Physical Health Matters Too

Project Evaluation Report

3 June 2014

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Evaluation of the Physical Health Matters Too Project

1. Executive summary

This evaluation of the Physical Health Matters Too (PHMT) project aimed to gather qualitative and quantitative data to describe the impact and outcomes of physical health screening in two Primary Care Partnership catchments.

PHMT was a response to the compelling research evidence of significantly increased mortality and morbidity for mental health clients. The Project focused on two PCP catchment areas of northern Melbourne (North East PCP and Hume-Whittlesea PCP).

The Project aimed to provide a greater focus on the physical health of mental health clients and to develop interventions designed to enable improvement of their physical health. The target group was clients of mental health agencies and Psychosocial Disability Rehabilitation Support Services (now known as Community Mental Health Support Services) in the PCP areas.

The context of increased health practitioner awareness, in combination with various State and Federal government health initiatives, provided the momentum to bring mental health and other primary care agencies together to collaborate in a Project partnership.

The partnership consisted of the two PCPs and fourteen other partners which included mental health services, community health services and divisions of general practice. They collaborated well to develop a physical health screening tool, provided opportunities for practitioner professional development, and established priority referral pathways.

Success factors for the Project included the high quality of the PCP leadership, the appointment of a Project Coordinator and the high engagement of the partners.

The data collected in this evaluation shows that since the Project commenced, approximately fourteen hundred physical health screenings have been completed by the Project partner mental health agencies.

Furthermore, there is anecdotal evidence that some of these screenings resulted in client referrals to other primary care services and there have been actions taken by clients to address their physical health concerns.

There is also evidence that many partners have embraced physical health screening as an integral part of their client care plans. They have developed policies and protocols designed to ensure the screening is offered regularly to all clients and that referral records are kept.

It is too early to say whether the screening has resulted in long term client health benefits. While the limited anecdotal evidence suggests some progress on client physical health issues, there would need to be significant data recording and research work done, ideally within mental health services, to track clients and assess their experiences and health outcomes over time.

2. Evaluation aims

The aim of this evaluation as stated in the project brief was to:

'Gather qualitative information and where possible, quantitative data, to describe the impact and outcomes of the implementation of physical health screening within mental health agencies in the North East and Hume Whittlesea Primary Care Partnerships (PCPs).'

These agencies were clinical mental health services and Psychosocial Disability Rehabilitation Support Services (PDRSS) in the two PCP areas.

This evaluation provides an overview of the whole Physical Health Matters Too project (PHMT) from its inception, with a focus on the period from the start of 2013 until now. It complements and updates an earlier comprehensive project report[1] written in January 2013 by Jean Crewe, the Project Coordinator.

My approach has been to focus on the issues identified in the implementation of the Project so far, and to refer briefly to the project context and origins to assist understanding of the factors which have been significant in the development and implementation of the Project.

In describing and evaluating the 'impact and outcomes' of the PHMT project to date, I have adopted a descriptive approach to tell the significant aspects of its 'story'. I have identified contextual issues, key achievements, success factors and limitations.

3. What were the PHMT project aims and objectives?

These have evolved during the life of the project and no single document provides the definitive view. The changing aspirations reflect the fact that there have been contextual changes, ongoing partner collaboration, continuous formative evaluation and subsequent modification of this project from its beginnings in 2010.

In overview, the intention of the PHMT project was to introduce some form of physical health screening of mental health patients and to support them in taking action on any physical health concerns which the screening may have highlighted.

3.1 The Evolution of the Aims

There are various documents which provide a good sense of the project's development, the evolution of its aims and objectives and the collaborative processes used to refine them.

