception screening, access can be prisoner self-referral or referral from any of the corrections staff (officers, pastoral care, teachers etc).
- Crisis intervention services are required to intervene early and prevent deterioration of health state.
- Nursing intervention that is consistent with professional standards is required. This includes administration of psychiatric medications in a safe manner, psychosocial rehabilitation, substance use interventions, offending issues etc.
- Provision of acute care will be required as hospital beds are often not immediately available.
- Systematic identification, treatment and supervision of prisoners with suicidal and self-harm tendencies.
- There needs to be a continuity of services and treatment for the prisoner – whether transferred to other wings or other prisons, or to a specialist secure hospital or released to the community. This is ensured by effective communication, referrals and advocacy. This element includes the preparation of the prisoner inmate for transfer or release. Other considerations may include referrals for accommodation, employment, substance use programs and other necessary supports.
- Links are needed with families and carers to assist with assessment and intervention and to support families and carers in their ongoing relationship with the prisoner.
- Maintenance of accurate, complete and confidential records of the mental health treatment.
- Nurses also have a role in the education of prison staff to enable them to identify and manage prisoners with a mental illness.

(Ogloff, 2002; Polczyk-Przybyla & Gournay, 1999; Weiskopf, 2005)

The newly released Department of Justice Mental Health Strategy also identifies the need for early intervention and continuity of care for prisoners with mental health issues.

The role of the Mental Health Nurse Practitioner at MAP

The use of Mental Health Nurse Practitioners (MHNP) at MAP will provide an opportunity to offer a cost effective and strengthened comprehensive and accessible service to prisoners with mental health issues, not only reducing the time constraints on psychiatrists but also contributing a broader nursing approach to prisoner health. The MHNPs will provide additional support and services in psychopharmacology, advanced nursing assessment and treatment, referral of prisoners to other healthcare professionals, ordering diagnostic investigations, and
recommending transfer to appropriate services. This will ultimately contribute to improved prisoner health outcomes, and enable more cost-effective services and support prisoners to make a successful return to the community.

Existing model highlighting identified service gaps and role of MHNP

Reception

Every weekday afternoon approximately thirty remanded and sentenced prisoners are transported to MAP for assessment by a Prison Officer, General Practitioner, and a Forensicare Registered Psychiatric Nurse (RPN). It is based on these assessments that certain recommendations and plans for clinical and correctional management are developed to best suit the needs of the prisoner. While the RPN screening assessments are done to a competent standard when acute mental health or self harm issues are recognised the usual intervention is to offer a follow-up appointment with a Consultant or Psychiatric Registrar for the next available opportunity (approx three weeks).

The introduction of two MHNPs to reception would enable systems to be modified so that every weekday there is an expert nurse on hand in reception to provide advanced biopsychosocial and risk assessments to the more complex and acute presentations. MHNPs will initiate case management when determined by the service needs of the patient. Applying appropriate interventions, including pharmacology and referrals to other services in shorter timeframes will enhance clinical outcomes. In addition, it is anticipated that these two staff members will collaborate with existing nursing staff to positively influence culture and the standard of care provided.

Outpatients

Every weekday morning two psychiatric nurses operate an Outpatients Clinic, providing triage assessment for the waiting lists of Psychiatrist and Registrar clinics and the AAU. All prisoners requesting a psychiatric medication review and/or more advanced assessment and diagnostic clarification are referred to the Psychiatrist and Registrar Clinics. These nurses also provide medications (including depot administration), and suicide risk assessment and planning to identified prisoners located outside of the AAU.

Though the number change from week to week, there are approximately thirty-five P1 rated prisoners (representing the highest psychiatric acuity as determined by clinical staff), and thirty S3 prisoners (those with current suicide and self harm issues requiring a local management plan).

The introduction of two MHNPs to the existing service will enable a higher level of nursing assessment and autonomous patient care, including the assessment and formulation of pharmaceutical and non-pharmaceutical treatment plans. It will reduce the current demand on Psychiatrists and Registrars to review all prisoners requesting a medication review and allow them to focus their resources on the more complex presentations. With a higher level of initial assessment the Consultant and Psychiatrist will receive improved and informed referrals. Consultants and Registrars will also be able to refer patients back to the MHNPs for follow-up and case management. The MHNPs will be well placed to oversee and prioritise the waiting list of admissions to the AAU from outpatients.

Suicide Risk Assessment

Suicide risk assessment is an integral function of the MAP clinical team. At present the primary intervention available for those prisoners identified at high risk of suicide is isolation in observation cells. Known locally as ‘Muirhead cells’ this strategy effectively reduces short-term
risk by simply reducing the prisoners’ means to self harm, but fails to address the sources of the prisoners distress. Every morning, the prisoners located in this area are assessed by a psychiatric nurse and their suicide risk assessment is presented to a collective group the High Risk Assessment Team (HRAT). Decisions around the prisoners’ risk management and prison placement are made at this forum. When the HRAT group are uncertain about the prisoner’s risk of self harm they will generally decide to maintain the prisoner in the Muirhead cell for further review and discussion the following day.

