Physical Health Matters Too

Community Mental Health Planning & Service Coordination Initiative

Project Report
January 2013

Prepared by:
Jean Crewe Project Coordinator

Contents

Executive Summary

Physical Health Matters Too represents an integrated approach to addressing the physical health needs of people with a serious mental illness. International research has highlighted that people with a mental illness have a life expectancy that is 20-25 years less than other Australians and experience higher rates of morbidity and mortality from cardiovascular disease and respiratory diseases.

Utilising recommendations from the *Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019,* as well as those outlined within the Ministerial Advisory Committee's report *Improving the physical health of people with mental illness: no mental health without physical health,* the project aimed to introduce physical health screening in clinical mental health and Psychosocial Disability Rehabilitation Support Services (PDRSS) across the North East Primary Care Partnership (NEPCP) and Hume Whittlesea Primary Care Partnership (HWPCP) catchments.

Through collaboration with the mental health, community health and general practice sectors, key project activities included:

- Literature review identifying different tools for physical health screening
- Participation in the Department of Health's Statewide Pilot of the *Single Page Health Screener for Health and Social Needs*
- Development of the *Physical Health Matters Too Screening Tool*
- Establishment and promotion of new and existing referral pathways
- Development of a number of resources to support the screening process including Information Sheet for Staff; Information Sheet for Consumers; Referral Pathways-Service Options for Consumers (According to Local Government Area); Community Health Services Chart; Referral Covering letter to GPs; Health Resources for Consumers and Services
- Facilitation of smoking cessation training by Quit Victoria within two clinical mental health services
- Mental health training offered to staff across five community health services
- A cross sectoral forum hosted for general practice staff
- Development of a clinicians handbook and policy and procedure to support physical health screening in one clinical mental health service
- Development of an information session to introduce the physical health screening process

The major achievement of the project has been the formal introduction of physical health screening in two Psychiatric Disability Rehabilitation Support Services (PDRSS), one clinical mental health service and one community health service in collaboration with its local PDRSS. In 2013, a further one PDRSS and two clinical mental health services plan to introduce physical health screening within their services.

A number of challenges were experienced throughout the project and given the project was largely unfunded, it was not surprising that some of the initial project objectives and timelines were difficult to achieve. A one size fits all approach to implementing health screening across multiple mental health agencies was not realistic for this project. Different stages of organisational readiness for change, agency considerations for programs beyond the project catchment (e.g., regional and

statewide programs) and bureaucratic agency requirements all contributed to a staggered approach to health screening implementation. Furthermore, due to competing demands and the time required for planning implementation (staff, consumer and carer consultation, training and the development of supporting documentation such as policy and procedure and screening guidelines and quality improvement measures) the commencement of physical health screening did not take place until late 2012. Consequently, this limited the availability of establishing any linkages between the project activities and the identified short and medium term outcomes originally proposed by the project's plan. Future regional project opportunities, alliance structures or individual agencies may want to use the work from this phase of the project to establish links to these outcomes.

1. Project Background

1.1 Physical Health & Mental Illness

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). Furthermore, the number of deaths in people with mental illness by physical causes far exceeds the number of hospital admissions for related conditions, indicating that despite high rates of poor lifestyle behaviours in those with mental illness, chronic conditions and illnesses are not being picked up or treated until it is too late (Vicserv, 2008). These statistics can be attributed to a variety of social factors including poverty, unemployment, social isolation, homelessness, alcohol and drug use and violence. In addition, medication side effects, poor access to health services and diagnostic overshadowing, further augment the risk of chronic diseases.

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. Whilst not mandated, mental health services are now beginning to acknowledge their role in responding to these recommendations (Felstead et al, 2011; Davidson & O'Brien, 2010). Surveyed attitudes of mental health staff indicate that staff feel that there is a role for them in addressing the physical health needs of their consumers (Yates, 2011; Eldridge, Dawber & Gray, 2011). Furthermore, Ussher et al (2007) suggests that people with mental illness are interested in improving their physical health and will engage in increased activity if they receive support to encourage and motivate them.

1.2 Policy Context

The Community Mental Health Planning and Service Coordination Initiative (CMHP&SCI) was developed to support the 2009- 2019 Victorian Mental Health Reform Strategy *Because Mental Health Matters* at a local level. The project aimed to address the following mental health reform areas:

4.4 Foster an integrated response to people's physical and mental health problems

***Through*:** Significantly reducing the separation between mental health services and the broader health system. An integrated response to consumer's physical and mental health problems is evident in each project objective as follows:

(a) improve the health screening skills of mental health practitioners
(b) coordinate delivery of health screening in mental health services across the project catchment
(c) develop referral pathways between the two sectors and
(d) support smoking cessation programs in mental health services

Breaking down the barriers between physical and mental health service provision is considered to have potential benefits; both in terms of capacity building and consumer outcomes for both sectors.

5.1 Promote a more coordinated and tailored approach to people with severe mental illness who require support and multiple services

Through: Specifically, the project will strengthen referral pathways and achieve continuity of care for consumers by facilitating improved cross sector collaboration, coordination and discharge planning. Collaboration and coordination in service delivery will be improved between specialist clinical, PDRSS and primary health services. Service access will be improved for adults with serious mental illness registered for services with AMHS or PDRSS. The project combines 2 Clinical/PDRSS Alliances, 2 Divisions of GPs & 2 PCPs that comprise 5 Local Government Areas and 6 Community Health Services. It is envisaged that the model developed in the current project will be transferable to other settings and locations.

2. Project Description

In 2010, stakeholder forums were held in the North West Metropolitan Region to scope potential projects for the Community Mental Health Planning and Service Coordination Initiative (CMHP&SCI). The forum participants were divided into 3 geographic groups to allow for local priority setting and problem definition. In the Northern area there was an overwhelming consensus from agencies to use the initiative to address the physical health needs of those with mental illness (Department of Health, 2010). Given the already existing structure of the NEPCP's role in strengthening relationships, improving service coordination and integrating health promotion activities, it was agreed that they would partner with HWPCP and coordinate the development of the project (Department of Health, 2010). A 0.4 EFT project coordinator was employed in April 2011 using NEPCP reserved funds. In June 2012, the Department of Health (DH) provided a small amount of funds to assist with workforce development and extending the role of the project coordinator.

A project steering committee was developed that consisted of representatives from interested agencies providing mental health or primary care services in the local government areas of Hume, Whittlesea, Darebin, Banyule and Nillumbik. Agencies nominated themselves as either Core Project Partners or Associate Partners. Core Project Partners became members of the steering committee whilst Associate Partners did not attend the steering committee but were able to participate in project implementation. It was agreed that rather than having direct consumer representation on the committee, the consumer consultation approach would be either via agency representatives or through the Project Coordinator attending consumer advisory groups. In September 2011, the project committee voted to rename the Northern CMHP&SCI *Physical Health Matters Too.*

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 on a bi-monthly basis 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 project occurs into agencies and networks

2.1 Project Aim, Objectives and Activities

2.1.1 Project Aim

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.

2.1.2 Project Objectives

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.

