Office of the Chief Psychiatrist

Chief Psychiatrist's Thematic Review Program

Physical Health Care Report - Baseline

WA Public Mental Health Services

September 2011

This report is as a result of the Chief Psychiatrist's responsibility under the *Mental Health Act 1996* to monitor standards of care.

It is provided to West Australian Mental Health Services to assist in their continuing quality improvement of clinical service delivery.

Dr Rowan Davidson
CHIEF PSYCHIATRIST

March 2012

Government of **Western Australia**
Department of **Health**

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Important Disclaimer

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Acronyms

DOH	Department of Health
MHA	Mental Health Act (1996)
MHS	Mental Health Service
NSMHS	National Standards for Mental Health Services
OCP	Office of the Chief Psychiatrist

Glossary

Community
In the context of treatment setting - where mental health services are provided to people in a location other than the mental health service, usually in the home.

Consultation – Liaison
A section of the mental health service that specializes in the interface between general medicine and psychiatry, usually taking place in a hospital or medical setting.

Consumer
A person who is currently using, or has previously used a mental health service. (*NSMHS, 2010*)

Day Program
A program operated by the mental health service during business hours that usually provides rehabilitation activities.

Inpatient Psychiatric Service
A ward / unit / facility in a general hospital, private psychiatric hospital, stand alone psychiatric hospital or some other location used primarily for the treatment of mental health problems and / or mental illness. (*NSMHS, 2010*)

Involuntary
Means a person who is, for the time being, the subject of involuntary orders for the detention in an authorised hospital an involuntary patient, or a Community Treatment Order. (*MHA, 1996*)

Open
In the context of a type of admission, or inpatient ward setting. See 'Voluntary'

Outpatient
In the context of treatment setting - where mental health services are provided to people who are not currently in an inpatient psychiatric service.

Secure
In the context of a type of admission, or inpatient ward setting. See 'Involuntary'.

Voluntary
Admission to a mental health unit for treatment that results from the client making a decision for admission and signing the necessary agreement for inpatient treatment. (*NSMHS, 2010*)

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Executive Summary

The Chief Psychiatrist has responsibility under the *Mental Health Act 1996* to monitor standards of psychiatric care across Western Australia. In exercising this responsibility the Chief Psychiatrist has been conducting Clinical Governance Reviews of all public mental health services since 2003. During the period 2003 – 2009 a total of 19 Clinical Governance Reviews were completed with 500 recommendations made.

A number of salient themes have emerged, with the majority of services reviewed receiving recommendations in relation to each of these areas. In October 2010 the Chief Psychiatrist implemented Thematic Reviews of Mental Health Services (MHS) to enable a more specific focus of these salient themes.

The methodology utilized for the Thematic Reviews includes collecting baseline data, data analysis and trends, developing and disseminating guidelines and audit and reporting.

The current review (Thematic Review 1) examined the provision of physical health care to patients with a mental illness and serviced by public mental health services (MHS).

A total of 75 interviews were conducted with mental health clinicians across 38 mental health services. Interviewees represented a total of 96 programs across 4 streams. In addition a total of 306 patients provided feedback in relation to the physical health care that they received.

The aim of the review was to establish what processes were occurring, within MHS, in relation to the provision of physical health care.

A standardized interview tool was developed to assist Reviewers in interviewing the staff of the MHS. Similarly, a patient specific questionnaire was also developed to be sent to patients in the mail as well as to be utilized for the face to face interviews.

Overall the findings indicate that although MHS staff are cognizant of the importance of monitoring both the mental and of physical health care of their patients the practicalities often preclude comprehensive attention to both. The recommendations presented in this report are aimed at ensuring a more consistent approach to the management of physical health care issues across the State.

A total of 11 recommendations have been made and the findings of the review will contribute to the development of the Chief Psychiatrists Guidelines for the Physical Health Care of Mental Health Patients. These guidelines will reflect the work already completed by local MHS and research groups.

It is envisaged that MHS will implement the recommendations associated with this report and this will be followed by an audit of implementation approximately 6 months post release of the report.

Introduction

The Chief Psychiatrist has responsibility under the *Mental Health Act 1996* to monitor standards of psychiatric care across Western Australia.

The Chief Psychiatrist's ***'Clinical Governance Trends 2003 – 2009',*** report was released in 2011. The report presented the findings associated with the reviews of public MHS since 2003. During the period 2003 – 2009 a total of 19 Clinical Governance Reviews were completed with a total of 500 recommendations made as a result.

A number of salient themes emerged, with the majority of MHS reviewed receiving recommendations in relation to each of these areas. Having identified these themes, the Clinical Governance Review methodology was modified to utilize a thematic approach. Specific methodology is documented in the enclosed '***Thematic Reviews of Mental Health Services Methodology 2010 - 2011***'.

There are a number of benefits, to the MHS, using this revised methodology, including:

- All services will have an annual review with the Office of the Chief Psychiatrist in relation to the specific theme.
- Less preparation and onus on the MHS
- Targeted recommendations – recommendations will only be made in relation to the thematic area(s) under review

The thematic approach also provides an opportunity for the Chief Psychiatrist to develop specific guidelines in relation to each of the clinical care areas examined. It is envisaged that the guidelines will be developed in conjunction with the Area Mental Health Services to ensure that they complement currently existing processes.

In October 2010 the Chief Psychiatrist implemented Thematic Reviews of MHS. The first area of clinical care under review related to the Physical Health Care of Mental Health Patients. This report highlights the findings of that review, presents factors for success, limitations of the review and recommendations aimed at improving MHS management of their patient's physical health care needs.

Dr Rowan Davidson
Chief Psychiatrist

Recommendations

1. All MHS have a policy relating to the initial and ongoing monitoring of the physical health care of mental health patients (as per the Chief Psychiatrist's Physical Health Care Guidelines).

2. All MHS with inpatient facilities ensure that all inpatients receive a comprehensive, documented physical health assessment (criteria as per the Chief Psychiatrist's Physical Health Care Guideline) within 48 hours of admission or as soon as reasonably possible following admission.

3. All MHS adopt standardized assessment practices in relation to the physical health care of mental health patients (criteria as per the Chief Psychiatrist's Physical Health Care Guideline).

4. All MHS develop processes to ensure that copies of the results of patients undergoing physical health care assessments by an outside practitioner are provided to the MHS.

5. MHS develop documented Memorandums of Understanding with relevant stakeholders to ensure that there is effective communication and continuity of patient care.

6. All MHS have a policy on monitoring the effects of atypical antipsychotic medication on patient's physical health.

7. All MHS utilise a referral form that includes physical health care information.

8. All MHS that employee GP Liaison Officer positions ensure that there is a current GP Liaison Officer job description form (JDF).

9. All MHS have a policy in relation to what equipment is required in treatment rooms to enable physical health care assessments and monitoring.

10. All MHS offering Exercise groups, as part of their rehabilitation program should ensure that all participants have had a physical assessment by a Medical Practitioner within the three months prior to commencing the Exercise Program.

11. MHS located within a General Hospital setting should endeavour to have integrated medical records.

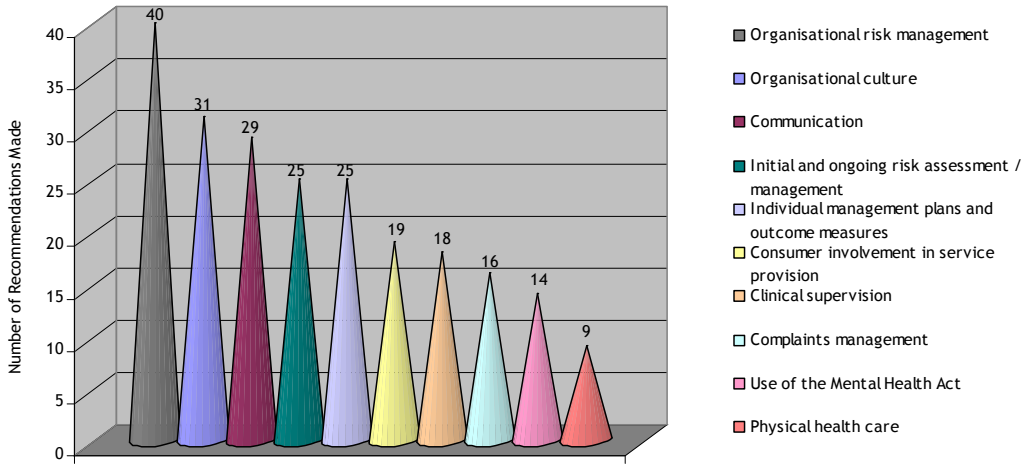
Context

CHIEF PSYCHIATRIST'S RESEARCH

The Chief Psychiatrist has been conducting Clinical Governance Reviews of all public mental health services since 2003. During the period 2003 – 2009 a total of 19 Clinical Governance Reviews were completed with 500 recommendations made.