These documents include:

- Notes from the second Community Mental Health Planning and Service Coordination Initiative Forum 2 held at CERES on 13th September 2010[2]
- Expression of Interest (EOI) form – project proposal: Community Mental Health Planning and Service Coordination Initiative, Department of Health, North and West Metropolitan Region[3]

The EOI was sent to the Department of Health in late 2010. It set out the project details as follows:

Aim: To close the physical health gap between the general population and people with mental illness

Target group: Clients of Mental Health Services

Catchment: Hume, Whittlesea, Darebin, Banyule, Nillumbik

Timeframe: 2 years

Anticipated impacts to be evaluated:

1. *Increase skill and promote greater awareness of the need for mental health professionals to recognise and respond to physical health needs of clients*
2. *Better screening and diagnosis of high prevalence conditions (diabetes, cardiovascular disease, chronic obstructive pulmonary disease & cancer) of people with mental illness*
3. *Increase access to health services by people with mental illness*
4. *Reduction in smoking prevalence among clients of mental health services*

Subsequent to the EOI being lodged, the project leaders and the Health Department engaged in a process designed to develop the objectives into a 'SMART' form (Specific, Measurable, Achievable, Realistic and Time-oriented).

3.2 Final Expression of the Project Aims

The project aims were then expressed with more limited goals, as described in the 2013 project report (ibid):

'To introduce physical health screening for consumers aged 16-64 years of age registered with clinical mental health services and/or PDRSS in the North East and Hume Whittlesea PCP areas.'

Four specific objectives related to the above aim were listed as:

Objective 1: A training program is developed and by March 2012 all mental health professionals from Case Management teams have undergone training and demonstrate knowledge and skills in using the selected physical health check.

Objective 2: 100% of consumers will be screened using the selected physical health check by March 2012 and new consumers, within 3 months of accessing services. Ongoing screening is supported in agencies policies and procedures.

Objective 3: To improve access to health services by people with mental illness in 50% of PCP member agencies by identifying and reducing barriers to access, improving referral pathways, working with referral sources to facilitate referrals (GPs and community health services) and provide workforce development and staff training, using CMHP & SCI partnerships by June 2012.

Objective 4: 100% of consumers, who smoke, according to findings from the selected physical health check, will be presented with the range of referral pathways into programs aimed at smoking cessation.

With the wisdom of hindsight, the Project leaders now see these four objectives as very ambitious for a project which was minimally funded.

It is with this rich background of development that the PHMT project is being implemented and this evaluation is occurring.

4. Background and context

4.1 Why PHMT now?

This PHMT project started to develop during 2010 as a result of health practitioners' growing awareness of the emerging evidence of poor physical health and significantly increased morbity and mortality rates for mental health patients.

The emerging need for action is highlighted and summarized well by Jean Crewe in her Project report (ibid) where she identified the following:

'*International research has highlighted the vulnerability that people with a serious mental illness face in developing physical health issues.*

In fact, people with a mental illness have a life expectancy that is an astounding 20-25 years less than other Australians, with extremely high rates of morbidity and mortality from cardiovascular disease and respiratory diseases (Coghlan et al, 2001).

Despite the incidence of cancer being similar for people with a mental illness and the general population, people with mental illness are 30% more likely to die from cancer (Vicserv, 2008)…….

…….A growing body of literature also exists to support the notion that mental health services have a responsibility to address the physical health needs of their consumers (Brown & Smith, 2009; O'Sullivan, Gilbert & Ward, 2006).

In Australia, a number of reports have outlined recommendations for managing the physical health care of consumers. These have included introducing physical health screening in clinical mental health services and improving consumer access to primary healthcare services……'

In 2010 the Victorian and Federal health contexts provided an environment which was conducive to taking action on these health trends for clients of mental health services. One key development was the state wide government initiative titled 'Mental Health Matters – Victorian Mental Health Reform Strategy 2009 – 2019' which has a focus on prevention, early intervention, social inclusion and recovery[4].

4.2 The Role of Primary Care Partnerships in Victoria

The broad goal of PCP work is to strengthen collaboration and integration across sectors in order to maximise health and wellbeing outcomes, promote health equity and avoid unnecessary hospital presentations and admission.

PCPs operate with seven guiding principles - tackling health inequities; person and family centred; evidence based and evidence informed decision making and action; cross sector partnerships; accountable governance; a wellness focus and sustainability.

At the time of this Project, they had four key domains of activity; partnerships, service co-ordination, integrated health promotion and integrated chronic disease management.