2.1.3 Project Activities

1. Selection of a physical health screening tool
2. Workforce capacity building for mental health services/community health services/GPs
3. Establishment of referral pathways between mental health, primary care and general practice
4. Introduction of physical health screening

2.2 Selection of a Physical Health Tool

In order to support the steering committee with the process of selecting an appropriate physical health screening tool, a literature review was undertaken **(Appendix A)**. Several existing health screening tools were reviewed including findings from recent projects where mental health services had embarked on physical health screening. The literature review was a valuable starting point for the project committee to ascertain what areas of health they felt were essential for mental health services to identify with their consumers. Meanwhile feedback was also sought from agency staff and consumers. This feedback was obtained via numerous avenues including:

- Agency representatives requesting feedback from their staff and consumers
- Project coordinator attending consumer and carer advisory groups
- Utilisation of findings from a survey of Neami staff who participated in the 2010 Service Integration Physical Health Screening Pilot

Whilst the project committee's intention was to find a screening tool that was comprehensive there was also a necessity to be realistic about the existing workloads of mental health staff. Therefore, the project committee felt a prerequisite of the chosen tool was that it could be administered efficiently and effectively.

In August 2011, the Department of Health (DH) began preparations for the piloting of a *Single Page Screener for Health and Social Needs*, which would become a new addition to the Service Coordination Template Tools (SCTT) 2012 suite. The Project Coordinator and NEPCP Executive Officer met with DH staff to talk about the tool and its potential to be used for the purposes of this project. The DH tool **(Appendix B)** was an adaptation of the Flinders GP screener for Chronic Disease. A working party with a range of academic experts was facilitated by DH to determine the wording and sequencing of the questions.

A copy of the draft DH *Single Page Screener for Health and Social Needs* was presented to the project committee. There was overwhelming consensus from the committee that unlike other screening tools the *Single Page Screener for Health and Social Needs* was easy to understand, used simple wording, was consumer centred and concise. Dianella Community Mental Health (CMH) agreed to trial the *Single Page Screener for Health and Social Needs* as part of the DH Statewide pilot. 7 consumers from Dianella CMH used the screen over a one week period. On completion of using the tool both consumers and staff completed a satisfaction survey. The majority of consumers indicated that they felt the questions were easy to understand and helped them think about health and wellbeing issues they would like to discuss. The majority of staff also agreed that the tool was easy to use, had appropriate questions that were suitably worded for consumers and that they were satisfied with the layout and use of the tool.

Overall, 307 consumers took part in the Statewide DH pilot. Using the *Single Page Screener for Health and Social Needs*, 74% of consumers identified 2 or more health issues and 25% indicated 5 or more. Overall, the tool was found to be easy to use by both consumers and staff. Consumers found it easy to understand (95%) easy to use (93%) and reported that it prompted them to consider other health issues (94%). For staff, ease of use, sequencing and layout were acceptable with an agreement of > 80%. Consumers welcomed being asked sensitive questions despite feedback from some service providers who felt some questions were too intrusive.

As a result of taking part in the pilot, Dianella CMH expressed some concern that the inclusion of the questions “I would rate my health as poor” and “I would rate my life circumstances as poor” were too broad. The project committee also raised concerns that the single page screener lacked questions on prominent areas of risk for those with mental illness. As a result, the Project Coordinator forwarded recommendations to DH that the questions “I would rate my health as poor” and “I would rate my life circumstances as poor” be removed whilst questions in the areas of cancer screening – pap, mammogram and prostate check, last GP check, sexual health, vision and hearing be added to the *Single Page Screener for Health and Social Needs*. However, given the improbability that these recommendations would be taken on, combined with the fact that DH’s timelines for release of the *Single Page Screener for Health and Social Needs* was not until mid to late 2012, the project committee developed its on version of a single page screener *Physical Health Matters Too Screening Tool* **(Appendix C)**.

2.3 Workforce Capacity Building

2.3.1 Mental Health Services

During the development phase of the project it was initially envisaged that all mental health staff would receive health equity training in order to understand the poorer health outcomes and prevalence of chronic disease in those with mental illness. Anecdotally, evidence soon indicated that this training was not required for all agencies, as many staff had been exposed to this information through previous workforce development, deaths of consumers as a result of poor physical health and/or previous involvement in pilot health screening initiatives. For those agencies who felt they required training in this area they proceeded to provide this training to their staff internally.

After a presentation, at the steering committee by the Northern Division of General Practice (NDGP) and North East Valley Division of General Practice (NEVDGP), PDRSS expressed a high level of interest in receiving information on the services GPs can provide to consumers with mental illness and chronic disease. This expression of interest was taken up by the Divisions who offered to provide a one hour session to staff on GPs services.

In regards to clinical mental health services, limited time and resources resulted in restrictions in the ability of staff to attend external training and networking opportunities. Consequently training was prioritised to supporting smoking cessation and internal site training for these sessions were negotiated with Quit Victoria.

Opportunities for GP Involvement in the Care of Clients with Mental Illness & Chronic Disease

Staff from Dianella CMH and Neami (all Northern region sites) received a presentation from the NDGP and NEVDGP on Opportunities for GP Involvement. It was acknowledged that in many instances, the role of mental health staff is to not only refer their consumers to GPs, but to also advocate for the most appropriate service options. In order to do this mental health services require some understanding of the various Medicare Benefits Scheme (MBS) items available to GPs for the management of consumers with chronic care and mental illness. The presentation highlighted how in many instances consumers with mental illness can be managed under both a chronic disease treatment plan and a mental health treatment plan hence giving them a broader range of services. The session provided an opportunity to also discuss how MBS items can be used to either complement services offered by community health or fill a void where services are not offered by a local community health service.

Physical Health and Mental Health

Staff at MIND participated in an internal half day training session on April 18th 2011.
The session covered topics including:

- What is healthy living?
- The relationship between physical health and mental health
- The seriousness and range of physical health problems experienced by people with mental illness
- Supporting people to improve their physical health
- The benefits of regular physical health checks

Occupational Therapy staff from BCH alongside Home and Community Care (HACC) staff from Banyule City Council requested a 1 hour information session on Physical and Mental Health. This session looked at the relationship between physical and mental health and the seriousness and range of physical health problems experienced by people with mental illness.

Smoking Cessation Interventions for Mental Health Practitioners

A mapping exercise on local smoking cessation supports highlighted that despite the existence of organisational no smoking policies, staff from clinical mental health services lacked training on the provision of smoking cessation interventions. Health professionals, such as clinical mental health staff, are a respected source of preventative information and by giving just brief advice (less than 3mins) can help 2% of smokers to quit (VicHealth Centre for Tobacco Control, 2001). With this in mind Quit Victoria offered to provide free training to the 3 clinical mental health services. Northern Area Mental Health staff from both the Darebin and Whittlesea sites each participated in a 3 hour session.

Topics covered included:

- Addressing smoking with consumers from a social justice perspective
- The benefits of quitting
- Understanding smoking behaviour and the stages of change model
- Integrating smoking cessation into the routine provision of consumer care using the 5 As framework
- An overview Quit Victoria's services and resources

Key points and comments arising from the training evaluation were:

- 91% of participants from the Whittlesea service and 69% of participants from the Darebin service agreed/strongly agreed that the training increased their confidence and willingness to ask about smoking and help consumers plan strategies to help them quit
- 91% of participants from the Whittlesea service indicated they would feel more confident in both raising the smoking issue with consumers more often and increasing their use of, and referrals to, Quit's services
- 77% of participants from the Darebin service indicated they would feel more confident in raising the smoking issue with consumers more often whilst 85% indicated they would increase their use of, and referrals, to Quit's services
- "Practical use of referrals and education with a framework to implement"
- "Raised profile of working with quitting smoking"
- "Would like more information on dealing with dysphonia post quitting"

Mind Melbourne North also sourced Quit training internally for their staff. As part of their Smoke-Free Wellness program, Neami have Quit training sessions incorporated within their staff training calendar throughout the year to ensure that staff possess the required skills to provide basic level brief interventions to their consumers.