There are a number of salient themes emerging, with the majority of services reviewed receiving recommendations in relation to each of these areas. Emergent themes are represented in the chart below.

Figure 1: Themes of Recommendations



Having identified these themes, the Clinical Governance Review methodology was modified to utilize a thematic approach. It is intended that one or a combination of themes will be identified as an annual focus. An outline of the methodology is summarised in the section entitled Methodology.

OTHER RELATED RESEARCH

There are three other major local projects which have contributed to our understanding of the physical health issues facing persons with a mental illness. They include the Duty to Care Report, the Clinical Case Note Audits and Clinical Guidelines for the Physical Care of Mental Health Consumers. The following section outlines their respective contributions.

Duty to Care Report

Individuals with mental illness are a particularly marginalized group with the facets of their illness having wide reaching effects on their physical, social and psychological well being.

A significant amount of research (Lawrence, Holman & Jablensky, 2001) has been conducted into the prevalence of physical health issues in persons with a mental illness. In particular a unique large scale study (*Duty to Care*) was conducted involving 240,000 Western Australians (8 percent of the population) who used a mental health service during the period 1980-98. The aim of the study was to examine the physical health of people with mental illness and to provide data that can be utilized to develop targeted interventions.

The Duty to Care Report was released in 2001 and highlighted the following findings.

Individuals with a mental illness are:

- 2.5 times more likely to die from a physical illness than the general population
- More likely to smoke (43% as compared with 24% of the general population).
- More likely to experience nutritional deficiencies, obesity and diabetes
- More likely to engage in high risk behaviour such as smoking, alcohol or drug abuse
- Less likely to engage in health-promoting activities such as good diet and exercise

Historically, there has been a separation between the provision of physical and mental health care for this particular population with mental health services catering for their mental health care and General Practitioners (GP) being responsible for the physical health of the individual. This division of care can lead to individuals with a mental illness not receiving adequate health care in relation to their health needs especially if they do not have a designated GP.

In addition to the large scale research noted above additional specific Physical Health Care research has been also been conducted by the Centre for Clinical Research in Neuropsychiatry (CCRN) – Clinical Applications Unit (CAU). A summary of the research findings is presented below.

Clinical Case Note Audits Undertaken by the CCRN - CAU

Physical Health Care Assessment in the Mental Health Population
The CCRN - CAU undertook an audit to characterize the psychiatric patient cohort across four Mental Health Service sites with regard to major preventable heart disease and also to investigate the process by which decisions are made associated to physical health risk. Data was collected from four sites.

Findings
The results of the research suggest that there is minimal focus on issues relating to cardiovascular disease within MHS settings. CVD risk factors including tobacco, substance and alcohol use were inconsistently collected across three of the four sites. Additional physical indicators including lipid profiles, height, weight and girth were inconsistently recorded in the clinical notes across all four sites. In relation to pre existing conditions the results suggest that abnormal results did not necessary equate to a follow up by the mental health service and a subsequent change in the clinical care of patients (Harrison, 2010).

The findings of the above research are supported by the findings associated with the current review.

Clinical Guidelines for the Physical Care of Mental Health Consumers

In 2009 the Department of Health commissioned the Community, Culture and Mental Health Unit, School of Psychiatry and Clinical Neurosciences, the University of Western Australia to develop Clinical Guidelines for the Physical Care of Mental Health Consumers.

The project began with a review of the national and international literature and research. From this a set of evidence based best practice clinical guidelines have been developed to assist clinicians in assessing and monitoring the physical health care of their patients.

The Researchers consulted with mental health staff, consumers, carers, and stakeholders with regard to the content and layout of the guidelines. There are several components to the guidelines including a clinician handbook, a psychosocial assessment pack, a carer handbook and a consumer diary.

The Clinician Handbook contains evaluation tools for five areas that are reported to impact on a patient's physical health including:

- Medication effects
- Lifestyle factors
- Physical conditions
- Alcohol and Illicit drugs and
- Psychosocial factors

The psychosocial assessment pack has been designed to assist clinicians in better understanding their patient's health related behaviours and social situation including culture, religion, spirituality, exercise, diet, smoking, oral/dental, sexual activity, alcohol and other drug use, psychosocial supports. The package contains a wall chart – metabolic syndrome algorithm, a clinical handbook detailing medication and assessment information, general screening forms outlining the tests required for general medication use, specific medication use such as lithium carbonate and for monitoring Clozapine.

The Consumer Diary has been developed to assist patients in assimilating information, keeping a track of appointments, implementing strategies to reduce relapse and to record personal information. It is intended to compliment the information contained in the Clinicians handbook.

The Carer Handbook has been developed to facilitate carers working effectively with patients and mental health services to ensure both the mental and physical health of those that they care for.

The guidelines have been produced by the University of Western Australia. Copies are available at http://www.psychiatry.uwa.edu.au/research/community-culture/physical-care-clinical-guidelines (Stanley, S & Laugharne, J, 2010).

Review Methodology

The Physical Health Care thematic review methodology incorporates four phases as outlined below.

Collection of Baseline Data

In order to ascertain how mental health services are currently functioning in relation to the physical health care of mental health patients, baseline data was collected from all public mental health services within Western Australia. The data was collected via interview between a representative of the OCP and key clinical staff of the MHS. A standardised interview form was developed and where necessary the mental health service was asked to provide supporting documentation (eg. policies, standardised forms).

This initial collection of baseline data was to understand the processes in place at mental health services, rather than compliance with the processes. The latter will be assessed during the audit phase.

Data Analysis and Trend Report

Data collected from all mental health services was analysed by the OCP and the current report developed. A copy of this report will be provided to the Director General of Health, Area Mental Health Directors and MHS.

Development and Dissemination of Guidelines

The OCP is in the process of developing Chief Psychiatrist Guidelines relating to Physical Health Care. These Guidelines are being developed to ensure that they complement currently existing processes.

Upon approval of the Guidelines, a copy will be sent to all MHS. It is not intended that these guidelines are prescriptive, but rather provide general direction in relation to the thematic area in order to assist mental health services that do not have processes in place.

Audit and Reporting

The audit process is differentiated from the baseline data collection process in that the intention of the audit phase is to assess whether processes identified in the collection of baseline data are actually operational. For those MHS that did not have processes in place, there is an expectation that these processes have been implemented following dissemination of the Chief Psychiatrist's Guidelines relating to the particular area under review.

Findings from Clinician Interview

Demographic Information

A total of 75 interviews were conducted with mental health clinicians across 38 mental health services. Interviewees represented a total of 96 programs across 4 streams. Table 1 provides a breakdown of programs by Stream.

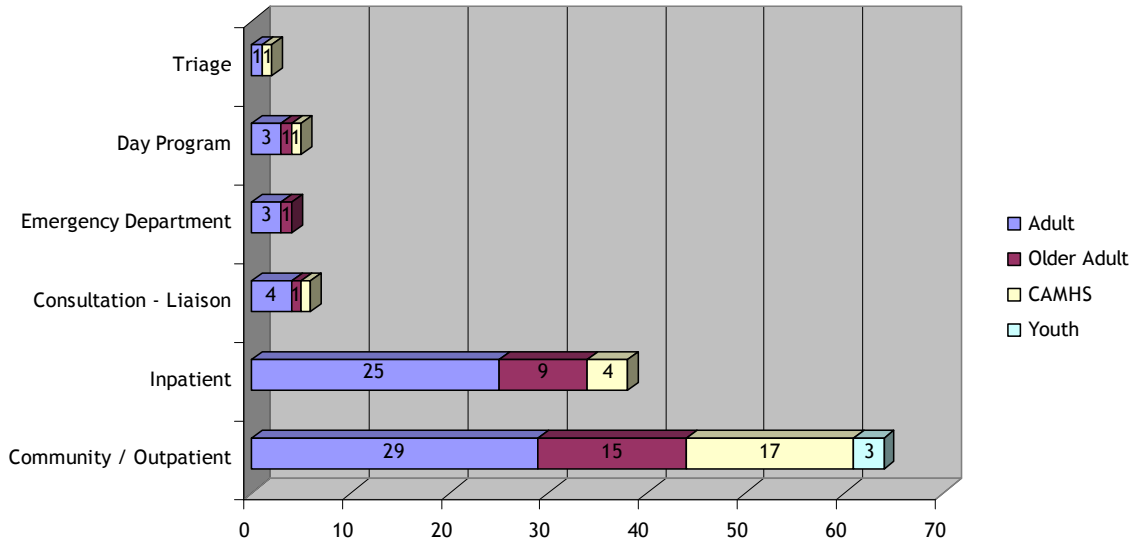
Table 1: Programs Reviewed by Stream

Stream	Number of Programs
CAMHS	20
Adult	53
Older Adult	20
Youth	3
Total	**96**

Note: Some interviews covered multiple programs and /or streams

Within each of the Streams there were a variety of settings including those listed in Figure 2. It was necessary to interview key clinicians in each of the program areas as practices varied within MHS.