A key feature of PCP activities is to 'place consumers at the centre of service delivery' and includes integrated chronic disease management involving planned and proactive care, with an emphasis on wellness rather than responding to illness.

The PHMT project was a key action designed to enable achievement of this goal with a focus on mental health services. It built on some pre-existing developments in the PCP catchments. These were:

- improved relationships and trust between mental health services and primary care agencies
- Victorian Government health policy on improving mental health clients' physical health
- The Victorian Government Community Mental Health Planning and Service Coordination Initiative
- The North East PCP Strategic Plan to support health promotion and preventative initiatives that lead to improvement in mental and physical health
- Mental health agencies increased awareness of consumers poor physical health
- Community Health Services prioritising mental health clients.

Both PCPs took on important roles in facilitating and resourcing the Project. They took a leadership role in the PHMT project from the outset by promoting it, facilitating thinking about the issues among service providers, bringing project partners together and providing resources to the project.

The most significant resource allocated to the project was the appointment of the Project Coordinator, who was employed on a 0.4 EFT time fraction from April 2011 until Dec 2012.

4.3 The Project Partners

Agencies which chose to participate in the project nominated themselves as either Core Project Partners or Associate Partners. Core partners were steering committee members, with some of them engaged in project implementation via screening or provision of referral services. Associate Partners tended to take up more of an observer role, although one of them (Sunbury CHS) participated in the screening.

The Project Report (ibid) listed the participating agencies as follows.

Core Project Partners:

Northern Area Mental Health	Darebin Community Health
North East Area Mental Health	Dianella Community Health
North West Area Mental Health	North East Valley Division of General Practice
NEAMI	Northern Division of General Practice
Mind	Royal District Nursing Service
Mental Illness Fellowship	Department of Health
Banyule Community Health	North East PCP
Nillumbik Community Health	Hume Whittlesea PCP

Associate Project Partners:

Vicserv	Arafemi
YSAS	Anglicare

WISHIN	Sunbury Community Health
Austin Child & Adolescent MH	Victorian Aboriginal Health Service

The project steering committee met approximately every two months during 2011 and 2012 to:

- oversee the development and implementation of the Project
- provide leadership in the implementation of the Project in the agency they represent
- support and advocate for the Project in other Alliance and Network settings
- ensure communication regarding the Project occurred across agencies and networks.

Agencies which participated in this Project were not directly funded by the Victorian Government and had to find any additional resources needed from within their existing budget and services. The major resource support provided was by the PCPs in funding the project coordinator role.

The resources needed by agencies were primarily those of client service staff time and also involvement by management to monitor/develop processes, ensure the development of policies and protocols, and adapting record-keeping practices.

5. Methodology

5.1 Overview

This evaluation involved data collection by means of a review of key PHMT background documents and conducting face to face interviews with stakeholders.

In addition, an evaluation project reference group was formed to provide periodic reflections, guidance and insights into the project. It consisted of the evaluator and:

- Julie Watson, Executive Officer of North East PCP
- Max Lee, Executive Officer for Hume-Whittlesea PCP
- Jean Crewe, PHMT Project Coordinator

This reference group met three times during the period October 2013 to February 2014.

Documents perused as part of this evaluation include:

- Minutes of the Project Steering Committee
- Project EOI prepared for the Department of Health
- Discussion paper on screening tools
- Project Report (ibid)

Face-to-face interviews were conducted with NEPCP Executive Officer and the PHMT Project Coordinator, as well as with key contact people from the project partner organisations. These included managers, coordinators and other key project staff.

Interviews were usually with one contact person, although in one case (NEAMI) I interviewed an area manager and the Health Promotions officer together.

Subsequent to these interviews, partners were followed up by requesting access to service staff to ascertain their experience of the PHMT project. About thirty minutes time was spent discussing the project with client support staff in each of two services.

5.2 Interview format

An interview structure was designed to gather data about aspects of the Project. The interview included asking questions of key service managers and developing a dialogue designed to assess their experience and perceptions of the Project. Please see Appendix 1 for more detailed information about the interview format.