Physical Health Monitoring in Mental Health

Financial support was provided through project funds for 3 psychiatric nurses from clinical mental health to attend a one day training session facilitated by the Centre for Psychiatric Nursing.
The aim of the session was to provide an opportunity for staff to update their knowledge and skills in relation to physical health monitoring of people with schizophrenia.

Recommendations

In relation to the orientation and ongoing workforce development of staff, the time and resources required for staff to attend training, particularly clinical mental health services, need to be considered. The workforce development sessions discussed were well received and agencies are encouraged to continue to utilise these partnerships for their going workforce development requirements. Other recommended training options are:

Diabetes Australia: Introduction to Diabetes for Mental Health Workers Diabetes and Mental Health.
This online training module has been specifically developed for workers in the mental health field. The program has been endorsed by the Australian College of Mental Health Nurses and may be an appropriate option in instances when restricted resources for workforce development exist.

- Information and education about the different types of diabetes (type 1, type 2 and gestational diabetes)
- How to identify those at high risk
- Screening and diagnosis of diabetes
- Prevention and management of diabetes, including the burden of ongoing self management
- Complications of diabetes, and the impact of diabetes complications on quality of life and wellbeing
- The strong association between diabetes and psychological problems.

Cancer Council: Cutting Cancer Risk in Mental Health Cancer Prevention and Mental Health
This free 4 hour session is aimed at mental health professionals and community workers who want to update their skills and knowledge about early detection strategies and ways to minimise cancer risk. It aims to give participants the skills and knowledge required to present cancer prevention education to individuals and consumer groups.

2.3.2 Community Health

The training needs of community health staff were varied across the project catchment. This is likely to be a reflection of staff experience, qualifications and previous opportunities for training in mental health. Furthermore, recent initiatives in dual diagnosis and chronic care have resulted in community health staff receiving an abundance of training in areas such as motivational interviewing and health coaching.

For the purposes of this project, utilising training through local primary mental health teams (PMHT) was seen as a means of not only having the flexibility to tailor training content, but to also provide an opportunity to build rapport and encourage partnerships between the mental health and community health sectors. Given that staff typically report that they are more likely to contact or refer to a service if they have had direct contact with a service provider this was seen as particularly important

The decision to offer training to community health services across catchments rather than to each individual service was made for several reasons. Firstly, it was deemed not feasible for each community health service to receive individual training sessions by local primary mental health staff. Due to the current mental health service structure this would have potentially resulted in the North East and Northern PMH teams providing up to 8 training sessions. Secondly, offering joint training provided the opportunity for staff from different community health services to network with one another.

Mental Illness Awareness

The session facilitated by Wayne Harrington was held for Reception and Intake teams at Darebin, Nillumbik and Banyule Community Health services in July 2011. This session was organised and funded by Nillumbik Community Health independently of the project after some initial discussions with the Project Coordinator.
The session included:

- Overview of the major mental illnesses, history of treatment and stigma
- Effective communication strategies in working with consumers with mental illness
- Negotiating key parts of the service system

How to Better Engage Mental Health Clients in a Primary Health Setting

This session was held on April 19th 2012 and was facilitated by the Northern and North East PMHT. The session had 28 attendees.
Topics covered included:

- Working with motivation, attachment & readiness in clients with mental illness
- Understanding the role of primary health workers in working with people with mental illness
- Negotiating local mental health service systems

Key points and comments arising from the training evaluation were:

- 61% of participants found the content of the session relevant/useful to their current job
- 52.9% of participants rated the content of the session as good
- “Was expecting hear more about strategies to better engage with mental health clients”
- “Information & examples may/could have been better linked to experiences and issues that CH services deal with”
- “The NEAMI guest speaker was informative and interesting”
- “Well facilitated”

Feedback from this session was very mixed. In some cases it seemed participant expectation versus session content were inconsistent. For example, some participants indicated they wanted to learn more about different mental health conditions which was not promoted as an objective of the session. It also appeared that there was too much emphasis throughout the session on navigating the mental health system and not enough on strategies to work with mental health clients.

Despite this mixed feedback, a comparison of pre and post training data indicated participants had

an increased level of confidence in working with people with a range of mental health diagnoses; effectively engaging with people with serious mental illness in health interventions and negotiating the local mental health service system.

Working with Clients Experiencing a Mental Health Crisis

This session was held on May 3rd 2012 and was facilitated by the Northern and North East PMHT. The session had 22 attendees. Topics covered included:

- Recognising warning signs of common mental health issues and crisis situations
- Understanding how to provide initial support to someone within your role
- Where and how to get help for these situations

Key points and comments arising from the training evaluation were:

- 73% of participants rated the content of the session as very good/excellent
- 73% of participants found the content of the session either extremely or very relevant/useful to their current job
- "Good to have a discussion in pairs, making the session relevant to the work we've done or are doing"
- "Facilitators spoke very well, were engaging and answered questions well"

A comparison of pre and post training data indicated a significant rise in participant confidence in recognising the common warning signs of a crisis situation; providing initial support to someone experiencing a mental health crisis and where and how to get assistance for someone experiencing a mental health crisis.

Working with Clients with Mental Illness

A 2.5 hour session for the Dianella Community Health Early Intervention in Chronic Care (EiCC) Team was held on August 8th 2012. The session was facilitated by Dominic Germano from the North West Area Mental Health Service (NWAMHS) Shared Care Team with 17 staff in attendance. Session content was based on a team training needs survey and included the following:

- What is anxiety, depression, bipolar disorder & psychosis
- Comorbidity of physical health and mental health issues
- What impedes and enhances engagement with mental health clients

Key points and comments arising from the training evaluation were:

- 94.1% of participants indicated that the session was relevant and useful to their current practice as a health professional.
- 76.4% of participants either agreed or strongly agreed with the statement that having now attended the session they had an increased understanding of how to engage clients with mental health issues.
- A number of participants outlined the use of case vignettes and examples as the most useful aspects of the session "case studies are very useful and led to clinically relevant discussions".

Dominic has agreed to host another session for DCH staff in 2013. Feedback from the original training needs survey and the workshop evaluation indicated that staff are interested in learning about referrals pathways into the mental health system, including information on local mental health services. The training session also provided an opportunity for staff from DCH to build a rapport with a NWAMHS clinician. To date discussions about the prospect of co-facilitated groups between the two services and opportunities for staff secondary consultation have been held.

Recommendations

Where appropriate, it is recommended that community health services utilise their local PMHT for their staff training requirements. As previously discussed the benefits in doing this can extend beyond just meeting staff training needs but in continuing to build cross sectoral partnerships as evident in the Dianella and NWAMHS scenario. Previously, in response to an internal training needs audit, the Banyule Community Health Allied Health Team has sourced training from the North East PMHT. More recently, Darebin Community Health has also requested additional training from the Northern PMHT in 2013.