Figure 2: Number of Program Areas Reviewed – by Setting and Stream



Entry to the Service

In order to understand the type of referrals that MHS were receiving staff were asked where they accepted referrals from. The aim was to establish if any one of the referrals sources provided more physical health care information, as part of the referral process, than the next.

Services reported accepting referrals from (but not limited to) the following sources:

- General Practitioners
- Other Mental Health Services
- General Hospital/Emergency Departments
- Self Referral/Family
- Courts/Justice
- Schools
- Private Practitioners
- Other Health Agencies (e.g. Aboriginal Medical Service)

While the list of referrals sources provided was not exhaustive it was apparent that referrals from General Hospitals/Emergency Departments, General Practitioners and Private Practitioners were more likely to contain some form of physical health care information as part of the referral process. This information was not standardised and the content was dependent on the Clinician completing the referral.

Referrals within some of the Older Adult services, from General Practitioners, appeared to be an exception. Given the co- morbidity issues associated with treating older adults a number of the older adult services require that patients have an organic /delirium workup prior to being admitted to the MHS. One Older Adult MHS required the following prior to acceptance of the patient - blood tests (FBP, CRP, U & E's LFT, TFT, Serum Calcium, phosphate, magnesium, B12, Folate, Syphilis serology, Fasting BSL and if diabetic a glycated haemoglobin), current medication levels, microbiology screening (MSU and Sputum) and an ECG (where possible). Feedback from the staff, at this MHS, highlighted the benefits of this level of screening prior to acceptance of the patient for ongoing treatment. The practices at the Older Adult MHS support the use of standardised referral forms and will be reflected in the recommendations associated with this report.

What is the Emergency Department Policy (ED) on physical assessment for mental health consumers?

Anecdotal information suggests that emergency departments require that all patients undergo a full medical review prior to being triaged to a mental health unit for ongoing treatment.

Twenty one programs, associated with a particular ED, indicated that the ED had a specific policy on the physical assessment of mental health consumers. Ten of those programs had policies stating that a mental health consumers must be 'medically cleared' before being transferred to the mental health unit. This was particularly important with first time presentations. For the remaining 11 programs physical assessments were only conducted if it was a first time presentation or if clinically indicated. Consumers who were known to mental health services were more likely to be transferred directly to a mental health unit than to be 'medically cleared' in the ED.

The notion of a mental health patient being 'medically cleared' is one fraught with controversy in that the comprehensiveness of the physical assessments is variable with some involving just a physical screening process and others a full medical assessment including a range of laboratory tests. The effectiveness of this process appeared to be influenced by whether the ED employed Psychiatric Liaison Nurses (PLN). Those programs with PLNs reported that they were more likely to get assistance from the ED staff, in relation to physical assessments, then those that did not.

Does the MHS receive information about ED visits (for out of area ED visits or services without their own ED)

Seven programs indicated that they received information about consumers presenting to EDs either via discharge summaries or hand over from PLNs although the latter was often an informal process.

The issue of communication between departments (EDs and MHS) appears to be affected by both the record keeping technology utilised and the structure of the medical records.

Electronic record keeping such as the Clinical Governance Management System (CGMS) and Treatment Episode Data Set – Discharges (TEDS) ensure that mental health units receive written information about the assessment and treatment patients have had, in the ED, prior to being transferred to the mental health unit. For those organisations that do not operate CGMS or TEDS the timeliness of discharge summaries can be protracted. If a patient is being discharged from an inpatient unit to a community MHS, the MHS is likely to receive the inpatient interim and final discharge summaries after the patient has already engaged with the community MHS.

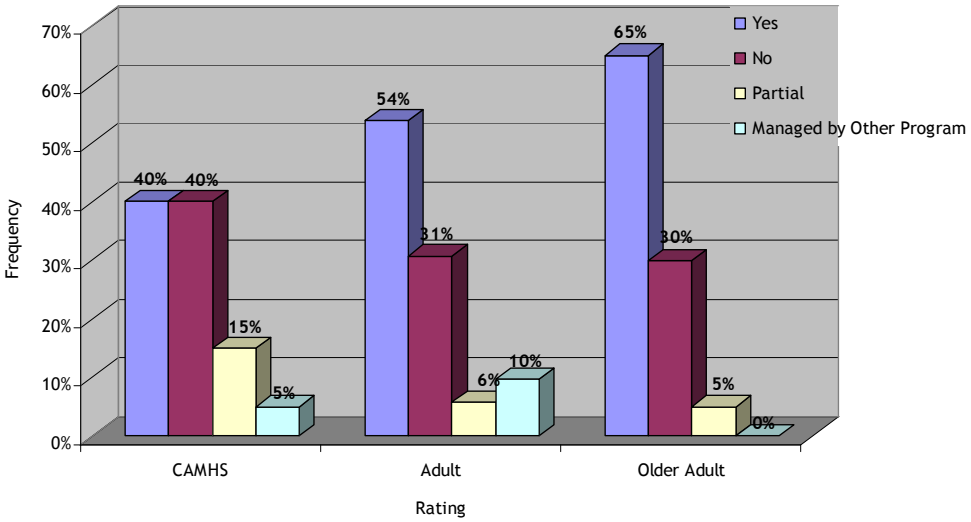
The separation of General Hospital and Mental Health Service clinical records was also seen to impact the effectiveness of the communication processes. If the patient had two clinical records, one for mental health and one for general health and the patient presented at the ED, the ED staff had to wait until the medical record, containing mental health entries was retrieved from the MHS before being able to accurately assess and triage the patient.

The communication and documentation processes associated with MHS that have integrated medical records were found to be more effective and comprehensive respectively.

Does the MHS currently perform physical assessments for Mental Health Consumers?

Historically there has been a separation between mental and physical health care with the latter being seen as the responsibility of the patients General Practitioner. As the significance of mental illness on a patient's physical health has become better understood it has been recognised that mental health professionals also need to be involved in the ongoing monitoring of their patients physical health. This is particularly important for those patients, who may not have an identified GP, may not wish to engage with a GP or who have issues with medication compliance.

Figure 3: Percentage of Physical Assessments Conducted on Entry by Stream



Of the 74 programs reviewed a total of 37 indicated that they conducted some form of physical health assessment on entry to the service. Twenty six programs indicated that they did not perform assessments on entry, five reported completing partial assessments and six stated they were not applicable for the area in which they worked (i.e. CAMHS Centralised Triage). A comparison of the streams indicated that 65% of Older Adult services performed physical assessments on entry, followed by 54% of Adult services and 40% of CAMHS services. The latter result is likely to be reflective of the rate of co morbid issues in the Older Adult population.

A review of the physical assessment protocols indicated that they were variable across the sector with some services conducting more comprehensive reviews than others. This was largely dependent on the individual clinician conducting the physical assessments, if a standardized assessment tool was utilised and what equipment the service has readily available to assist with the assessment.

Currently in WA there are two projects which provide clinicians with guidance in relation to the collection of initial baseline physical examination data. The WA Statewide Standardised Clinical Documentation Steering Committee has adapted the New South Wales Mental Health Physical Examination form for use by clinicians collecting initial baseline data. In addition researchers from the School of Psychiatry and Clinical Neurosciences at the University of Western Australia have developed best practice Clinical Guidelines for the Physical Care of Mental Health Consumers. These guidelines are aimed at assisting clinicians in taking a more holistic approach to the care of mental health patients and as such include additional sections on lifestyle and psychosocial factors. Specific details of the assessment domains are located in the Formal Documentation section of this report (page 25).

Physical Assessment / Health Care within the MHS

Does the MHS have the necessary equipment immediately available to conduct a full physical assessment of a mental health consumer?

As with the physical health assessments, the review also found that there is a diversity of equipment, within MHS used to conduct these assessments. The physical health assessment criterion appears to be dependent on the individual clinician and the equipment that is available to them.