5.3 Project Partners Interviewed

The Project partners contacted for interview were taken from a list provided by the Reference Group. The partners listed were as follows:

1. Northern Area Mental Health
2. North West Area Mental Health
3. North East Area Mental Health (NEAMH)
4. NEAMI
5. MIND
6. Dianella PDRSS
7. Mental Illness Fellowship (MIF)
8. Infiniti Healthcare Solutions (Formerly Northern Division of General Practice)
9. Sunbury Community Health Service (Associate member)

Data collected via the interviews is recorded in the table found in Appendix 2 of this report.

5.4 Observations on the interviewing experience - strengths & limitations

Setting up initial meetings and interviews with project partner representatives was positive overall - for most services access was provided quite readily. For a minority of project partners, it took many weeks from the start of the project (months in one case) for the first interview to occur.

I believe that this service availability reflected several factors. These include the extent to which a service had progressed with implementing the screening process, how embedded it is in their work practices, and the capacity of staff to respond to this evaluation in a context of many other immediate work pressures. Some services were also undergoing the recommissioning process at the time of this evaluation.

After the majority of first interviews were completed, the Reference Group considered exploring the feasibility of enriching the data and increasing its validity by seeking the views of frontline service staff, and, if possible, consumers. It was agreed that I would approach services again in early 2014 to request access to frontline service staff and also explore access to consumer opinion.

I contacted some services in late January 2014 requesting access to staff to ascertain what the 'on the ground' experience of the Project has been, what it was like to use the screen

and what insights they had into the consumers' experience. Eventually, I was able to interview small groups of staff from NEAMI and NEAMH in February.

Some of the impediments for the data collection in this evaluation have been changes to staffing (departures and/or role changes) in partner organisations, the recommissioning of the (now) Mental Health Community Support Services and the starting of the Partners in Recovery program. These factors contributed to my difficulty in obtaining timely additional information from some services.

There was also consideration given to interviewing consumers to gauge their experience of the screening process. Eventually this avenue of data gathering wasn't pursued because of the limitations I experienced in attempting to gain increased access to the services, as described above.

In summary, my overall experience of working with the project partners is they were generally very committed to the holistic treatment of mental health clients/consumers and were open and generous in their approach to the initial interviews. Many provided additional supporting materials at the interviews, and some followed up later with more contemporary data about client participation in physical health screening.

One interviewee's observation summarised the general approach in this sector: 'There is lots of goodwill and people are passionate about the issues'. This reflects my own experience in working with these services.

6. Data collected

6.1 Overview

The data collected is both qualitative and quantitative and is briefly summarised in Section 6.2 below. Aspects which are important to note include:

a. Different services used different screening tools (see table in Appendix 2 for details). Although one pro-forma screening tool was developed by the PHMT project, most services used their own tools. These were more comprehensive than the PHMT version which was designed to be easily adapted by services which did not have resources to develop their own
b. Quantitative data was collected about how many clients were offered and/or undertook some form of physical health screening
c. Where it was available, data about consumer responses to their screening is included
d. Inclusion of some data about referral of consumers to other medical services
e. Whether screening has been incorporated into service practices and protocols.

6.2 Major Trends

This section provides an overview of the major data trends and draws on the detailed information gathered from each of the service providers, as documented in Appendix 2.

Many interviewees observed that, particularly in the last two years, there seemed to be a general readiness in mental health services for physical health initiatives and finding ways to integrate them into client programs.

The data indicates that physical health screening has taken place in all of the partner services, with many individual services having completed several hundred screenings. In totality, the partners had completed over fourteen hundred screenings by late 2013.

In the services interviewed, there is good evidence that physical health screening has reached many in the target client population and is now embedded in many organisations' service protocols. Some services were in the early stages of introducing the screening whereas others were very well established with well documented protocols.

Building referral pathways to other primary health providers has also been important for the partner services. One interviewee observed 'an amazing shift' in the ways in which mental health staff and chronic care staff started to work together in their organisation to provide more holistic care for their clients.