Other training options for community health staff include the Northern Metropolitan Region Home and Community Care (HACC) Calender HACC Training Calender which includes a free 2 day training session on Introduction to Mental Health for Non Mental Health Workers. The majority of community health services in Victoria receive HACC funding, making them eligible to attend this training. There are also a number of opportunities in the North West region for staff to receive training in Mental Health First Aid (MHFA). MHFA training can assist in early intervention and in the ongoing support of people with mental illness. There are a number of services in the North West region (e.g., North West Area Mental Health Service) who have staff members accredited to facilitate MHFA. Services such as Sunbury Community Health have partnered with Western Region Health Centre to provide subsidised training in their region.

2.3.3 General Practice

Mind the Gap – Managing Physical and Mental Health Comorbidities

In March 2012, the Northern and North East Divisions of General Practice facilitated Mind the Gap training for 20 GPs. The content of this training is typically geared towards working with clients with high prevalence disorders however this session included some information on lower prevalence disorders. Input from carer and consumer representatives from MI Fellowship was found to be particularly useful for GPs.

Key points and comments arising from the training evaluation were:

- 90% of participants felt the training entirely met their needs on how to utilise a variety of strategies and treatments suitable for use in comorbid mental and physical health issues
- 89% of participants felt the training was entirely relevant to their individual general practice
- 86% of participants felt the training entirely met their needs for increased knowledge of patient self-management issues and consumer/carer perspective and experiences of mental health issues, chronic health conditions, and comorbidities, plus confidence in the provision of psychoeducation to consumer/carers.

Physical Healthcare for Mental Health Patients – Working Together to Share the Load

In July 2012 an evening information session was held for general practice staff. The session used a case study and panel discussion to inform staff of the options available when working with patients with physical and mental health comorbidity.
The purpose of the session was to:

- Bring a range of services together to talk about their roles and how they currently work with someone with a mental illness
- Identify possible future opportunities for working together with these clients
- Provide an opportunity to hear about successful examples of team approaches to the management of physical health needs of people with mental illness

Members of the discussion panel included:

Dr Lindsey Hyde– GP, Reservoir Medical Centre
Susan D'Amico- Mental Health Nurse, Primary Mental Health Team
Jessica Schwartz- Team Leader, Northern Area Mental Health
Carol Phillips- Diabetes Educator/Community Health Nurse, Banyule Community Health
Kirra Johnson- Service Manager, Neami Heidelberg
Judi Brewster- Project Officer Special Settings Quit Victoria

Dr David Fong from Doutta Galla Community Health presented on Working with Mental Illness & Physical Health in a General Practice Setting whilst Lizi Wallace and Jessica Schwartz from Northern Area Mental Health Service presented on Mental Health Nursing in a Primary Care Setting.

Key points and comments arising from the training evaluation were:

- The majority of participants indicated that the session entirely met the three learning objectives.
- Participants particularly benefited from hearing about the different services available for clients, including where to refer and how.
- Participants indicated an increased awareness of chronic illness and mental health including strategies for management.

Recommendations

Communication between general practice and the community health and mental health sectors requires ongoing work. Guidelines for GP Feedback and GP Feedback Forms can be used to guide and develop this process. GP's who attended the Mind the Gap training responded positively to resources developed under the project such as the Community Health Services Chart and the Referral Covering Letter to GPs. The Project Coordinator worked closely with the two Divisions of General Practice and received support with the consultation, development and marketing of project activities. Given recent changes to the structure of Divisions of General Practice, with the introduction of Medicare Locals, it is hopeful that a similar level of engagement in future initiatives will be possible.

Full copies of evaluation reports for some of the training sessions discussed in this report are available. Please contact NEPCP: nepcp@bchs.org.au

2.4 Referral Pathways

Due the size of the project catchment there was a varying degree of referral pathways across the region. For example, in the NEPCP there were clear referral pathways established between Banyule Community Health, Neami Heidelberg, Neami Briar Hill and the North East Area Mental Health Service. In addition, Neami Thornbury, Neami Regent and Darebin Community Health also had strong pathways between services. In the HWPCP, Dianella's Community Mental Health and EiCC team were slowly establishing stronger connections through the co-facilitation of a program for mental health consumers. Furthermore, Plenty Valley Community Health was working in close partnership with Whittlesea Community Mental Health Service on a DH funded project.

In instances where agencies indicated they felt either referral pathways were lacking or required further improvement, the Project Coordinator took on the responsibility of initiating and facilitating discussions between the relevant services. Some of these discussions required only initial support from the Project Coordinator with services then making their own plans to action tasks that would encourage better collaboration between services (e.g., staff attending joint meetings, co-facilitating groups etc.) whilst others required several facilitated opportunities and still continue to negotiate future partnerships.

Workforce development sessions provided throughout the project aimed to reiterate referral pathways between services (i.e., the focus of the evening GP information session was to not only highlight the comorbidity of physical and mental health but to provide an opportunity for different sectors to converse on how they could work together). The *Victorian Community Health Priority Tools 2009* also provided assistance for consumers with serious mental illness to access services at community health within a timelier manner. This supported the promotion of community health as a viable referral option for mental health services and GPs.

To support the screening process and promote referral pathways, a number of resources were developed in consultation with the project committee. They included:

- Information Sheet for Staff
- Information Sheet for Consumers
- Referral Pathways-Service Options for Consumers (According to Local Government Area)
- Community Health Services Chart
- Referral Covering letter to GPs
- Health Resources for Consumers and Services

These resources can be accessed via the **Resources** tab under **Physical and Mental Health** on the NEPCP website www.nepcp.org.au

2.5 Introducing Physical Health Screening

In order to successfully introduce the implementation of physical health screening, agencies were required to undertake a number of change management processes including the development of policy and procedure, quality improvement measures such as auditing and screening guidelines and orientation. This combined with the competing demands of a number of initiatives, such as metabolic monitoring, agency redesign and system reforms, resulted in a varied approach to agency implementation across the region.

2.5.1 Psychiatric Disability Rehabilitation Support Services (PDRSS)

Dianella Community Mental Health (Dianella CMH):

During 2010/2011, 9 consumers of Dianella CMH passed away from physical health issues. For Dianella CMH, the need to recognise and prioritise improving consumer health outcomes was an extremely important one. Dianella CMH chose to introduce the *Physical Health Matters Too Screening Tool* as part of a wider review of their mental health programs which aimed to streamline access for consumers and promote a 'no wrong door' approach. A program workflow, that outlined a consumer's journey from the initial needs identification process including timelines and requirements for initial assessment and the development of a consumer's Individual Program Plan (IPP), was developed to support this process. It was agreed that the physical health screen would be offered to consumers within the development of a consumer's IPP. For quality assurance purposes, an Access database was established to support this practice and to identify when a worker was required to have completed the relevant documentation.

In addition to introducing physical health screening, the Dianella CMH team and Ei&CC team, decided to team up and co-facilitate a 12 week *Improving My Health* program. This program aims to improve client health outcomes by building, establishing and sustaining partnerships between the Ei&CC and CMH teams. Whilst the program is continually being developed it has been generally well received by consumers and staff.

Mind:

Due to internal staff changes early in the project, Mind was not adequately represented at the project steering committee until late 2011. Consequently, Mind's timelines for implementation have since been slightly behind schedule with that of other project participants. Nevertheless, to date staff from Mind Melbourne North have undertaken an introductory session in physical health and mental health and completed Smoking Cessation training facilitated by Quit. In 2013, Mind Melbourne North plan to implement the *Physical Health Matters Too Screening Tool* as a regular addition to the periodic assessment and outcome measures they use with consumers.