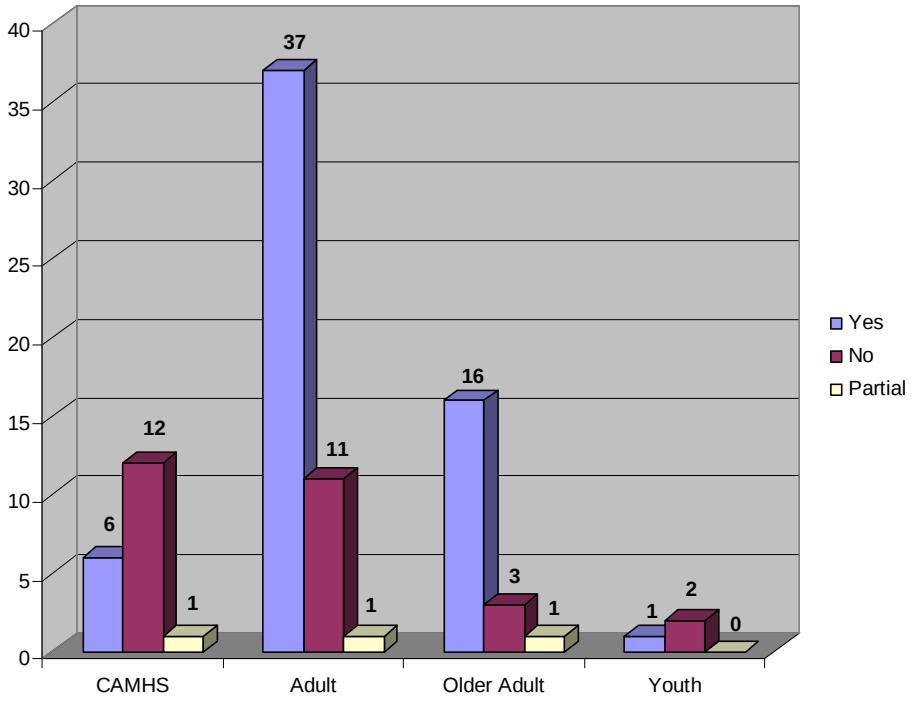
MHS require a range of equipment in order to complete both an initial assessment and the ongoing monitoring of a patients physical health. If utilising the form referred to in the previous section the MHS will require, at a minimum:

- A private well lit area with an examination bed and sink
- Stethoscope
- Sphygmomanometer
- Thermometer
- Tendon hammer
- Tuning fork (256 Hz)
- Weighing scales
- Tape measure
- Urinalysis sticks
- Auriscope and ophthalmoscope
- Snellen chart
- Penlight
- Height measure
- Disposable gloves
- Examination lubricant
- Neurological testing pins
- Extended Physical examination and investigations
    - Peakflow monitor
    - Glucometer
    - Alcometer/breathalyser
    - Oximeter
- Pathology venipuncture and associated collection equipment *(only required if not outsourced to a Pathology Centre)*
- Pathology specimen containers *(only required if not outsourced to a Pathology Centre)*

(New South Wales Health (2009) Policy Directive: Physical Health Care within Mental Health Services)

Figure 4 suggests that the availability of equipment in WA to facilitate physical health assessments was most prominent in the Adult sector however, when comparing the streams by percentages (16/20) 80% of the Older Adult programs had equipment, followed by (37/52) 71% of the Adult programs and (6/20) 30% of the CAMHS programs. MHS with dedicated treatment rooms were more likely to have equipment. Rural sites and those with patients requiring home visits faced additional challenges, needing to have mobile physical health assessment equipment.

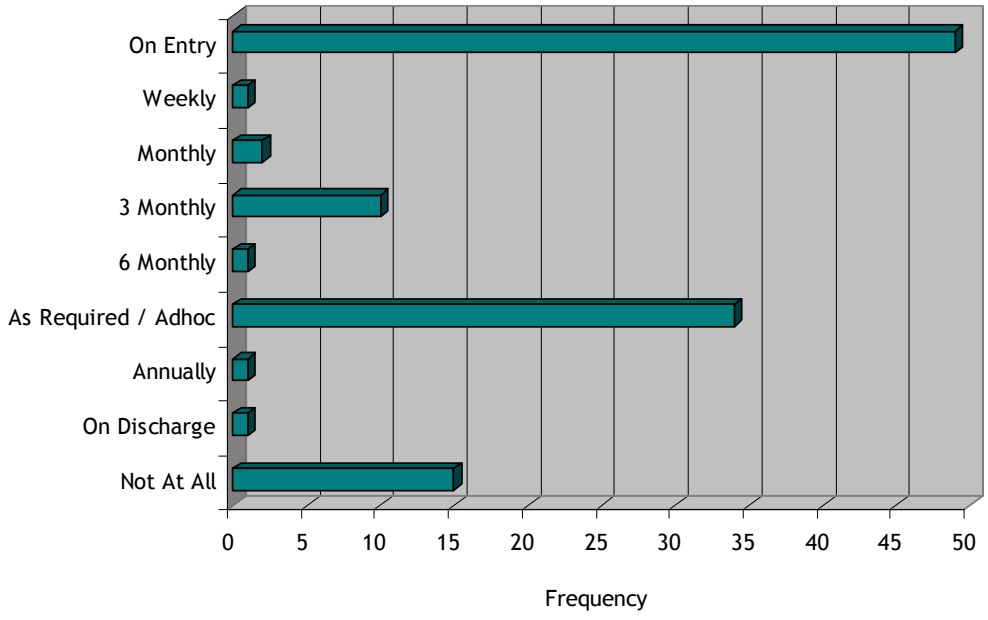
Figure 4: Availability of Equipment for Physical Examination
Note - where physical health care of patients is managed by a different program within the service, these have been removed from the data set as 'Not Applicable'



How often does the MHS perform physical assessments of consumers?

In relation to the frequency with which Physical Health Assessments are being conducted Figure 5 indicates that it is variable across the state.

Figure 5: Frequency of Physical Health Assessments



While the majority of MHS reported performing some form of physical assessment on entry the frequency of physical health care assessments post entry was variable with the majority of ongoing reviews being adhoc or as and when required. Research (*Stanley & Laugharne, 2010)* suggests that the physical health care of patients with a mental illness should be monitored on a three monthly basis or more often if clinically indicated.

Who is predominantly responsible for conducting the Physical Assessments for patients active with the service?

In relation to who was responsible for conducting the Physical assessments Table 2 summarises the interview responses.

Table 2: Practitioner Responsible for Physical Health Care Assessments
Please note that some programs provided more than one response to this question

Responsible Practitioner	Number
Consultant Psychiatrist	8
Medical Officer	21
Registrar	7
Intern	4
Nurse	1
General Practitioner	34
Other Practitioners (AMS, Paediatrician)	8

Those MHS that employed medical officers were more likely to conduct physical assessments on entry to the service. The effectiveness of General Practitioners (GP) completing the physical health care assessment was dependent on the relationship between the GP and the MHS and the level of communication between both parties. The relationships between GPs and Older Adult MHS were seen to be the most effective. This is likely to be related to the frequency of co – morbid conditions needing to be managed for this group of patients as well as the initial protocols that were set up by the Older Adult sector. The majority of Older Adult services will not accept the referral of a patient without a full physical health care assessment having been completed as part of the referral process. This process is less well defined in the Adult sector with referral details often being very brief. Overall the data suggests that information regarding patient results being provided by the GP to the Adult MHS occurs inconsistently across the sector and is dependent on the individual GP (or Practice Manager) and clinician involved.

Does the MHS have a General Practitioner Liaison Officer?

General Practitioners have a unique role in the health care system in that they can offer a comprehensive service for the patient and their family that extends beyond triage or follow-up, and ensures a comprehensive approach to the patient's overall wellbeing, including physical and mental health. The general practitioner has the added advantage of providing continuity of care over a lifespan. GPs are also uniquely positioned to offer early intervention and timely responses in mental health illness diagnosis, relapse, and referral, as well as ongoing management of ongoing issues.

There are benefits for the both the GP and the patient, in the relationship, including:

- Increased access to MHS
- Collaboration in patient care
- Communication
    - To improve communication between the mental health service and general practitioners.
    - Timely notification to GP of patient admission to acute psychiatric units.
    - Timely discharge summaries from community MHS to GP's.

The introduction of GP Liaison positions into MHS is a fairly new initiative, in WA, with only 12 programs indicating that they had an established GP Liaison position within the MHS (these 12 programs were within seven MHS).

What is the role of this individual in relation to Physical Care Assessments?

The role of the GP Liaison Officer in relation to physical health care assessments involves facilitating:

- General practice referrals to mental health inpatients
- Regular physical assessments for mental health patients
- Effective communication processes between the GP and the MHS
- Those patients that are not linked in with a GP to find one that suits their needs
- Discharge planning from inpatients and community teams.

To date the MHS employing a GP Liaison Officer have been allowed to develop the position to fit the requirements of the individual mental health service. The content of the job description across the seven sites appears to be influenced by the individual in the position and the challenges faced within the MHS with regard to the relationship between the GP and the MHS.

If GP conducts regular assessment is the MHS notified of the outcome?

33 of the 48 outpatient / community based programs indicated that GPs conducted regular assessments of their mental health patients. For the remaining programs, the lack of GP involvement seemed to be related to the ability of the MHS to find GPs that bulk billed, GPs that were mental health friendly and access to GPs generally in the rural and remote sector. Older Adult MHS reported having a better relationship with the GPs given that they have a set of information that the GP is required to complete prior to acceptance of a referral.

Programs reported a lack of feedback from GPs regarding the physical health care of mental health patients with only 14 programs indicating that they were informed when the GP conducted an assessment.