Introducing MHNPs will provide an additional resource for high level clinical risk assessment. MHNPs will be available Monday to Friday to attend HRAT meetings and advocate for the needs of the patient in line with contemporary evidence based practice. Where existing psychiatric nurses occasionally lack confidence and skill in assessing whether a prisoner is to be removed from a Muirhead, the MHNP will be available to offer a second opinion and undertake comprehensive risk analysis that is likely to result in shorter periods of prisoner isolation.

**Complex mental health needs case management**

As the primary psychiatric assessment prison in Victoria, MAP receives a number of resource intensive and complex prisoners from other prisons. Often these prisoners are not suitable for the AAU. These men typically have a diagnosis of mental disorder plus comorbid severe personality disorder, and/or intellectual disability. At present there is no clinical case management model operating amongst MAP outpatients. By default the prisoners with complex mental health needs and those requiring referrals to external services are allocated ad hoc to the two Psychiatric Registrars.

It is envisioned that the MHNPs will each assume a case management role for a small number of these resource intensive patients to offer advanced nursing assessment, evaluation of holistic forensic mental health issues, and treatment planning based on evidence based principles. For example, the MHNP may order diagnostic investigations, undertake pharmacotherapy and medication management, counselling and psychoeducation, development of relapse prevention and risk management plans.

This role will be undertaken during daily outpatient’s clinics, and will include significant collaboration with other stakeholders e.g. including Corrections Victoria, Sentence Management Unit, Corrections Psychology, Justice Health, Area Mental Health Services, and the existing Forensicare Clinical team.
Inclusion criteria:

• Remanded and Sentenced male prisoners aged 18 to 65 entering reception at Melbourne Assessment Prison.
• Prisoners requiring advanced level forensic psychiatric nursing mental state assessment and/or suicide risk assessment and treatment (including pharmaceutical treatment).
• Higher needs prisoners aged 18 to 65, accommodated within Melbourne Assessment prison and referred by the MAP Clinical Team for Case Management. These prisoners will have an established diagnosis of a mental disorder in addition to one or more of the following comorbidities:
  o Personality Disorder.
  o Intellectual Disability and/or Acquired Brain Injury.
  o Significant Drug and Alcohol Issues.
  o Acute or Chronic suicide and self-harm concerns.

Exclusion criteria:

• Prisoners accommodated on Acute Assessment Unit.
• Prisoners with extremely complex needs receiving direct treatment from the MAP Consultant Psychiatrist.
• Prisoners identified by Consultant Psychiatrist awaiting involuntary psychiatric assessment and treatment.
• Prisoners with comorbid acute medical concerns.

Discharge from MHNP:

• Once a prisoner is rated a P2 (no longer presenting with acute psychiatric concerns, determined by the clinical team) or less he may be moved to an alternate prison site at the discretion of Corrections Victoria’s Sentence Management Unit. In these cases the MHNP will hand over care to the receiving prison’s health services.
• Once treatment planning goals are met.
• Released from custody at court (e.g. granted bail or time served).
• Released from custody as planned (e.g. parole or end of sentence).
• Prisoners admitted to AAU or Thomas Embling Hospital – though episode of care may be reinstated on discharge from these locations.
• The MHNP will provide referrals to continuing care providers (e.g. A.M.H.S.) as required.

Nurse Practitioner Timetable:

NP’s are allocated one study day per week and attend MAP to work 0800-1630 four days per week, this may be divided into eight half days to suit study requirements or the needs of the prison. In order to maximise resource distribution, the NPs will be encouraged to take their Study leave day on separate days of the wee. Attendance of Outpatients meeting on Friday Mornings will be necessary- See example below:

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Governance and Accountability:

Line management and professional supervision of the MHNP is provided by the Director of Nursing Practice. Clinical Supervision is provided by a nominated Consultant Psychiatrist, a Pharmacist and a Nurse Practitioner. The MHNP will work closely with the MAP Consultant Psychiatrist and Unit Manager during day-to-day operations.

The MHNP will present cases when the clinical team meets weekly to discuss outpatients’ clinical pathways and consult on treatment plans using each member’s knowledge and skills.

The MHNPs are accountable for health outcomes. They are responsible for all aspects of their clinical decision making. Medical practitioners do not have legal liability for MHNP decisions and actions.

The MHNPs will recognise the limits of their practice, seek out expert advice, and make referrals as necessary to ensure the delivery of quality patient care. The MHNP is solely responsible for the maintenance of their clinical skills and professional development in line with the expectations of the Nurses Board of Victoria and the Australian Nursing and Midwifery Council Nurse Practitioner Competency Standards.
References:


