Improving Access to Primary Health Care Services for people with serious mental illness Demonstration Project

Final Project Report
August 2010

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Executive Summary

Background

The poor physical health of people with a serious mental illness is an issue which the Department of Health (DH) Integrated Care Branch has identified as a priority area in *Because mental health matters: Victorian mental health reform strategy 2009-2019.* Other reports such as the Western Australian *Duty to Care* report highlight the need for improved strategies to support clients with a serious menial illness and their broader health needs (Coghlan et al. 2001). *Primary health care in Victoria: A discussion paper* (Department Human Services 2009) sought to promote a comprehensive view for the future of the primary health care system which strengthens the role of Community Health services in supporting better health for Victorians and particularly for marginalised groups in the community who experience poorer health outcomes.

Research has shown that people with serious mental illness are more vulnerable to chronic conditions such as diabetes and heart disease. Barriers to the provision of adequate health care are present, including client service access challenges and mental health and medical health service system challenges. This supports the recommendations from Coghlan et al. (2001) to provide better support for the broad health needs of clients with serious mental illness.

These reports led the Department of Health to explore this complex issue further by funding a demonstration project in 2009 – 2010: *Improving Access to Primary Health Care Services for people with serious mental illness*.

The target group for this project was clients with a serious mental illness who are case managed either by public mental health services or psychiatric disability rehabilitation and support services. A description of these services is provided in Appendix 2.

Two organisations were selected to conduct the demonstration project. EACH represented the project in the Eastern Metropolitan Region (EMR) and Inner South Community Health Service (ISCHS) represented the project in the Southern Metropolitan Region (SMR).

EMR project context

The Outer East region encompasses three local government areas of:

- City of Maroondah
- City of Knox
- The Shire of Yarra Ranges

The region covers a large geographical area including semi rural. Project partners therefore included:

- Community Health Services - four
- Divisions of GP - three
- Area Mental Health Service (AMHS) - several
- Primary Care Partnership (PCP)
- DH

It was decided through consultation with the steering group and DH that the bulk of the consultations and trials would take place in Maroondah LGA.

SMR project context

The Inner South East Region local government areas include:

- City of Port Phillip
- City of Stonnington
- and parts of City of Glen Eira

The region covers a smaller geographical urban area. Project partners included:

- Community Health Centre - one
- Division of GP - one
- AMHS - one
- PCP
- DH

Governance was provided by a central, overarching steering committee and a regional steering committee in both regions. The central and regional steering committees were responsible for supporting and providing guidance to the project sites.

The projects were undertaken during the period June 2009 to August 2010.

The following report has been prepared jointly by the projects.

Project Aims

The aims of the projects are to improve:

- Access to service (through screening and identification of physical health needs).
- Access to models of care that support identified client needs.

Project Methodology and Process

A review of literature and existing programs and projects was undertaken (Appendix 1) to provide an overview of approaches and evidence supporting chronic disease management and outlining the need to focus on the physical health needs of people with serious mental illness.

Both projects conducted a needs analysis which included identification of existing tools, practices and pathways. The Supporting Physical Health Needs: Attitudes and Practice Survey was conducted with AMHS staff by both projects. Consideration was given to the Chronic Care Model (CCM) and principles of Service Coordination (SC) and how they can be applied to the projects.

Project plan development involved data collection, analysis, and consultation to ascertain current practice and opportunities for improvement; collaboration between project workers; and DH and agency approval of the project plan.

Implementation involved consultation with partner agencies throughout the project period both at the governance level and between project and agency staff on a day to day basis.

Models of Care

Models of care were developed by both projects incorporating physical health screening within AMHS. The Service Coordination Tool Template (SCTT) Health Behaviours, Health Conditions Profile and an adapted version of the ISCHS Client Physical Health Guide were used. A trial of the models of care within AMHS pilot sites occurred.