Clinicians provided the following direct responses in relation to this item:

- *"Communication very variable. As a group Child Psychiatrists have tried to improve relationships with GPs - variable response"*
- *"We receive very little feedback from GPs. Usually the patients feedback regarding their GP visit"*
- *"We do not have a communication system in place yet, but we are hoping to develop this"*
- *"In the rural areas it is harder to get GP input"*
- *"The communication is one way. If GP's change medications they do not inform the MHS"*
- *" We do not have a 'tight relationship' "*
- "*No feedback is provided. If information is needed then contact is made to request information*"
- *"Half give feedback and half do not. Good relationship. Service always advises GP in writing*"
- *"GPs are responsible for conducting physical assessments. They are considered the case managers. The MHS does not necessarily receive a copy of the report, but they are advised of issues and will follow up with GP if required"*
- "*Our GP Liaison Officer is trying to improve these relationships*"
- "*The communication is good - we just ring up and speak with the GP*".

- *"Can't rely on the processes. Only if coming in as a referral from a GP, but not in any standardised reportable way"*
- *"All of our patients have a GP and we have strong links with GPs"*
- *"Communication processes are ad hoc. Have difficulties hearing from back GP – our therapists send fax to GP after every session"*
- "*Access is difficult (only a few GPs who bulk bill). GP's don't always do physical exam. Older Adults tend to have systems in place (doctors/carers) to help"*
- *" We send 3 monthly letters to the GP for communication of treatment"*

As is indicated by the Clinician comments above the practices in relation to communication with GPs are variable. It is clear however that the MHS recognise the need for improved communication processes with GP and the associated benefit to the patient, carer, and MHS that effective communication provides.

If the feedback, from the GP is verbal, is there a documented requirement that the clinician receiving the information documents the outcome in the consumer's medical record?

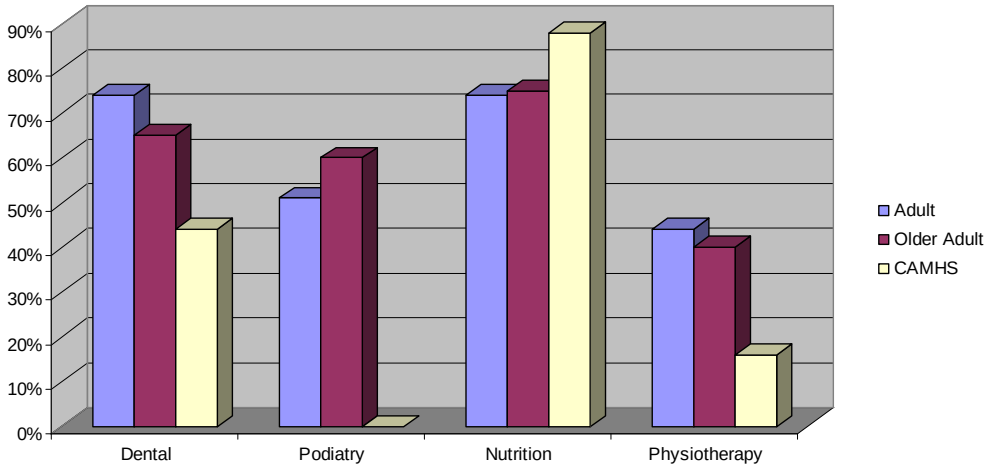
Discussions with clinicians indicated that there is no specific requirement for clinicians to document discussions with other stakeholders although it was recognised by many that this would be considered good practice. The practices were variable within and between MHS and appeared dependent on the level of detail provided to the clinician by the stakeholder, the individual clinician's style of practice and the specific requirements of the MHS.

Access to Additional Services

As is summarised in Figure 6 below some MHS assist patients in accessing ancillary services including dental, podiatry, nutrition and physiotherapy. These services were provided in a range of ways including: by in house staff employed specifically to provide these services, via links with general hospitals or by access to private or community services located near the MHS.

The provision of dental services by Graylands Hospital contributed to 74% of patients in adult programs, across all MHS, having access to dental services. It can be suggested that the similarly large percentage (74%) receiving access to Nutrition services is in part due to the prevalence of cardiovascular risk factors (smoking, physical inactivity, and obesity) and a recognition and recent focus, by MHS, on issues such as metabolic screening and the provision of education and groups on healthy lifestyle. Podiatry services were predominantly provided to those patients with diabetes, or Older Adult patients whose foot care is important in maintaining their mobility. Physiotherapy services were provided less consistently across the MHS and were dependent on MHS being able to access general hospital Physiotherapists.

Figure 6: Percentage of Programs with Access to Additional Services



These figures relate specifically to ancillary services accessed by patients via the MHS. Patients were also able to access private agencies providing these services and were able to gain access to community services via their General Practitioner. The effectiveness of the latter two avenues of access was dependent on the motivation of the patient coupled with the encouragement of the GP.

Twenty-one programs reported access to other specialties as required (speech therapy, urology, pain management, etc.) Thirty-nine programs reported links with other agencies, NGOs, to provide comprehensive care. Some MHS did report that there were issues regarding waitlists for some public services.

Does the service have communication links in place with specialist care physicians, surgical and / or specialty areas?

Thirty nine of the MHS indicated that they had links with external agencies that provide services addressing physical health care issues. These agencies included General Practitioners, General Hospitals, Geriatricians, Paediatricians, Aboriginal Medical Service, Medical Specialists and Non Government Organisations providing healthy lifestyle activities. The formality of the links with such agencies was variable with some MHS having Memorandums of Understanding with external agencies and others having only an unwritten historical understanding. The latter being problematic when clinicians move from one service to another and there is no written agreement for the next clinician to refer to.

How are physical health care investigations managed within the service - eg. pathways, data collection, who requests investigations, who signs off on investigations?

Thirty one programs provided feedback on how physical health care investigations are managed within the MHS. They reported a range of avenues including via General Practitioners, Interns, Medical Officers and Specialist Consultants. The frequency of investigations is dependent on the clinical presentation of the patient and may occur following anomalies identified during daily observations, feedback from the patient or a request from the treating team. For outpatients and community based patients the need for investigations is discussed by the team with the Team Leader having the overall responsibility of ensuring the appropriate investigations are undertaken. The Consultant Psychiatrist, Medical Officer or Registrar is usually responsible for ensuring that the appropriate investigations are undertaken for inpatients.

Mental Health Inpatient units – How often are routine observations conducted - weight, pulse, blood pressure?

The data collected indicates that the frequency of routine observations being conducted was variable across the inpatient units and even within the same MHS. Twenty one inpatient units reported conducting routine observations as part of their regular nursing procedures. The frequency of collecting the data varied from 'as clinically required' to daily. Those MHS engaged in metabolic screening projects were more likely to collect the data on a regular basis.

In relation to the use of observation charts, although not specifically reviewed in this thematic review the comments reflected in the data set suggest that the use of nursing observation charts on inpatient units are common practice on initial entry to the MHS and that the ongoing frequency is dependent on the clinical need as assessed by the treating team.

Do long stay inpatients have appropriate access to health promotion, screening and preventative activities?

A total of 12 programs reported having long stay patients. Of those 9 reported that patients had access to preventative activities including pap smears, prostrate exams, mammograms etc. Discussions with staff indicated that if an inpatient advised staff of a particular health issue an investigation would be conducted. If the individual was an outpatient or community patient they were more likely to be referred to a GP for follow up.

Stand Alone services (ie. MHS not attached to a General Hospital) - how are issues related to physical health care managed?

For those services that are not attached to a general hospital, issues relating to physical health care are generally managed by the GP. Some mental health services also reported that they have the ability to refer directly to a specialist if required. Leaving the responsibility of patient's physical health entirely to the GP does raise the issues documented in previous sections in relation to those patients who do not have a GP, lack of effective feedback loops between the MHS and the GP (which may lead to a lack of continuity of care), lack of access to GPs in the rural sector and a paucity of GPs who bulk bill. It is imperative that MHS develop strong working relationships with GPs and ensure that there are effective communication processes in place to provide the best outcome for patients.

Substance Abuse and Dependence

The effective management of both substance abuse and mental illness is challenging. Dual diagnosis can mean an increase in challenging behaviours including self-harm and aggression, avoidance of services, and resistance to or non-compliance with treatment and recovery programs. Research suggests that people with a dual diagnosis respond well to comprehensive programs that address both their mental illness and their substance abuse. Sane (2010).

Does the service have an established liaison pathway for assisting patients with substance abuse / dependence issues?

Historically the issue of mental illness and substance abuse is one that has been fraught with controversy in that many MHS are not well prepared to deal with patients having co morbid issues and as such often only one of the two problems is identified. If both are recognized, the individual may be bounced back and forth between MHS and drug and alcohol services or may be refused treatment by both given the inability to identify which is the primary problem.