Neami:

Neami Heidelberg and Briar Hill sites had previously taken part in the 2010 Service Integration Physical Health Screening Pilot and consequently were committed to launching physical health screening at Neami on a national level. Given some of the considerations required for launching a physical health initiative nationally the Neami Health Promotion Team developed the *One Minute Health Prompt* as the physical health screening tool for Neami. The *One Minute Health Prompt* utilises a number of questions from different health screening tools and initiatives including the

Adapted SCTT, Rethink, One Minute Health Check, Go for 2 and 5 and Measure Up. The *One Minute Health Prompt* was launched in mid November 2012 with all Managers and Senior Practice Leaders trained in the tool. Remaining Neami staff will be trained using a train the trainer model with all new staff trained via Health Promotion Champions at each site in conjunction with the State Health Promotion Officer. It is anticipated that staff will start using the *One Minute Health Prompt* in January 2013.

In December 2012, Neami received a Victorian Health Promotion Award for their Smoke-Free Wellness Program under the category of 'Tackling Health Inequalities'. In collaboration with Quit Victoria this program aims to create an environment conducive to supporting people with a severe mental illness who wish to reduce or quit smoking. Key activities of the program have included the development of a Smoke-Free policy, the distribution of resource kits to support worker and consumers in reducing/quitting smoking, brief intervention training for staff and delivery and evaluation of smoking cessation support groups.

Sunbury Community Health (SCH) & Western Region Community Mental Health (WRCMH):

As an associate project partner, SCH was in a unique position from other community health services involved in the project in that their local clinical mental health service (Mid West Area Mental Health Service) sits under the Western CMHP&SCI project. However, utilising their strong partnership links SCH and the WRHC (who amongst its numerous services, provide psychosocial rehabilitation and recovery services to those living in Sunbury) developed The Physical Health Assessment Program (PHAP). Using the *Physical Health Matters Too Screening Tool*, Community Health Nurses from SCH will provide people with a mental illness referred directly by WRHC Community Mental Health program, an overall physical health check. At the end of each appointment the team in consultation with the consumer will receive a comprehensive care plan outlining actions to be taken from this first visit. Individual goals which are set by the consumer and any referrals that need to be made to internal or external services will be developed. To date, staff have reported that the screening tool was easy for consumers to use and consumers felt comfortable asking questions about the content. In future, the program aims to review and evaluate the effects that this has on individuals and their experience of the process.

2.5.2 Clinical Mental Health Services

Austin Health - North East Area Mental Health Service (NEAMHS):

Alongside Neami Heidelberg and Briar Hill, NEAMHS also took part in the 2010 Service Integration Physical Health Screening Pilot. During this pilot there was a focus on clinical teams at NEAMHS undertaking physical health screens with their consumers. With the introduction of physical health screening as part of core business, Austin Health will be introducing screening practices beyond NEAMHS and into their Veteran's Mental Health Program and Secure Extended Care Unit (SECU).

General physical health screening was introduced simultaneously with metabolic monitoring and the MHA 32 annual examination in November 2012. Case managers are responsible for general physical health screening whilst registrars/consultants are responsible for metabolic monitoring and the MHA 32. Previously metabolic monitoring and the continuation of general physical health screening post the 2010 pilot was ad hoc. By launching clinical and general physical health screening across the

entire adult mental health service with the support of guidelines, policy and procedure and quality improvement measures, Austin Health are now addressing the physical health needs of their consumers as part of core business.

In November 2012, an information session was held to orient NEAMHS staff to the new physical health program. The one hour session was facilitated by the Manager of the Continuing Care Service and the Project Coordinator. During the session staff were introduced to the *Physical Health Matters Too* Clinician Guidelines. These guidelines outlined the requirements for staff and are supported by an organisational physical health screening policy and procedure. Staff were also provided with a pack of the information and resources designed to support the screening process. NEAMHS plan to undertake joint screening with Neami for any shared clients.

Northern Area Mental Health Service (NAMHS):

Over the past 18 months, the introduction of systematic metabolic monitoring has been a strong area of focus across the entire North West Area Mental Health Service (within the scope of this project this includes Darebin Community Mental Health Service (DCMHS) and Whittlesea Community Mental Health Service (WCMHS)). Similarly to NEAMHS, in the past metabolic monitoring at NAMHS had been ad hoc. Furthermore, there was no history of general physical health screening. At NAMHS, a decision was made that in order to assist the required change management processes, it was necessary to introduce metabolic monitoring and general physical health screening independently. In September 2012, champions from each team were provided training on metabolic monitoring with the plan to use a train the trainer model to ensure that all staff receive training. At DCMHS metabolic monitoring is now undertaken by medical, allied health and nursing staff. Nursing staff are trailing a new metabolic tool with more vulnerable consumers such as those on a depot or clozapine. Metabolic monitoring will be aligned with 6 monthly reviews of Individual Service Plans (ISP).

From April 2010-June 2012, Plenty Valley Community Health Service received funding under the Chronic Disease Innovations Grant to work, in partnership with WCMHS, with a cohort of 30 clients with a mental illness who either had a chronic disease or were at risk of developing a chronic disease in the future. The project aimed to provide this cohort physical health assessments, care planning and improved access to community GPs and services available at PVCH. WCMHS showed a commitment to continuing to focus on some of the outcomes the Innovations Project generated by using growth funding to recruit to 2 full time positions that have a focus on supporting clients with their physical health needs. These positions are supported by the strong partnership with PVCH and in addition to providing consumer support will also aim to increase engagement with GPs, develop local protocols for shared clients with Neami Whittlesea, implement the role of Quit Educators to facilitate smoking cessation groups and identify how WCMHS may be able to prioritise early identification in the future.

In regards to the *Physical Health Matters Too Screening Tool*, its implementation has been handed over to the working group who were previously responsible for implementation of metabolic monitoring. NEAMHS have kindly provided a copy of their physical health policy and procedure and guidelines for clinicians to assist this working group. Carer and consumer sessions will be held in early 2013 to provide information on the introduction of physical health screening processes.

3. Discussion

Physical Health Matters Too represents an integrated approach to addressing the physical health needs of people with a serious mental illness. The collaboration between the mental health, primary health and general practice sectors was exciting. The high level of commitment from agencies, with little to no resources or funding, was a cross sectorial acknowledgement that addressing the physical health needs of people with mental illness is everyone's responsibility. In many instances the project was able to build on existing relationships to assist the work. On other occasions, the role and expertise of the PCP in bringing agencies together to either form or improve working relationships, was integral.

The major achievement of the project has been that within the NEPCP and HWPCP catchments, two PDRSS, one clinical mental health service and one community health service in collaboration with its local PDRSS have formally introduced physical health screening in their agencies. A further one PDRSS and two clinical mental health services are currently planning to introduce screening within their services in 2013.

Key success factors to the project included the clear link between policy and practice and other work occurring in the region. The project utilised a number of recommendations from the *Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019* as well as those outlined within the Ministerial Advisory Committee's report *Improving the physical health of people with mental illness: no mental health without physical health*. There was also evidence of synergies between the project and other work occurring in the region in areas such as care planning, dual diagnosis and chronic disease. With this in mind it was important to take into account existing relationships, previous workforce development initiatives and existing referral pathways.