Training

A range of training relating to components of the model of care was provided for AMHS, GPs and Community Health (CH) to:

- Increase knowledge, confidence and skill of AMHS to discuss physical health needs with their clients
- Increase knowledge, confidence and skill of AMHS to refer their clients to appropriate Primary Health Care Services

- Increase knowledge, confidence and skill of GPs and CH Allied Health staff working with people with serious mental illness
- Increase knowledge, confidence and skill of GPs and CH Allied Health staff to support meaningful and realistic goal setting for physical health needs
- Increase consumer health literacy

Training included: Health Coaching; Mental Health In-service; "Mind the Gap"; Health Literacy; Physical Health Information Sessions; Physical Health Screening Tool Orientation; Mental Health First Aid; Working with clients Motivation; and Consumer Medication Workshop.

Training was evaluated and recommendations made.

Access Strategies

Investigation of access strategies included trialling of:

- "Meet and greet" between Allied Health and Mental Health staff
- "Open Day" at Allied Health site
- Peer Mentor support
- Telephone Health Coaching
- A brief audit to increase understanding of appointment non-attendance

Trial Challenges

A range of challenges were identified from the model of care trials:

- Aspects of the model of care were not utilised by clinicians
- Clinicians anxiety around assuming responsibility when a client refuses referral for an identified physical health need
- Inconsistent perceived time to complete health screening amongst clinicians
- Confusion by clinicians over how to administer the SCTT Health Conditions and Health Behaviours forms
- Health screening tool needs to include action taken and referral feedback
- Ensuring timely and appropriate access to Allied Health
- Physical distance of location between partner agencies (EMR)
- Engagement with privately funded GPs was a challenge for both projects, an example of this was training organised specifically for GPs was not well attended

Key Findings

AMHS

- Physical health screening of AMHS clients is best placed to be undertaken by the AMHS
- This responsibility needs to be reinforced by agency and government policy
- Agency drivers, supports and resources are vital to the success of this work
- Practice and attitude change is a slow and challenging process for all change in workplaces, and has held true in this project

Clients

- Choice and opportunity is important to clients; high cost, limited range and lack of choice of services create barriers for clients
- Health services need to be provided in a place and manner accessible and acceptable to clients
- Relationships with case managers/professionals are important and take time to build and establish trust
- Practitioner engagement with clients allowing clients to be 'heard' is critical to client outcomes

Primary Health Care

- Effective strategies for improved communication with GPs requires further process refinement
- Feedback processes to GPs need to be embedded
- Service providers should communicate relevant information to each other (with consent) to reduce multiple referrals and 'telling the story' many times
- Health Coaching training was well received by GPs who attended

Key Recommendations

Project Funding

1. Funding should continue in order to:
   - Develop and embed the system and process outcomes of the demonstration projects
   - Evaluate the impact of access to Primary Health Care Services for people with serious mental illness

Project Consolidation within AMHS

2. Further development to consolidate projects within trial AMHS agencies including:
   - Providing information to clients regarding the purpose of physical health screening within AMHS
   - Clinicians take into account the impact of mental illness on a client's ability to enact the developed health plan
   - Definition, agreement and communication of referral pathways between GPs, CH and mental health services
   - Development of communication pathways between AMHS and GPs
   - Development of agency policy to document agreed commitment, responsibility and role regarding the physical health of clients accessing AMHS
   - Behaviour change training for all staff
   - Monitoring and reporting back on implementation outcomes i.e. percentage of clients screened and referred where required

Model of Care

3. The Department of Health roll out a model of care in mental health settings, as trialled by the projects, that responds to the physical and broader health needs of clients

Training

4. All Allied Health staff should be trained in Mental Health First Aid
5. All Primary Health Care and Mental Health Services participate in behaviour change training
6. Mental Health and Community Health services provide regular information sessions for clients, on topics identified by clients

Health System

7. The role of peer mentors in providing a link between clients and health care professionals should be explored
8. Further development of the relationship between AMHS, PDRSS, GPs and CH, including joint team meetings and service development, to increase staff knowledge and confidence in working with this population group
9. Further investigation to look at both the service and client factors (including high cost, limited range and lack of choice) that may influence clients to not engage or attend appointments or groups, and identified strategies trialled.
10. Explore and develop the role of the Primary Mental Health team in linking GPs, AMHS and CH

Next Steps

Recurrent funding to progress the projects has been provided by DH through the Early Intervention in Chronic Disease Initiative, as well as funding to the PCPs to undertake “systems work”. It is anticipated that this funding will allow the project to build on the momentum that has been gained through the pilot phase and embed significant changes within the broader health and mental health systems in accordance with these project recommendations.