More recently the issue of dual diagnosis is one that MHS have had to address and of those MHS reviewed 60 programs reported that they had established pathways for assisting patients with substance abuse / dependence issues.

Table 3: Management of Substance Abuse / Dependence Issues
Please note that some programs provided more than one response

Method of Management	Frequency
In-house (staff on site)	19
Specialist called in to service (shared-care model)	12
Referred to Specialist Service (eg. DAYS, Mission Australia, Next Step)	38

MHS reported three pathways including utilising on site staff, using a shared care model or referring patients onto a separate specialist service. The latter was the most commonly used pathway, followed by on site staff and shared care.

How is information communicated between the services?

Discussions with MHS staff indicated that where there is a shared-care model in place, communication between the two services is effective, with the relevant information is being relayed and recorded in the clinical records. The communication processes vary with some MHS having joint meetings with drug and alcohol workers, others relying on verbal and written feedback from co workers.

Is there any joint work between the services and does the service provide any training in substance abuse / dependence?

24 programs reported undertaking some form of joint work with Drug and Alcohol Specialist Agencies. This takes the form of shared ward rounds / team meetings and co-management of cases. Six programs also provided and / or attended joint training sessions with Specialist Drug and Alcohol Agencies.

Formal Documentation

Does the MHS have a standardised physical assessment protocol which is documented in the consumer's medical record?

A total of 24 programs reported that they utilised a Standardized Physical Assessment Form. The majority of the forms, with the exception of those MHS involved in piloting the Standardised Statewide Assessment Form, were developed in house by MHS staff. Although this practice has led to MHS having forms that are tailored to meet their specific needs it means that there is a lack of continuity across the state in relation to what information is collected.

As discussed previously in the section entitled 'Physical Assessment / Health Care within MHS' (page 17) there are two recent initiatives that have contributed to the implementation of standardized assessment documentation across WA. These include The WA Statewide Standardized Clinical Documentation project (SSCD) and the research conducted by the School of Psychiatry and Clinical Neurosciences at the University of Western Australia regarding the best practice Clinical Guidelines for the Physical Care of Mental Health Consumers (UWA).

The standardized form developed by the Statewide Standardised Clinical Documentation Group contains the following fields:

- Demographic information about the patient and the facility
- General Appearance and Observations including:
    - Pulse
    - Blood Pressure (lying and standing)
    - Temperature
    - Respirations
    - Urinalysis
    - Height
    - Weight
    - Body Mass Index
    - Blood Sugar Levels
    - Waist
    - Hip
    - Waist / hip ratio
- System Review (e.g. relevant positive or negative symptoms)
- Cardiovascular
- Respiratory
- Gastrointestinal
- Neurological
    - Consciousness
    - Pupils
    - Cranial Nerves
    - Power
    - Sensation
    - Tone
    - Reflexes
- Gait
- Abnormal Involuntary Movement Scale (AIMS)
- Additional Examination
- Pregnancy Status
- Overall Impressions
- Immediate Actions (e.g. investigations ordered, urgent treatment, consults requested)

(Statewide Standardised Mental Health Clinical Documentation Steering Committee, 2011)

In addition to the domains above it has been suggested that following supplementary baseline data be collected in order to present a comprehensive physical health care picture. The following additional domains have been developed and it is suggested that both sets of data be collected on a three monthly basis *Stanley & Laugharne (2010)*.

- Lifestyle
  - Exercise
    - Activity level
  - Diet
    - Nutritionist
    - Eating Guide
  - Smoking
  - Dental
    - Last Appointment
  - Contraception

- Physical Disorders & Allergies
  - HIV/STI
  - Hepatitis C/B
  - IBS/Gastrointestinal Disorders
  - Type 2 Diabetes

- Alcohol & illicit Drug use
  - Alcohol (AUDIT, SADQ-C)
  - Other Drugs – (DAST-10, SDS)

- Psychosocial
  - Familial support
  - Social support
  - SES & Employment and Culture/Religion

While it would be considered best practice to collect all of the data listed above it may not necessarily be practical. The following scenarios are likely to impact on the level of detail that can realistically be collected on a three month basis:

- Clinicians with high case loads who are less likely to have the capacity to all aspects of the patients care
- Clinicians caring for patients who live in rural and remote areas
- Patients who are managed by a Consultant Psychiatrist only (no case manager)

The Chief Psychiatrist would recommend that information collected in relation to the domains identified by the SSCD be considered as standard practice with collection of data to address the additional domains, as identified in the UWA research, as best practice.

If No, what specific health care information is documented in the consumer's medical record?

Those MHS that did not utilise a standardized physical assessment form tended to complete and document a brief physical assessment in the integrated patient notes. The content and comprehensiveness of these assessments was largely clinician dependent. Those MHS that have an inpatient unit and employ Medical Officers or have access to Interns or Medical students are more likely to perform regularly physical health checks than those that do not.

Medical students and Interns conduct brief physical health assessments and document their findings in the patient's medical record. The notations relate to general health, head, ears, eyes, nose and throat (HEENT), respiratory, cardiovascular, abdominal, extremities, neurological.

Does the MHS have a current policy relating to the physical health care of consumers?

Sixty four of the seventy four programs reviewed did not have a current policy in relation to physical health care. Practices appeared to be service and clinician dependent and were heavily influenced by the stream being catered for and staff mix. Inpatient units were more likely than community services to attend to physical health care issues. Discussions with metropolitan community mental health staff indicated that the physical health aspect of care was likely to the responsibility of the patients' General Practitioner unless the issue had a specific impact on the patient's mental health status (i.e. possible causal relationship between some of the newer antipsychotic medications and metabolic abnormalities). MHS that employed Medical Officers were more likely to have a focus on physical health care issues. Patients on atypical antipsychotics including Clozapine were more likely to have their physical health care monitored regularly. MHS with staff undertaking metabolic screening projects were more likely to monitor the physical health care of their patients regularly.

If a mental health consumer has an identified physical illness does the MHS have a protocol on this is to be managed (i.e. Policy on Managing Co - morbid issues)?

Approximately half of the programs reviewed had a specific documented policy on managing co morbid issues. Interviews with staff at the remaining programs indicated that a number of MHS had unwritten practices relating to the management of co morbid issues in particular patients with co morbid drug and alcohol issues. Staff inferred that there was an understanding with a number of agencies including the Aboriginal Medical Service and Drug and Alcohol Services, general hospitals and private practitioners that cases involving co-morbid issues would be co managed by the relevant services.

Does the MHS have any specific protocols relating to consumers and the development of the metabolic syndrome?

24 programs across 14 different mental health services reported that they had a policy relating to Metabolic Syndrome. The review noted that there are a number of local research projects being conducted by Psychiatric Registrars as part of their ongoing professional development. Particularly patients on atypical antipsychotics were likely to be included in the screening process. A number of MHS reported having adapted the clinical monitoring system for Clozapine (Castle, 2006) and are collecting the following data on a three monthly basis:

- Patient demographics
- Doctor details
- Drugs prescribed
- Dose prescribed
- Waist circumference
- Blood Pressure
- Fasting blood glucose
- Lipids
- Triglycerides
- Intervention required

Does the MHS have any specific protocols relating to consumers on Clozapine?

57 programs across 28 different mental health services reported that they had a policy relating to Clozapine. The programs that did not have a policy on Clozapine use were services where this was not relevant (eg. no prescribing, CAMHS services, triage-based services). During the review it became evident that despite MHS having Clozapine policies adherence to the policies was inconsistent. These findings led the Chief Psychiatrist to conduct a Targeted Review of Clozapine Monitoring across all Western Australian MHS. The report from this review is likely to be available in July 2012.

Are there any other specific medication/syndrome protocols /policies used by the MHS?

20 programs across 13 different mental health services reported that they had other specific policies related to medication including, but not limited to, policies on monitoring the side effects of atypical antipsychotics, long term medication use, and medication for co morbid conditions.

Information Provision

Does the MHS have pamphlets or information readily available for consumers and carers on general physical health issues and the links between physical and mental health issues and the side effects of medication?

The majority of MHS had a pamphlet stand in the waiting area which contained a range of pamphlets on physical and mental health issues. Information was not routinely provided to patients unless they specifically asked for it. MHS staff responsible for refilling the pamphlet stand indicated that they did so regularly suggesting that patients and carers did take copies of the pamphlets.

Does the MHS conduct any groups/education sessions for consumers and carers in relation to physical health issues or psychotropic medication and side effects?

25 programs reported that they provided education sessions for consumers and carers in relation to physical health issues. The types of groups run included:

- Healthy Living
- Wellness
- Exercise
- Pharmacy /Medication

One area requiring attention related to those patients attending the Exercise groups. Despite the potential health risks, associated with this group, none of the MHS running these groups required patients to have a physical prior to being accepted into the Exercise Group. These groups were also likely to be run by Allied Health staff employed by the mental health staff that are not trained in completing comprehensive physical examinations.