The health outcomes for clients who have undertaken screening are less easily identified. However, the early anecdotal evidence is very positive, with service providers pointing to observable differences in clients' behaviours, referrals being acted upon and client self-reporting of an improved sense of well-being.

The reported feedback about the physical health screening process from both support workers and reported comments from clients has been consistently positive. The following quotes illustrate this dimension.

NEAMI Community Rehabilitation Support Worker (2014):

'I completed the Health Prompt with a consumer and when I met with him again, he had informed me that he had followed up with a number of blood tests and received referrals for an MRI and CT scan, which was very overdue.

He found that he had scarring on the liver and is now on the waiting list for treatment. He was very positive about the fact that he found it early. I believe that having the prompt gave him more confidence to follow this up with his GP.'

MIND Community Rehabilitation Support Workers:

'(the screening tool) Is quite user-friendly, gets the guys thinking more broadly about stuff, lets us focus on physical as well as mental health, think it's a good comprehensive list and a useful prompt, I find it straight-forward and user-friendly, I think it has led to further action – have referred people to appropriate services as a result – e.g. podiatrist, optometrist.'

'The list does not necessarily motivate people immediately but it raises conversations about each issue and serves as a useful psycho-education tool'.

Where the screening has indicated a need, referrals to other primary health providers have occurred, with reports of consumers being satisfied about their access to such services. For example, support workers at NEAMHS reported prompt treatment when clients were referred to the BCHS dental service and also prompt client support from dieticians and podiatrists.

7. Data analysis

7.1 Overview

I have observed a passion, pride and commitment of mental health practitioners to the building of a consistent holistic approach to the overall health of 'mental health' clients. Although there is some evidence of physical health initiatives being started in two partners prior to the PHMT project, the project itself created significant momentum and support, resulting in its widespread development and application within the partners.

Given the diverse nature and circumstances of the mental health services being considered in this evaluation, it is not surprising that the PHMT project has been implemented by services in a variety of ways.

This variety is characterised by:

- the type of screening which has occurred
- the number of screenings offered or completed
- the extent to which the screening is embedded in organisational practices
- the ways in which client records are kept and their availability
- the relationships with referral services.

For purposes of clarity, the following discussion acknowledges that there is variation in screening tools used. Because all versions of screening tool covered the areas set out in the PHMT model tool as a minimum, I have referred to the screening tools generically in the following sections.

7.2 What are the similarities and differences in implementation?

From the data available in late 2013, the project partners together had recorded a total of about 1400 physical health screenings completed. Their general practice has been to ensure that screening is at least regularly offered to consumers, and the data indicates a very high overall take up rate, with 3-5% of consumers declining to do it.

Even where consumers have declined to do the screening, support workers have noted that it is, at the very least, a physical health reminder and/or health consciousness raiser and can be returned to at a later date, e.g. during cyclic client reviews.

Where screening has occurred, there is evidence of referrals being taken up by consumers. The data table in Appendix 2 indicates a wide variety of referrals to specialist medical practitioners and GPs. Some services (e.g. NEAMH) also offer access metabolic screening as well as allied health and medical specialists, assisted by the existing service connections with the Austin Hospital.

Support workers at NEAMH also commented on the benefits of being easily able to refer clients to Banyule Community Health Service for priority dental and podiatry services. Other workers at one NEAMI service centre observed that the majority of their consumers had GPs

and the screening prompt alerted consumers and GPs to physical health issues that may not have arisen otherwise.

As is evident in the data, the level of screening is quite variable across the project partners. NEAMI and NEAMHS are two large agencies where screening is extensive and embedded into the organisation systems. This embeddedness is reflected in the screening being part of the organisation's policies and practices, including the cyclic individual case reviews.

It is significant that for both of these services, some early collaborative work (in 2009) on physical health screening had been started prior to the formation of the PHMT project. This had helped to orient these services into early adoption and development of screening once the substantive Project was started, and also informed the PHMT project development.

Other larger services, Dianella PDRSS and NAMH, have also progressed the screening to it being incorporated into their service protocols, with strong referral practices and integration of physical health support services.