Terminology and Abbreviations

Terminology

"Model of care"
Literature suggests that there is no consistent definition of a "model of care". As described by Queensland Health (2000) "a "model of care" is a multifaceted concept, which broadly defines the way health services are delivered."

Abbreviations

ABHI	Australian Better Health Initiative
AH	Allied Health
AMHS	Area Mental Health Service
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
CCM	Chronic Care Model
CCT	Continuing Care Team
CCU	Community Care Unit
CDM	Chronic Disease Management
CH	Community Health
CHS	Community Health Service
COPES	Carers Offering Peers Early Support
CPHG	Client Physical Health Guide
CTO	Community Treatment Order
DH	Department of Health
DHS	Department of Human Services
EACH	EACH Social and Community Health
ECT	Electroconvulsive Therapy
EICD	Early Intervention in Chronic Disease
EMR	Eastern Metropolitan Region
GP	General Practitioner
HARP	Hospital Admissions Risk Program
HC	Health Coaching
HCA	Health Coaching Australia
ISCHS	Inner South Community Health Service
ISEMHA	Inner South East Mental Health Alliance
ISEPICH	Inner South East Partnership in Community and Health
LGA	Local Government Area
MH	Mental Health
MHFA	Mental Health First Aid
MST	Mobile Support and Treatment service
PCP	Primary Care Partnership
PCRG	Project Consumer Reference Group
PHC	Primary Health Care
PHCS	Primary Health Care Services
PDRSS	Psychiatric Disability Rehabilitation Support Service
PEAR	Program Evaluation Action Research
PHAMS	Personal Helpers and Mentors
PMHEIT	Primary Mental Health Early Intervention Team
RIC	Readiness, Importance and Confidence
SC	Service Coordination
SCTT	Service Coordination Tool Template
SEBDA	South East Bayside Diabetes Alliance
SMR	Southern Metropolitan Region
SRS	Supported Residential Service
T/IRP	Treatment and Individual Recovery Plan
TOR	Terms of Reference

1. Introduction

1.1 Purpose of this Report

The following report has been prepared by the Eastern Metropolitan Region (EMR) and Southern Metropolitan Region (SMR) project workers for the Improving Access to Primary Health Care Services for people with serious mental illness Demonstration Project. The report details the development, implementation, process and outcomes of models of care and strategies trialled by both projects. This report has been prepared for the Department of Health (DH) Integrated Care Branch, Chronic Disease Management (CDM).

1.2 Background

People with a severe mental illness often do not have the same access to treatment for physical health conditions nor do they experience the same life expectancy as other people in the community. The Western Australia Duty to Care report launched in 2001 reported on a health study of 240,000 mental health service users between 1980 and 1998. The report compared hospital admission rates, cancer incidence rates and death rates between this population and that of the general Western Australian population (Coghlan et al. 2001).

Among the findings were:

- The overall death rate of people with a mental illness was 2.5 times higher than the general population
- Despite a downward trend in the death rate due to heart disease in the general population the death rate in people with a mental illness due to heart disease had increased in women and remained steady in men
- Cancer rates were about the same as the general population despite the high incidence of smoking but once a cancer was diagnosed there was a 30% higher death rate
- People with mental illness often suffer poorer nutrition, dental decay and are vulnerable to chronic conditions such as diabetes and the negative health effects of weight gain due to medication

Barriers to the provision of adequate physical health care have been identified including:

- People with serious mental illness are often defined solely by their mental illness
- Lack of integration between mental health and medical health
- Primary care providers' confidence in working with this client group and lack of professional support
- Mental health providers tend to overlook physical health concerns
- Inability to receive timely access to primary health care for mental health clients
- Difficulties with information sharing related to electronic systems, confidentially and privacy
- Client concerns – including transport, isolation, cognitive impairment, attention difficulties or other behavioural factors or previous negative experience with providers or stigma associated with disclosing a mental illness

The Victorian Mental Health Reform Strategy *Because mental health matters* (Department of Human Services 2009) is a whole of Victorian government 10 year plan for mental health. The vision of Because mental health matters is that all Victorians have the opportunities they need to maintain good mental health while

those experiencing mental health problems can access timely, high quality care and support to live successfully in the community.