A number of challenges were also experienced throughout the project. Given the project was largely unfunded it was not surprising that the some of the initial project objectives and timelines were difficult to achieve. A one size fits all approach to implementing health screening across multiple mental health agencies was not realistic for this project. Different stages of organisational readiness for change, agency considerations for programs beyond the project catchment (e.g., regional and statewide programs) and bureaucratic agency requirements, all contributed to a staggered approach to health screening implementation. Furthermore, due to competing demands and the time required for planning implementation (staff, consumer and carer consultation, training, development of supporting documentation such as policy and procedure and screening guidelines and quality improvement measures) the commencement of physical health screening did not take place until late 2012. Consequently, this limited the availability of establishing any linkages between the project activities and the identified short and medium term outcomes originally established by the project's objectives. Future regional project opportunities, alliance structures or individual agencies may want to use the work from this phase of the project to establish links to these outcomes.

Another challenge for the project was the numerous changes to project committee representatives, mainly due to staff turnover. On these occasions the Project Coordinator was often required to dedicate time to ensure the new agency representative had an adequate understanding of the project to date including future actions and agency commitments. This was extremely important as

the role of an agency representative was to not only attend project committee meetings but to drive project implementation within their agency. Future projects may want to consider nominating change champions from each agency to form a working group (supported by managers) who are responsible for leading implementation within their agency. A project governance model that consists of a project steering committee and project working group may assist with improved communication between the manager and practitioner levels and in the case of Physical Health Matters, where the EFT of the Project Coordinator was 0.4 across two PCP catchments, may have assisted the coordination of agency implementation.

In the initial stages of the project, the Project Coordinator mapped previous and current physical health screening initiatives in Victoria. The Project Coordinator initially established links with several key physical health projects which enabled the sharing of resources and information. This was later supported by a DH facilitated Mental Health and Physical Health interest group. Speaking to other Project Coordinators and reading project reports was an extremely useful project starting point as it provided information on existing resources that were developed to support health screening initiatives and in some instances an analysis of health screening data. Examples include data from the 2010 Service Integration Physical Health Pilot which provided information on what areas of health are particularly concerning for consumers (e.g., gambling, oral health and falls). Whilst, the 2010 EACH and Inner South Community Health Demonstration Project, provided a host of resources used during project implementation including health screening information sheets for consumers and clinicians, evaluation forms etc. It is recommended that similar future initiatives avoid duplication of resources by attempting to utilize and share resources. Furthermore, PCPs and former GP Divisions have a number of great resources that can be used or amended to suit the implementation of similar future initiatives.

4. Conclusion

Physical Health Matters Too demonstrated a strong commitment across sectors to work towards improving the physical health of those with serious mental illness. Despite the project coming to a formal conclusion in December 2012, the work of Physical Health Matters Too will continue to carry on across the catchment, as mental health agencies continue to introduce and embed physical health screening processes. At several agencies, physical health screening has now been incorporated into internal agency protocols, training, performance measures and policy. Current structures, such as local alliances and other network settings, including the ongoing role of PCP's in supporting Service Coordination practices, provide scope for sustaining partnerships and opportunities for collaboration between sectors. By utilising a strategy that supported individual, organisational and system level strategies for project implementation, it is anticipated that 100% of consumers accessing clinical mental health services and PDRSS, will routinely have their physical health needs screened.

Further details regarding this project can be provided upon request. Please contact Jean Crewe on jean.crewe@bchs.org.au

5. References

Brown, S and Smith, E (2009) Can a brief health promotion intervention delivered by mental health key workers improve clients' physical health: a randomised controlled trial, *Journal of Mental Health*, vol, 18, no, 5, pp, 372-378

Coghlan, R, Lawrence, D, Holman, D, Jablensky, A (2001) *Duty to Care, Physical illness in people with mental illness,* Department of Public Health and Psychiatry and Behavioural Science, The University of Western Australia, retrieved http://www.psychiatry.uwa.edu.au/research/community-culture/healthright#background

Davidson, M and O'Boyle, S (2010) *Improving Access to Primary Health Care Services for People with Serious Mental Illness,* Final Project Report

Eldridge, D, Dawbar, N and Gray, R (2011) 'A well-being support program for patients with severe mental illness: a service evaluation,' *BMC Psychiatry,* vol, 11, no, 46, pp, 1-9

Felstead, B, Edward, K, Howey, J, Lakshmana, R, Nelson-Hearity, R and Nasso, M (2011) 'Let's make is work: collaborative physical health screening for consumers of mental health services', *The Australian Journal on Psychosocial Rehabilitation,* Winter, pp. 54-57.

Ministerial Advisory Committee for Mental Health, 2011, *Improving the physical health of people with severe mental illness: no mental health without physical health,* retrieved http://www.health.vic.gov.au/search.htm?g=mac+improving+the+physical+health+of+people+with+severe+mental+illness

O'Sullivan, J, Gilbert, J and Ward, W (2006) Addressing the health and lifestyle issues of people with a mental illness: the healthy living programme, *Australasian Psychiatry,* vol, 14, no, 2, pp, 150-155

Ussher, M, Stanbury, L, Cheeseman, V, Faulker, G (2007) 'Physical activity preference and perceived barriers to activity among persons with severe mental illness in the United Kingdom, *Psychiatric Services,* vol, 58, no, 3, pp, 405-408

VicHealth Centre for Tobacco Control (2001) Tobacco Control: A Blue Chip Investment in Public Health, The Cancer Council Victoria, Melbourne, retrieved http://www.quit.org.au/resource-centre/training/training-for-health-professionals/important-role

Vicserv (2008) *Pathways to Social Inclusion: Health Inequalities*, Melbourne, retrieved http://www.vicserv.org.au/uploads/documents/pathways/paper2.pdf

Victorian Department of Health (2009) *Community Health Priority Tools,* retrieved http://www.health.vic.gov.au/communityhealth/demand/prioritytools.htm

Victorian Department of Health (2012) *Single Page Screener of Health and Social Needs,* retrieved http://docs.health.vic.gov.au/docs/doc/Single-page-screener-of-health-and-social-needs--Consumer-administered

Victorian State Government (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*, Mental Health and Drugs Division, Department of Human Services, retrieved http://www.health.vic.gov.au/mentalhealth/reform/documents/mhs_web.pdf

Yates, K (2011) 'The attitudes and practices of Victorian PDRS staff in addressing the physical health needs of consumers, *The Australian Journal on Psychosocial Rehabilitation*, Winter, pp.54-58.

Appendix A

Community Mental Health & Service coordination Initiative – Northern Project
Addressing the Physical Health Needs of People with a Mental Illness

Screening Tools Discussion Paper

A growing body of literature exists to support the notion that mental health services have a responsibility to address the physical health needs of their clients. Consequently a number of organisations have received funding to implement pilot projects on physical health screening. This paper reviews some of the findings and screening methods used by recent projects to assist the Northern Steering Group in its adoption of an appropriate screening mechanism. The following Projects have been reviewed:

1. Banyule Community Health (BCH) Service Integration Project: Improved Access to Physical Health Services for People with Mental Illness and Dual Diagnosis
2. Inner South Community Health and EACH: Improving Access to Primary Health Care Services for people with a Serious Mental Illness
3. MI Fellowship: Physical Health Promotion for People Living with a Mental Illness
4. St Vincent's: Physical Health at St Vincent's Mental Health
5. Psychiatric Rehabilitation Australia (PRA): Back on Track Health Program

Some key points for consideration when reading this document are:

- what areas of health do we want to screen for? E.g., do we want to screen for chronic conditions and /or psychosocial issues?
- what is the current capacity and willingness of staff to undertake physical health screening?
- realistically how much time do staff have to undertake screening?
- what is the view of consumers and carers?
- Other considerations? E.g., how it will fit with IT systems?