For the other partners the screening is valued, but it was relatively new to them and on the way to being consolidated into their regular practices.

7.3 Project development – key features

As has been mentioned earlier in this report, some forms of physical health screening were being used by two services on a limited scale in early 2009. However, it needed a shared vision and collaborative environment for a wider range of health practitioners to identify the need for broader physical health screening and to agree to take action on it.

It also needed a means by which the Project could be developed and implemented more broadly. Effective physical screening required support in both its development and subsequent service integration.

The role of the PCPs was critical in developing this collaborative and integrated approach and getting the partners together. Several interviewees referred to the pivotal role of PCP leadership in this project.

As one interviewee observed: *'Support by the PCP was crucial to success in providing coordination and being a driver of change'.*

Another interviewee observed that: '*The PCP Executive Officer and Project Coordinator were great. The PCP has championed the approach across the service system – Community Health Services, GP's and area mental health'*.

The effective way in which the Project Coordinator took up her role was also pivotal in partner support and relationship development.

The important role of leadership was also evident within some of the partner services, where the senior staff were responsible for allocation of dedicated resources to their screening programs, and developing policies and practices to embed them.

In summary, developing the vision and supporting collaborative service engagement and integration was central to the successful development of this Project.

7.4 Consumer health impacts –strengths and limitations

On the evidence so far, it can be argued that in most services, a high percentage of all clients have been involved in using a physical health screening process as part of a more integrated health approach. In addition, referral mechanisms and protocols seem to be well developed.

However, the long term health outcomes for consumers are less easily identified. So far, the anecdotal evidence is very positive with interviewees pointing to observable differences in some clients' behaviours and client self-reporting of improved well-being.

The data indicates some evidence of consumer behaviour change. Some short term benefits have been identified: smoking cessation, medical referrals, improved dental care and other allied health interventions (e.g. podiatry).

Services have no formal mechanisms to assess the impact of screening on individual clients, although it could be inferred from their cyclic client review processes. Providers have observed that there is now considerable data collected (via individual client records) and, with resourcing for further research, it could be 'mined' for more information about the impact of the screening.

Some interviewees saw that the screening also provided increased physical health awareness and education for mental health support staff and case managers, as a support for them in working on these issues with their clients.

The role of other primary health service providers, for example; GPs, Dentists and Allied Health practitioners, has been important to the success of the Project.

Generally it would come as no surprise that most people interviewed observed that it is far too early to definitely conclude about changes in any long-term client health outcomes. It would be a separate and more complex research process to follow longitudinal client physical health trends and to assess the impact of the screening.

NEAMI is planning to do a comprehensive evaluation of its client screening data in 2014 and has employed a project research officer for this task.

8. Conclusions

There is a key question of how success for the PHMT project is to be judged. I refer to the early discussion of the Project aims in Section 3 of this report where the overall aim was described as:

'To introduce physical health screening for consumers aged 16-64 years of age registered with clinical mental health services and/or PDRSS in the North East and Hume Whittlesea PCP areas.'

It has been demonstrated that, on balance, this broad aim has been achieved with various exemplars of good practice in evidence. Most partners see the Project as a successful and positive experience.

The original objectives which specified such measures as '100% of consumers will be screened…..by March 2012…. etc', were highly ambitious and were appropriately modified in practice as the Project developed. I believe the project cannot be realistically judged according to these standards, although such objectives may be relevant over a longer time period.

The Project had the leadership, networking and change management support critical to enable its early success. Partners commented on the valuable opportunities to share resources and experiences, to learn across intra and inter-organisational boundaries, and to work with the challenges of culture change within services.

The Project co-ordination provided the drive and support for services to build and implement their approaches to clients' physical health. This project leadership is seen as a critical success factor.

There is a question about whether there are sufficient resources available for effective screening to embed it in all partner services – especially the smaller services. There is also a question of whether the recorded screenings have actually resulted in creating behavioural change in large numbers of consumers.

For services which are well-resourced and have the physical health screening processes built into their practices, it is reasonable to expect an ongoing improvement in consumer coverage and engagement over time.