Primary health care in Victoria: A discussion paper (Department of Human Services 2009), is intended to promote a comprehensive view for the future of the primary health care system in Victoria for discussion and debate with the Victorian sector and key stakeholders.

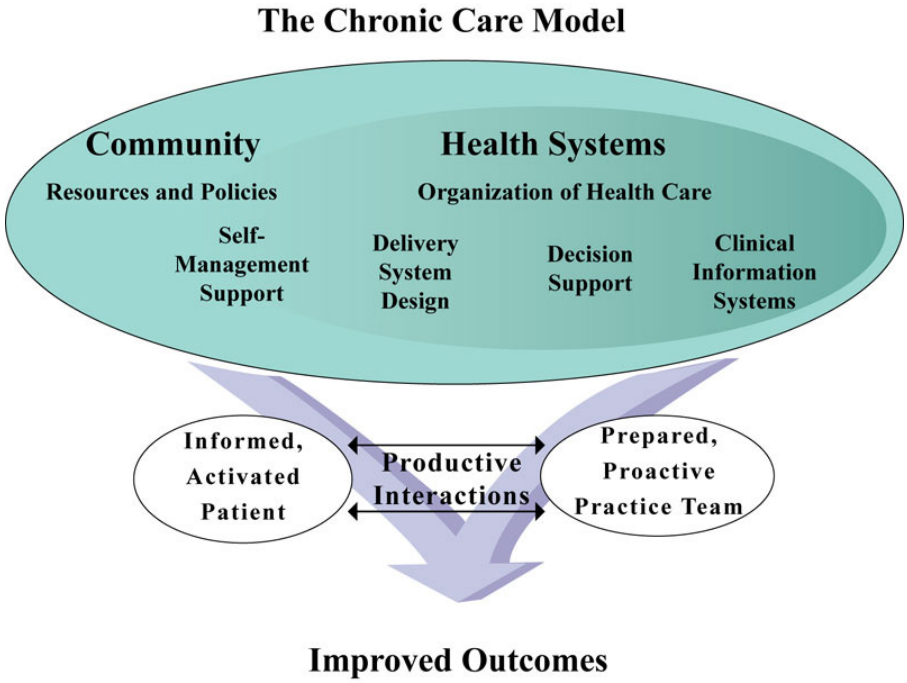
These two initiatives underpinned the decision to fund two demonstration projects separately implemented in EMR and SMR: Improving access to Primary Health Care Services for people with serious mental illness.

Both demonstration projects were locally renamed with EMR referring to the project as “Health Project” and SMR called their project “Health Matters Inner South”. These names will be used throughout this report.

The Chronic Care Model (CCM) has been adopted by the DH as the model of choice to support clients with chronic and complex needs.

The model consists of 6 interdependent components:

- Health System
- Community Resource Mobilisation
- Self-Management Support
- Delivery System Design
- Decision Support
- Clinical Information Systems



The use of the CCM (Wagner 1998) will provide the framework for the work undertaken in this project.

1.3 Aims and Objectives

The overall aims of this project are to improve:

- Access to service (through screening and identification of physical health needs)

- Access to models of care that support identified client needs

The target population for this project is people with a serious mental illness who are case managed through public mental health services.

Due to the geographical, demographical and service structure differences of the EMR and SMR the objectives were locally defined.