Significant evidence indicates that people with a mental illness experience poorer physical health when compared to the general population[1]. In fact the death rate of those with mental illness is 2.5 times greater than that of the general population equating to a life expectancy of 50 – 59 years of age[2]. Currently ischaemic heart disease causes the highest number of deaths and in recent years, unlike the general population, this rate has not declined in those with mental illness[1]. Other co-existing physical conditions found in people with serious mental illness include diabetes, hyperlipidaemia, cardiovascular and respiratory disorders, obesity, HIV/AIDS, Hepatitis C, osteoporosis, irritable bowel syndrome, Parkinson's disease, accidental poisonings (related to prescribed and illicit substance use) and poor nutrition[1]. This population group also requires 23% more dental treatment services and has 36% more extractions than other low-income consumers[1]. Although the incidence of cancer appears to be similar for people with a mental illness and the general population, people with mental illness are 30% more likely to die from cancer[2]. Furthermore the number of deaths in people with mental illness by main physical causes far exceeds the number of hospital admissions for related conditions. This indicates that despite the fact that those with

[1] VICSERV's *Pathways to Social Inclusion: Health Inequalities* ,August 2008

[2] Coghlan R, Lawrence D, Holman CDJ, Jablensky AV, Duty *to Care: Physical Illness in People with Mental Illness*. Perth: The University of Western Australia, 2001

mental illness have high rates of poor lifestyle behaviours including smoking, alcohol and other drug abuse, poor diet and lack of exercise, chronic conditions and illnesses are not being picked up or treated in those with mental illness until it is too late[1].

Banyule Community Health (BCH) Service Integration Project: Improved Access to Physical Health Services for People with Mental Illness and Dual Diagnosis

The BCH Service Integration project used a modified version of the Department of Health's Service Coordination Tool Templates (SCTT) **Health Conditions (Appendix 1)** and **Health Behaviours (Appendix 2)** profiles as screening tools[3]. The SCTT is a suite of templates used to facilitate and support service coordination. Profiles such as the health conditions and health behaviours are designed to assist in broad based screening and needs identification and are neither diagnostic nor assessment tools.

Health behaviours profile: screens for nutritional risk, smoking, oral health, alcohol use, gambling, physical activity and physical fitness.

Health conditions profile: looks at overall health, pain, chronic conditions, oral health, vision, hearing, falls and current illnesses and medications. On completing these profiles, if a referral is then determined necessary these profiles can be sent alongside with the information regarding the purpose of a referral.

These profiles were selected as screening tools for the pilot project for several reasons including:

1. No formal training required to administer profiles
2. SCTT profiles are sanctioned by the Department of Health (DoH)
3. Profiles are easy to use and not lengthy in content
4. Community health currently use the SCTT to make and receive referrals
5. Profiles were seen as a good method for screening in order to make appropriate referrals for further assessment and treatment.

The profiles were adapted slightly by BCH with specific questions around sexual health and mental health added to the health conditions profile and adjustments made to the time frames for last general health and oral health assessments in the health behaviours profile e.g., question about last general health assessment was changed from 2-5 years to 6 months and oral health from 3 years to 12 months.

An evaluation conducted with Neami staff indicated some positive aspects of the SCTT were[4]:

- Sexual health questions were good as this is not something workers would necessarily ask about
- Brought areas such as vision, hearing etc. to attention which are often overlooked
- Questions were direct and specific

On the other hand some of the more negative aspects reported were:

- Coding on forms was too time consuming and confusing
- No men's health questions e.g., prostate cancer checks etc.
- Some questions were confusing or too limiting

[3] State Government Victoria, *Service Coordination Tool Templates2009 User Guide*, 2009

[4] Cassell, E & Hiser, G, *SCTT Health Survey-Evaluation*, October 2010

Inner South Community Health and EACH: Improving Access to Primary Health Care Services for people with a Serious Mental Illness

Inner South Community Health (ISCHS) and EACH received funding to implement a demonstration project. EACH's project was titled the Health Project whilst ISCHS's project was known as Health Matters Inner South. Both projects chose to adapt a different screening tool[5].

The Health Project was looking for a tool that encompassed a range of health issues include oral health, vision, hearing and physical activity. After guidance from the DoH they decided to trial the SCTT **Health Conditions (Appendix 3)** and **Health Behaviours (Appendix 4)** profiles. Unlike BCH they did not adapt the tools but utilised them in their original format. Findings from the Health Project trial was that whilst some aspects of the SCTT were viewed positively there was a general consensus that a simpler version of the tool would be beneficial. It was suggested that similar questions on physical health issues could be asked in one form. Some confusion also arose around completing the Health Conditions and Health Behaviours forms. However it was felt that this could be addressed through further training and support.

Health Matters Inner South also considered the SCTT profiles for their screening tool however the Area Mental Health Service had a preference for the **Client Physical Health Guide (CPHG)** which was developed by ISCHS **(Appendix 5)**. The CPHG has 14 questions that cover areas including physical activity, oral health, sleep, vision, falls, sexual health, foot care, constipation, urinary tract infections and drug and alcohol use. A referral action plan is also included with a planned date of review (every 6-12months). The CPHG was developed using questions that cover screening for multiple disciplines such as dietetics, diabetes education and podiatry. The CPHG has since been adapted slightly to a more 'tick a box' format to assist with ease of using form.

MI Fellowship: Physical Health Promotion for People Living with a Mental Illness

MI Fellowship has recently launched their project and has chosen the **Physical Health Check (PHC)** which was developed in the UK **(Appendix 6).** The PHC was designed for use by mental health staff to improve the monitoring of physical health in people with mental illness and is divided into 4 sections[6]. Questions in the first section cover information about current medications, known illnesses and lifestyle factors such as diet, exercise and smoking.

The second section records information about currently physical symptoms and includes a body outline as an aid. The third section contains questions concerning health screening including gender specific tests. Finally the last section is an action plan where the service provider and consumer can record agreed actions arising from the screening.

The PHC was originally developed by a multidisciplinary research group consisting of a consultant psychiatrist, 3 community mental health nurses, an occupational therapist and a social worker. A GP, pharmacist and dietitian were also consulted on specific issues. The current PHC has been developed by Rethink which is a national mental health membership in the United Kingdom[7]. The PHC is free to download and use and no special training is required.

MI Fellowship have chosen this tool as they like the visual aids it uses to identify consumer's needs and the action plan and referral for GP's that promote a coordinated approach to supporting the

[5] Davidson, M & O'Boyle, S., *Improving Access to Primary health Care Services for people with serious mental illness Demonstration Project, Final Project Report,* August 2010

[6] Phelan, M, Stradins, L, Amin, D, Isadore, R, Hitrov, C, Doyle, A & Inglis, R, The physical health check: a tool for mental health workers, *Journal of Mental Health*, vol, 13, no, 4, 2004

[7] Rethink, *Physical Health Check*, 2008

consumer to reach their identified goals. Phelan et al (2004) in their study on the PHC within a sample of 60 clients identified the following outcomes:

- Mean completion time of assessment was 18min (however duration ranged anywhere from 5-60 minutes depending on the number of identified needs and the communication skills of the consumer)
- Tool was useful in revealing a wide range of physical health needs amongst consumers
- In the majority of cases the service provider and consumer were able to agree on one or more actions arising from the assessment.