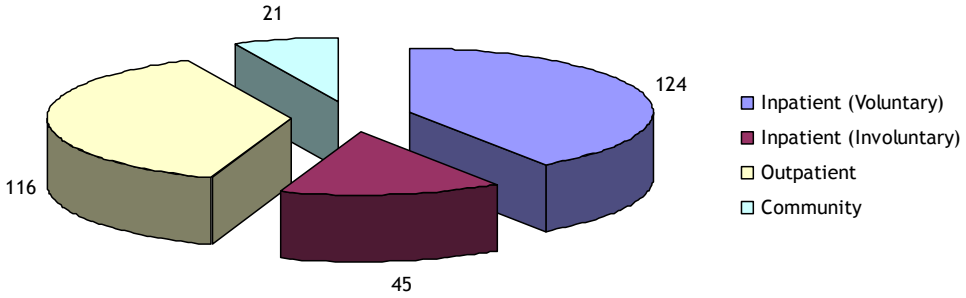
While the Chief Psychiatrist is supportive of Exercise groups being provided as part of the patient's management plan it is imperative that patients are 'cleared' to participate prior to attendance. This clearance may be completed by the MHS medical Officer or Psychiatric Registrar or may be completed by the patients GP.

Consumer Feedback

Demographic Information

1,500 Consumer Questionnaires (Appendix A) were sent to a random sample of mental health consumers across all four streams. A total of 207 questionnaires were completed and returned (14% return rate). The questionnaires were in relation to the aspects of clinical care under examination. In addition to the questionnaire, a consumer reviewer formed part of the thematic review team, and interviewed 99 consumers across multiple sites. In total, 306 consumers provided feedback to the review team (overall 20.4% response rate).

Figure 7: Consumer Feedback by Type of Admission



169 of the 306 respondents (55%) reported that the mental health service they attend conducted a physical health check when they were admitted to the service. 50% of physical health checks were performed by Nurses, 44% by Doctors, and 6% by others (usually a Case Manager).

Table 4: Physical Health Checks Performed (Consumer Feedback)

Physical Check Performed	On Admission	Routinely
Blood Pressure	181	143
Blood Test	148	124
Temperature	149	108
Height	133	63
Weight	169	124
X-Ray / Scan (inc. ECG)	7	0
Urinalysis	11	6
Other (BSL, ENT, Heart Rate, etc.)	10	5

Of the 151 patients who said that their physical health was checked on an ongoing basis, 56% reported that their nurse checked their health, 33% said it was their Psychiatrist, and 31% said their GP.

This finding is contradictory to previous comments in which the community MHS indicated that they utilised GPs to manage physical health care issues. Given the small sample size it is difficult to interpret the meaning of the consumer data and as such this question would require further testing.

Contributing Factors to Success

There are a number of factors which appear to contribute to the success of the effective management of physical health care within this population.

- The Older Adult stream attends to physical health care better, than other streams, due to co-morbidity issues and strong links with General Practitioners
- Variances in the level of initial screening are dependent on the referral source with those patients referred via Emergency Departments or other medical specialty areas being more likely to receive an initial physical health care assessment.
- Relationships with GPs were crucial in the ongoing management of physical health conditions.
- Inpatient services attended to physical health care issues whilst the individual was an inpatient with more variability post discharge to community.
- There was a trend for Rehabilitation programs to provide physical activity groups and groups with a focus on healthy lifestyle.
- The inconsistent availability of treatment rooms and equipment required to conduct physical health screening impacted negatively on success.
- Links with other agencies such as the Aboriginal Medical Service contributed to better outcomes.
- Appointment of designated Medical Officers, GP Liaison, Nurse Practitioners contributed to improved processes and more consistent management of physical health issues.
- Variable compliance with Clozapine and other atypical antipsychotics monitoring impacted on success.
- Services who engaged or encouraged clinicians with a particular area of interest in metabolic screening had a more consistent approach to regular screening and subsequent compliance with monitoring of medication side effects.

Limitations of the Review

As with all research there are limitations that need to be considered when interpreting the data. The limitations of this review have been summarized below.

One of the main limitations to this Thematic Review was the low response rate from Consumers in relation to the Consumer Questionnaire sent out. While 1500 questionnaires were sent to MHS for dissemination, only 207 (14%) were returned despite including a self addressed, stamped envelope to assist consumers in returning their forms.

It should be noted however that the OCP is unable to establish if all 1500 of the questionnaires were sent out to consumers. In order to maintain confidentiality the OCP sent packs of questionnaires and consent forms (already packed in envelopes) to the MHS. The MHS were required to identify, randomly, from PSOLIS a range of consumers (current and or recently discharged) across all of their programs and send the packs to them. This process maintained the Consumer's confidentiality and allowed consumers to make their own choice about whether they participated in the review. A return rate of 14% is significantly lower than would be expected (normally around 25%) so may indicate that not all of the 1500 packs were actually sent out.

On a positive note the number of responses from Consumers was increased to 306 with a total of 99 face to face interviews also conducted by our Consumer Reviewer. This translates to an overall response rate of 20.4%. Despite this the response rate remains a limitation and needs to be considered in the development of future review methodology.

In addition future reviews should consider asking the MHS to document the number of consumers that the information is sent to. While it may not increase the uptake, it would allow a more accurate presentation of the uptake.

Conclusion

The findings of this Thematic Review indicate that while attention to the physical health care of mental health patients has increased over the past few years the processes associated with initial physical health care assessments, the ongoing management of physical health issues, the monitoring of metabolic syndromes and ensuring that patients are provided with education regarding the relationship between physical and mental health are inconsistently applied across WA.

The results would suggest that there are some very practical considerations that impact on the ability of the MHS to provide of physical health care provision including:

- Access to a treatment room and the equipment to perform physical health care assessments
- Employment of Medical Officers to assist with physical health care assessments
- Standardized referral and initial assessment documentation to guide clinicians and ensure the collection of consistent data across the state
- Strong relationships with General Practitioners or providers of physical health care to optimise the management of clients' mental and physical health care needs

The Chief Psychiatrist also recognises the significant work being undertaken by both the WA Statewide Standardised Clinical Documentation Steering Committee and the School of Psychiatry and Clinical Neurosciences at the University of Western Australia. The Chief Psychiatrist Guidelines for Physical Health Care will reflect and endorse these bodies of work.

References

Castle D., et al (2006). Clinical Monitoring System for Clozapine. Australasian Psychiatry, Vol 14(2): 156-168.

Harrison, C.A (2010). Physical Health Assessment across Four Mental Health Sites: Clinical Case Note Audits, Report of Findings. Centre for Clinical Research in Neuropsychiatry – Clinical Applications Unit.

Lawrence D, Holman CDJ, Jablensky AV (2001*). Preventable Physical Illness in People with Mental Illness*. Perth: The University of Western Australia.

New South Wales Health (2009). Policy Directive: *Physical Health Care within Mental Health Services* New South Wales Government.

Tosh G, Clifton A, Mala S, Bachner M (2010). *Physical health care monitoring for people with serious mental illness* Cochrane Database System Review. March 17;(3):CD008298.

Sane (2007) *Dual Diagnosis* Sane Australia. Retrieved from: http://www.sane.org (2010).

Stanley S, and Laugharne J (2010). *Clinical guidelines for the physical care of mental health consumers*. Community, Culture and Mental Health Unit, School of Psychiatry and Clinical Neurosciences, The University of Western Australia. Perth: The University of Western Australia.

Appendix A

OFFICE OF CHIEF PSYCHIATRIST

PHYSICAL HEALTH CARE QUESTIONNAIRE 2010

RATIONALE

There is a substantial amount of research indicating that physical and mental health is vitally related. Individuals diagnosed with a mental illness are often likely to have poorer physical health outcomes, *Duty to Care Report, Healthright (2001)* than those who do not. Psychotropic medications also have side effect profiles which may affect physical health adversely.

The Chief Psychiatrist has responsibility for monitoring the standards of psychiatric care provided throughout Western Australia. In 2010, the Office of the Chief Psychiatrist will be introducing a focus on the quality of physical health care provided to individuals with a mental health disorder or illness. This enhanced focus on the quality of physical health care is consistent with the direction provided by the National Standards for Mental Health and the work being conducted by the WA HealthRight.

Improving the processes, associated with physical health care, within Mental Health Services will be the Chief Psychiatrist's priority over the next 12 months

MENTAL HEALTH SERVICE DETAILS

MHS: _____ Region: _____

Service Manager: _____ Contact: _____

Person (s) Being Interviewed: _____

Role: _____Contact: _____

Program Name(s): _____

Date of Interview: _____ Interviewer: _____

Stream: ☐ Adult ☐ CAMHS ☐ Older Adult

Setting: ☐ Inpatient ☐ Open ☐ Secure ☐ Both

☐ Outpatient ☐ Community ☐ Day Program

☐ Associated Inpatient Unit

☐ Consultation / Liaison ☐ ED Liaison

If Day Program – is there a requirement that consumer have a link with community team?

