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FMH8 Assess and formulate an individual's needs for forensic mental health treatment and care

OVERVIEW

This standard covers assessing an individual in order to develop their care plan. The individual's mental health problems have already been identified, and the task here is to assemble and interpret the information that can be used to formulate their problems and shape a unique care plan. The involvement and partnership working of the multidisciplinary team through the Care Programme Approach is essential for the development of a workable care plan, consistency of treatment and management.Users of this standard will need to ensure that practice reflects up to date information and policies.Version No 1

KNOWLEDGE AND UNDERSTANDING

You will need to know and understand:

1. tools for assessing risk and treatability (e.g. SVR 20 and START)
2. clinical assessment tools (e.g. BDI, BSI)
3. interview techniques
4. investigative methods & procedures
5. local guidelines or policies on Advance Statements (Scotland) / Advanced Directives (England, N. Ireland & Wales)
6. inquiry reports on forensic mental health settings, including recommendations and analysis of practice in the assessment of individuals
7. formulation of mental health problems
8. self-harming behaviours, including ligation
9. offending behaviours, especially violent behaviour not related to mental illness
10. mental health disorders
11. psychopathy and personality disorder
12. drug, alcohol or substance misuse
13. risk assessment
14. identifying benefits to individuals from different settings and treatments
15. current mental health legislation and regulations
16. the legal rights of individuals
17. how to develop the individual's participation in the assessment process
18. how to adapt communication styles in ways which are appropriate to different people (e.g. culture, language or special needs)
19. establishing rapport with people at different levels of ability and awareness

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20. methods of communicating sensitive information to individuals
21. how to involve the individual in the assessment and treatment planning process (e.g. understanding mental illness, anger management)
22. the religious beliefs of different cultures
23. the effects of culture and religious beliefs on individual communication styles
24. the different features services must have to meet people's gender, culture, language or other needs
25. the effects of different cultures and religions on care management
26. the principle of confidentiality and what information may be given to whom
27. how information obtained from individuals should be recorded and stored.

PERFORMANCE CRITERIA

You must be able to do the following:

1. develop a clinical risk assessment using a standardised assessment tool (e.g. HONOS SECURE, HCR20)
2. gather information about the individual's historical risk (e.g. personal and family history, criminal history, violent history, nursing notes)
3. identify complex problems the individual may have (e.g. co morbidities, substance misuse and assessment of Personality Disorders, Learning Disability)
4. engage with the individual in identifying their perceptions of complex problems including their existing adaptive coping strategies, skills and abilities
5. perform an assessment of functional ability in the fields of self care, leisure and productivity in collaboration with the individual
6. assess the physical needs of the individual
7. identify assess the individual's needs holistically, identifying health and social care needs including factors relating to the impact of culture, race, gender, spirituality, social class and lifestyle
8. formulate the individual's problems and engage with them to develop an outline care pathway to recovery for them based on the formulation
9. identify other relevant risk factors for the population group the person falls into (e.g. sex offender risk factors)
10. identify with the individual the indicators that might show the individual is approaching a state of relapse
11. collaborate with the individual in formulating plans for future care and treatment (e.g. in an Advance Statement that is realistic and practical to implement)
12. produce an historical risk document which can be passed on to different forensic health care providers and can be updated as new information is made available
13. collate the outcomes and discuss the results of the assessment to inform an initial care plan.

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ADDITIONAL INFORMATION

This National Occupational Standard was developed by Skills for Health.This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):Dimension: HWB6 Assessment and treatment planning