St Vincent's: Physical Health at St Vincent's Mental Health

St Vincent's Mental Health Department has developed a metabolic monitoring strategy for all consumers[8]. Metabolic monitoring involves baseline screening on entry to the service and included tests such as height, weight, BMI, blood pressure, lipids, liver function, urea and electrolytes, prolactin and ECG. These measures are repeated at 3 monthly and 6 monthly intervals with the results documented and tracked within the client's clinical file. Where health problems are identified the clinician then assists the consumer to be reviewed by their GP or other health professionals. 3 years post implementation of the strategy areas for attention include increasing rates of weighing and waist measurement and enhanced referral on to GPs, dietitians and healthy lifestyle groups.

Psychiatric Rehabilitation Australia (PRA): Back on Track Health Program

PRA is a specialist provider of psychiatric disability services across NSW. In 2009 they received a one off grant from the Commonwealth government with the aim to increase the level of access to primary health care and preventative programs that are used by people living with mental health problems. During the project PRA staff developed the **My Health Needs Checklist (Appendix 7)** as a means for consumers to complete independently and use as a tool to assist them in self managing their physical health needs. Questions for the checklist were developed through liaison with various health professionals to determine what health questions would assist a person to highlight if they were at risk of developing or had a physical health need. Liaisons were had with a physician, nurse and diabetes educator from a local GP Division. Feedback on the checklist was then obtained from a group of consumers with the checklist later trailed with individual consumers by the Programs Health Adviser (nurse). Information received to date indicates that consumers are utilising the checklist to review their health and have subsequently made appointments to address their health needs with a GP. The Program is currently seeking more detailed feedback from consumers and staff about the use and effectiveness of the *My Health Needs Checklist*.

[8] Organ, B, Nicholson, E & Castle, D, Implementing a physical health strategy in a mental health service, *Australasian Psychiatry*, vol, 18, no, 5, 2010

Appendix B

Single page screener of health and social needs

Consumer administered

Purpose: to assist service providers to screen for a consumer's needs.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Please complete the following details to help us get to know you and provide you with the best possible service.

Your participation in completing this questionnaire is voluntary, and we treat your information in the strictest confidence, in accordance with privacy legislation.

What is the main reason you are here today?

The following statements are examples of things that may be problems/issues for people. **Please tick any of the statements which apply to you, and tick any items you would like to discuss.** Ignore any statements that do not apply to you. Give the completed the form to your service provider at the start of your appointment.

Question	(tick✓)	I would like to discuss this (tick ✓)
I have difficulty with daily tasks (such as getting dressed, showering or preparing meals).	☐	☐
I have been told by a doctor or other health professional that I have a health condition (for example arthritis, high blood pressure, diabetes, heart disease, a cancer, osteoporosis, asthma, lung disease, chronic kidney disease or other condition).	☐	☐
I have recently had problems with my teeth, mouth, gums or dentures.	☐	☐
I am concerned about my medications.	☐	☐
I am concerned about my lack of physical activity.	☐	☐
I am concerned about my weight.	☐	☐
I have recently lost weight without trying.	☐	☐
I currently smoke tobacco.	☐	☐
I have quit smoking tobacco in the last 5 years.	☐	☐
I am concerned about how much alcohol I drink.	☐	☐
I am concerned about my use of drugs.	☐	☐
I am concerned about my gambling.	☐	☐
My financial situation is very difficult.	☐	☐
I often feel sad or depressed.	☐	☐
I often feel nervous or anxious.	☐	☐
I have felt afraid of someone who controls or hurts me.	☐	☐
I am homeless or at risk of homelessness.	☐	☐
I would rate my health as poor.	☐	☐
I would rate my life circumstances as poor.	☐	☐

Produced by the Victorian Department of Health, 2012

This information collected by: SPSHSN Page 1

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Single page screener of health and social needs *Consumer administered*

Appendix C

Physical Health Screening Tool

Name: _____ Date: _____

	Please respond to the following by ticking those statements that apply to you and any items you would like to discuss further:	(√)	I would like to discuss (√)
1	I have been told by a doctor or other health professional that I have a health condition (arthritis, high blood pressure, diabetes, heart disease, a cancer, osteoporosis, asthma, lung disease, chronic kidney disease or other condition)		
2	I have had a GP check up in the last 6 months which included blood tests and a blood pressure check.		
3	I have had a pap smear in the past 2 years (for women)		
4	I have had a mammogram in the last 2 years (for women over 40 years old)		
5	I have had a prostate check in the last 12 months (for men over 50 years old)		
6	I would like a sexual health consultation (contraception, family planning, STIs)		
7	I am concerned about my medications		
8	I have recently had problems with my vision		
9	I have recently had problems with my hearing		
10	I have recently had problems with my teeth, mouth, gums or dentures		
11	I am concerned about my weight		
12	I have recently lost weight without trying		
13	I am concerned about my diet		
14	I am concerned about my lack of physical activity		
15	I have difficulties with my balance		
16	I have difficulty with daily tasks (getting dressed, showering)		
17	I currently smoke tobacco		
18	I am concerned about how much alcohol I drink		
19	I am concerned about my use of drugs		
20	I am concerned about my gambling		
21	I have trouble managing my finances		
22	I often feel sad or depressed		
23	I often feel nervous or anxious		
24	I have felt afraid of someone who controls or hurts me		
25	I am homeless or at risk of homelessness		

Developed by the *Physical Health Matters Too Project Steering Committee*, with support from the Victorian Department of Health under the Community Mental Health Planning and Service Coordination Initiative

1

Physical Health Screening Tool

Name: _____ Date: _____

Summary table of referral pathways. Refer to **Service Information- Referral Pathways for Consumers** document for more details regarding individual services and contact details.

Question(s)	Referral to
1. Chronic Condition	GP or Chronic Disease Program
2. GP Check Up	GP
3. Pap Smear	GP
4. Mammogram	Breastscreen Victoria or GP
5. Prostate	GP
6. Sexual health	GP or Community Health Nurse
7. Medications	GP
8. Vision	GP or Optometrist
9. Hearing	GP or Audiologist
10. Oral Health	Dental Program
11-13. Nutrition	Dietitian
14-15. Physical Activity & Balance	Physiotherapist
16. Daily Tasks	Occupational Therapist
17. Tobacco	Quit or Smoking Cessation Program
18-19. Alcohol and Drugs	Alcohol and Drug Counsellor
20. Gambling	Gambling Counsellor
21. Finances	Financial Counsellor
22-23. Anxiety and Depression	General Counsellor
24. Family Violence	Family Violence Program
25. Housing	Housing Service

Referral Action Plan

Taking into account any issues you and the consumer have subsequently identified, summarise the action required.

Date Referral Sent	Agency	Service Type	Phone Number	Purpose of Referral	Consumer Consent	Referral Method	Feedback to

Developed by the *Physical Health Matters Too Project Steering Committee*, with support from the Victorian Department of Health under the Community Mental Health Planning and Service Coordination Initiative