The anecdotal evidence of the impact of physical health screening indicates some positive client outcomes. Assessing the quality of the screening process itself and individual or collective client outcomes was not feasible in this evaluation, although it is desirable in the longer term.

It will be difficult to accurately assess the impact of the screening until there is a suitable form of data collection and analysis within all agencies to enable individual client's experience to be assessed comprehensively and longitudinally.

I have observed a passion, pride and commitment of mental health practitioners to the building of a consistent holistic approach to the overall health of 'mental health' clients. Although physical health initiatives were started in two services prior to the PHMT project, it seems that the Project itself created significant momentum across partner organisations and supported broader integration of mental health and other primary health services.

In summary, I see sufficient evidence to conclude that the PHMT Project has achieved many of its aims and is having a positive impact on clients. It has also achieved some other important outcomes in providing a trusting, collaborative and relationship enhancing environment within which health service integration can continue to build.

9. References

1. *Physical Health Matters Too*, Community Mental Health Planning and Service Coordination Initiative, Project Report January 2013 & supplementary appendix July 2013, by Jean Crewe (Project Coordinator)
2. Notes from the second Community Mental Health Planning and Service Coordination Initiative Forum 2 held at CERES on 13th September 2010
3. Expression of Interest (EOI) form – project proposal: Community Mental Health Planning and Service Coordination Initiative, Department of Health, North and West Metropolitan Region
4. (www.health.vic.gov.au/mentalhealth/reformstrategy)
5. http://www.vicpcp.org.au/

Appendix 1 – Interview Format

This interview framework was used for individuals and staff groups and modified as needed to ensure a productive dialogue.

Areas covered were:

a. The interviewee's name and organisational role, as well as their role in this Project

b. In thinking about the Project overall, did they have a sense of success and satisfaction? Other experience?

c. Thinking back to the start of the Project, what they recalled as the purpose of the project and the key early steps in its development, and what was their understanding of the aims of the Project now

d. What had been their (and their organisation's) experience of taking up this Project?

   - What progress was made?
   - What have been the enabling factors?
   - What have been factors which have limited the take-up?
   - Has the screening become a normal part of their operating protocols & procedures?

e. How successful has the Physical Health Screening project been? Why did they say this?

f. Has the screening resulted in clients taking active steps to attend to their physical health challenges? What evidence is available about this?

g. What have been the referral mechanisms and pathways and what records are kept of them?

h. Overall, what has been their experience of this Project so far? Do they believe that this Project could be generalizable to other health settings?

Appendix 2 - Data Summary as at 14 March 2014

The following data was collected primarily via interviews with key service staff and also from documentation provided by the services.

Key partner agency	Numbers of consumers & screening version	Additional information (e.g. organisational practices, embeddedness, employee feedback)
Northern Area Mental Health (NAMH)	Offered to approx. 320 consumers, 194 accepted (only 3 without physical health issues). Using a variant of SCTT tool given to clients to complete. Piloted PHMT tool but decided to use their own tool.	Practice now embedded into the management of consumers care plans – priority - 'part of core business' No formal evaluation of client behaviours, but anecdotal evidence is encouraging. Joint consumer groups with NEAMI. Manager's role key in getting Physical Health Nurse position in place.
North East Area Mental Health (NEAMH)	280 clients – very low consumer refusal rate (anecdotal at 2%-3%) Screening tool based on PHMT but a combined Physical and Emotional Health screen modified by Austin Health to be less of a 'checklist' and promoting client engagement. 2 other forms used as well (including a metabolic screening tool)	Well-developed data base recording client screening and prompts. Referral and follow-up built into the systemic processes. Procedures manual produced and plan to expand this approach into other parts of NEMHS. Connections to Austin Hospital and BCHS has enabled resourcing to support the screening (i.e. access to specialist practitioners and programs). Key points from interview with support workers on 5 March 2014: • Consistent use of prompt and metabolic screening and built into their work system • Screening resulted in client referrals to BCHS dental service and prompt treatment • Screening tool useful to start conversations • Dietician support following screening useful • Overall impression was that of staff being positive about the tool, but I wonder whether this screening process is being seen as an imposition on an already stretched workforce. This may impact on the quality of the screening.