Number of Staff: _____Approx Number of Patients: _____

Prog Description: _____

ENTRY TO THE SERVICE

How do patients come into the program?

☐ ED ☐ Self Referral ☐ GP ☐ Other MHS

☐ Other _____

1. Does the MHS liaise with specific ED(s)? Please specify Yes / No

2. If yes, what is the ED policy on physical assessments for Mental Health Consumers?

3. Does the MHS currently perform physical assessments on consumers on entry to the MHS? Yes / No

4. Does the service receive information about ED visits? (For out of area ED visits, or services without their own ED)
Yes / No

PHYSICAL ASSESSMENT / HEALTH CARE WITHIN THE MHS

5. Does the MHS have the necessary equipment immediately available to conduct a full physical assessment of a mental health consumer? Yes / No

   Comments:

6. How often does the MHS perform physical assessments of consumers?

   ☐ On Entry ☐ Monthly ☐ 3 Monthly ☐ 6 Monthly

   ☐ Annually ☐ Not at All

7. Who is predominantly responsible for conducting the Physical Assessments for patients active with the service?

   ☐ Consultant Psych ☐ Psych Registrar ☐ Medical Officer ☐ Nurse

   ☐ General Practitioner (GP - go to Question 9) ☐ Other _____

8. Does the MHS have a GP Liaison Officer? Yes /No

9. What is the role of this individual in relation to Physical Care Assessments?

   _____

   _____

   _____

   _____

10. If GP conducts regular assessment is the MHS notified of the outcome? Yes / No

    If yes, how? ☐ Written ☐ Verbal

11. If verbal is there a documented requirement that the clinician receiving the information documents the outcome in the consumer's medical record? Yes / No

12. Does the MHS have external links with agencies addressing specific physical health issues:

Dental	Yes / No
Podiatry	Yes / No
Nutrition	Yes / No
Physiotherapy	Yes / No
Optometry	Yes / No
Other(s)	

    _____/_____/_____

13. Does the service have communication links in place with specialist care physicians, surgical and / or specialty areas? (Please provide copies of relevant documentation - eg. policies, MOUs, etc.)

    Yes / No

    _____

    _____

    _____

    _____

14. How are physical health care investigations managed within the service - eg. pathways, data collection, who requests investigations, who signs off on investigations?

15. Mental Health Inpatient units – How often are routine observations conducted - weight, pulse, blood pressure?

16. Do you have any long stay inpatients (ie. longer than one month, lack of accommodation etc)? Yes / No

17. Do long stay inpatients have appropriate access to health promotion, screening and preventative activities (i.e. pap smears, breast examination, prostate exams, diabetes, annual medical) Yes / No

    If yes, please give details

18. Stand Alone services (ie. not attached to a hospital) - how are issues related to physical health care managed?

SUBSTANCE ABUSE AND DEPENDENCE

19. Does the service have an established liaison pathway for assisting patients with substance abuse / dependence issues? Yes / No
    (If yes, please provide details)

20. How is information communicated between the services?

21. Is there any joint work between the services? Yes / No
    (If yes, please provide details)

22. Does the service provide any training in substance abuse / dependence? Yes / No
    (If yes, please provide details)

FORMAL DOCUMENTATION

23. Does the MHS have a standardised physical assessment protocol which is documented in the consumer's medical record? Yes / No
    (If yes, please provide a copy)

    If No, what specific health care information is documented in the consumer's medical record?

24. Does the MHS have a current policy relating to the physical health care of consumers?
Yes / No

(If yes please provide a copy)

25. If a mental health consumer has an identified physical illness does the MHS have a protocol on this is to be managed (i.e. Policy on Managing Co - morbid issues) Yes / No

26. Does the MHS have any specific protocols relating to consumers and the development of the metabolic syndrome?
Yes / No

If yes, please give details (provide a copy of the policy)

_____

_____

_____

_____

27. Does the MHS have any specific protocols relating to consumers on Clozapine? Yes / No

If yes, please give details (provide a copy of the policy)

_____

_____

_____

_____

28. Are there any other specific medication/syndrome protocols /policies used by the MHS?
Yes/No

If yes, please give details (provide a copy of the policy)

_____

_____

_____

INFORMATION PROVISION

29. Does the MHS have pamphlets or information readily available for consumers and carers on general physical health issues and the links between physical and mental health issues?
Yes / No

(If yes please provide a copy)

30. Does the MHS provide consumers and carers with information on the possible physical side effects of any medication the consumer has been prescribed? Yes / No

    Comments:

    _____

    _____

    _____

    _____

31. Does the MHS conduct any groups/education sessions for consumers and carers in relation to physical health issues or psychotropic medication and side effects? Yes / No

    If yes, list

    _____

    _____

    _____

Appendix B

The questionnaire below was distributed to all mental health services as part of Thematic Review 2 in 2011. The questions relevant to the Physical Health Care of Mental Health Patients are questions 13 - 15.

OFFICE OF CHIEF PSYCHIATRIST

CONSUMER QUESTIONNAIRE 2011

Instructions

Please complete the questions and return the completed questionnaire in the envelope provided.

The questions relate to the following areas:

- Your involvement in your treatment
- Physical Health

Interview Details

What is the name of Mental Health Service you are currently attending?

_____

Date: _____ **Type of interview:** ☐ Face to Face Interview

☐ Telephone Interview

☐ Questionnaire

Involvement – Decision about Treatment and Support

Please think about your current episode of care and answer the following questions. Please tick the appropriate boxes and make comments in the spaces provided.

1. Are you (please tick all that apply):

☐ Inpatient - Voluntary ☐ Inpatient - Involuntary
☐ Outpatient (seen at clinic only)
☐ Community services (seen in your home)

2. Do you know who your key worker or case manager is? (A case manager is a person within the Mental Health Service who is responsible for your care. This is the person you contact if you need support)

☐ Yes
☐ No

3. Have you got an individual management plan? (a piece of paper where the staff have written down the treatment and support you are to get).

☐ Yes
☐ No (If **No**, go to Question 4)

3.a) Were you involved in drawing up your individual management plan?

☐ Yes
☐ No
☐ Partly
☐ I don't have a Management Plan

3.b) Do you agree with what is in your individual management plan?

☐ Yes
☐ No
☐ Partly
☐ I have not seen my Management Plan

3.c) Have you been provided with a copy of your individual management plan?

☐ Yes
☐ No
☐ I don't have a Management Plan

4. Have you ever been asked to complete a 'Kessler 10' form?

☐ Yes
☐ No

5. Have other members of your family been invited to be involved in your treatment?

☐ Yes
☐ No
☐ Partly

6. How good are the staff members at this Service at including your family in your care?

☐ Very good
☐ Good
☐ Fair
☐ Poor

7. Has anybody discussed your possible discharge plan with you?

☐ Yes
☐ No
☐ Partly

7.a) What have they talked about?

_____

_____

Mental Health Act

8. Have you ever been made an involuntary patient under the Mental Health Act (1996)?

(Please tick all that apply)

☐ Yes - made an inpatient and admitted to hospital
☐ Yes - put on a Community Treatment Order
☐ No

9. Was it explained to you why you were being made involuntary?

☐ Yes
☐ No

9.a) If yes, who explained to you:

_____

_____

10. If you were put on a Community Treatment Order, did you receive a copy of your Community Treatment Order form?

☐ Yes
☐ No

11. If your Community Treatment Order was extended, did you receive a copy of the Community Treatment Order Extension form?

☐ Yes
☐ No

12. Have you received a copy of any other Mental Health Act Forms?

☐ Yes
☐ No

12.a) If yes, which ones:

_____

Physical Health

13. When you first entered the service (for your current admission) did you receive a physical health check?

☐ Yes
☐ No

13.a) If yes, who checked your physical health? (please tick all that apply)

☐ Doctor
☐ Nurse
☐ Other _____

13.b) What, of the following, did they check? (please tick all that apply)

☐ Height
☐ Weight
☐ Blood pressure
☐ Temperature
☐ Blood test
☐ Other _____

14. Is your physical health checked on an ongoing basis?

☐ Yes
☐ No

14.a) If yes, who checks your physical health on an ongoing basis? (please tick all that apply)

☐ Doctor
☐ Nurse
☐ GP
☐ Other _____

14.b) What, of the following, do they check? (please tick all that apply)

☐ Height
☐ Weight
☐ Blood pressure
☐ Temperature
☐ Blood test
☐ Other _____

15. How often does the Service check on your physical health?

_____

_____

Any Other Comments

Is there anything else you would like to tell us about your treatment at the mental health service?

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for completing this questionnaire.

Please place the questionnaire in the envelope provided and return it to the person who gave it to you - or you can post directly to the Chief Psychiatrist