Key partner agency	Numbers of consumers & screening version	Additional information (e.g. organisational practices, embeddedness, employee feedback)
NEAMI	400 Health Prompts completed in Victoria (as at Oct 13) Small number of repeats. Small numbers declined (approx. 5-7%) Health Prompt (HP) tool – Diagram and Physical Health questionnaire. Strengths-based and holistic. Administered by support workers. Required to offer to clients every 6 months. Strong health promotion approach. Will be conducting a HP evaluation in late 2014.	NEAMI has an Australia-wide focus which influences their approach, especially with respect to tools used. PHMT introduced late October 2012. Health Prompt built into operating protocols. Quote: 'Health Prompt is the foundation for NEAMI's whole physical health initiative'. NEAMI has a long history of anti-smoking activity. HP now part of regular file audit process, i.e. embedded into protocols. Staff health consciousness was an important starting point. Embedded into staff induction programs. Key points from interview with support workers on Feb 18: • Too early to say re broad health trends for consumers • Practice of screening is embedded • Consumer physical health awareness builds over time with the use of the Prompt • Assists in collaborative health partnership with consumers • Most consumers have GPs • Staff suggestion that Physical Health Prompt would be useful for GPs to use with patients.
MIND – area-based PDRSS	Liaison with NEMHS to prevent duplication for clients Use PHMT screen – now included in CRM (Client Review Monthly template) Various levels of adoption by various MIND services - some services had completed many screenings (e.g 19 clients) with others only just	Key role in influencing PHMT initiative in MIND more broadly. Relatively early days (introduced April 2013) for MIND – key need to broaden perspective of support workers (Community Mental Health Practitioners) to work more holistically with clients. Support workers found tool useful to start up a conversation with clients of Physical Health needs. PHMT now embedded in many but not all local practices. Feedback from clients is

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	starting. Total of 56 screenings completed by end Nov 2013.	positive. Feedback from site managers (late November 2013) of limited scope but includes the following key points: • Screening tool compared favourably to previously used WHOQOLS tool because it generated more discussion with clients • Manager responses indicated an engagement with the screening tool and a willingness to critique its strengths and areas for improvement
Dianella PDRSS	Approximately 246 clients – uptake rate >90%. Strong anecdotal evidence of significant and widespread positive client outcomes. Use PHMT tool. Significant part of clients' Recovery Action Plan (RAP).	An audit requested clients' physical health - initiated 2 years ago by General Manager (after 9 deaths of clients). Started a 10 week 'Healthy Living Program' which has evolved into a monthly program – 'Healthy Moves Program'. Strong service integration with a range of Dianella specialist practitioners (including GPs). Strong client ownership of program – detailed data would be in RAPs and case notes. Good outcomes for staff satisfaction and retention.
Sunbury CHS (Associate member)	WRHS (PHAMs) - small service - 30 clients referred to SCHS in Sunbury. Sunbury CH utilising PHMT physical health screening tool (with one additional care question) in partnership with Western Region Health Service – day program (PHAMs) located opposite Health Service.	Pilot program started in January 2012. Not direct providers of MH services. Community Health Nurses pivotal - use screen as a prompt. Measurement of client outcomes seen as complex, e.g. do we measure the specialist goals – the sub-goals within each intervention area? Holistic approach to client evaluation – embedded into care plans (tracked and updated regularly).

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		Overall success asserted – based on anecdotal evidence re consumer take up rate.
Infiniti Healthcare Solutions (was Northern Division of General Practice)	No direct clients. Provide mental health awareness and training programs and encourage GP and Practice Nurses role in Mental Health (MH) coordination for MH clients. Resources GPs regarding Mental Health awareness. Infiniti contracted by Northern Melbourne Medicare Local.	Enabling factors for PHMT success was PCP Executive Officer and Project Coordinator's roles in driving and coordinating the project.