The objectives of the Health Project were to:
- Identify effective pathways and mechanisms for referrals
- Identify and select reliable effective health screening tools to trial at clinical services
- Identify, modify or develop new service options or recommendations
- Identify training needs for clients based on health literacy (use of peer mentors instead)
- Identify training needs for service providers
- Deliver training to identified target groups

Objectives of Health Matters Inner South were to:
- Improve integration and communication between Area Mental Health Service, GPs and CH Allied Health services.
- Improve referral and access pathways for clients and primary care service providers
- Increase skill and confidence of primary care service providers working with people with serious mental illness
- Improve care coordination for clients
- Improved and sustainable needs identification processes

1.4 Project Deliverables

- Training package for primary health care services and mental health services
- Report which documents models of care trialled, referral and screening tools and recommendations supporting the identification of physical health needs including chronic conditions

1.5 Regions

The project regions included EMR and SMR. An overview of these regions and their differences is provided in Appendix 3.

1.6 Governance

Governance was provided by a central, overarching steering group and a regional steering committee for Health Project and Health Matters Inner South project sites.
The Central Steering Committee was responsible for supporting and providing guidance to the demonstration project sites. Terms of Reference (TOR) were developed and agreed by all members of the Central Steering Committee.

Membership included representatives from:
- DH – Primary Health Integration Unit, Primary Health Programs
- Mental Health and Drugs Department of Human Services (DHS)
- Regional DHS (one per demonstration region)
- VICSERV
- Area Mental Health Service (AMHS)
- Western Region Health Centre
- General Practice Victoria representative
- Client / Carer representative

- Project site representation

The Health Project Steering Committee was established to provide expertise, direction, and support throughout the project. Representatives from all partner agencies of the Health Project were invited to participate. TOR developed for the Central Steering Group by DH was also implemented for this steering committee. Meeting bi-monthly, representatives included:

- Knox Community Health (CH)
- Ranges CH
- Yarra Valley CH
- Knox Division of GP's (now Greater Eastern GP network)
- Melbourne Eastern GP Network
- Eastern Ranges Division GP's
- Outer East PCP
- Eastern Health
- DH EMR
- Two peer mentors who were already employed in the PHaMs program at EACH were also included to provide client perspective.

The Health Matters Inner South Steering Committee was established to provide expertise knowledge, advice, and support and to guide the work of the project, TOR were developed and implemented locally. Meeting monthly with representation from partner agencies:

- The Alfred Psychiatry- AMHS
- Inner South East Partnership in Community and Health (ISEPICH)
- Southcity GP Services
- ISCHS (Psychiatric Disability Rehabilitation Support Service PDRSS and CH)
- DH SMR

1.7 Timelines

The projects commenced at different times due to recruitment reasons, in May 2009 for Health Matters Inner South and in August 2009 for Health Project.

An overview of timelines for key activities can be reviewed in Appendix 4.

1.8 Evaluation

The original DH project brief allocated a percentage of the budget to engage an independent body to evaluate the two pilot projects; however this evaluation has not occurred. This report provides process evaluative data and impact evaluation from a range of project activities and the perspective of the two project workers.

2. Project Methodology

Both projects were required to conduct an initial broad needs analysis to direct the project plan and activity development which fits within the framework of the CCM. This involved mapping existing process and areas where improvement could be made through the identification of:

- Existing screening tools
- Practices
- System support
- Referral pathways
- Availability of relevant service information
- Care planning pathways, practises and documentation
- Information sharing

2.1 Project Methods

A range of activities were undertaken to support project development and progression, including:

- Brief literature review
- Review of existing programs and projects
- Project plan development
    - Stakeholder consultation
    - Collaboration between project workers
- Department and agency approval
- Implementation
    - Ongoing consultation

2.1.1 Review of Literature

A review of literature was undertaken to provide an overview of approaches and evidence supporting chronic disease management and outlining the need to focus on the physical health needs of people with serious mental illness. Past and current projects with similar aims and care models involving Mental Health Services, GPs and community health services were also reviewed to inform project activities and strategy trials. Literature reviewed has been listed in Appendix 1 of this report.

Key findings from literature:

- People with serious mental illness are at higher risk of chronic illness than the general population
- There is an inconsistent non-systematic approach by mental health services to respond to the physical health needs of their clients
- The client must be at the centre of care for optimal health outcomes
- The CCM is an internationally recognised, evidence-based guide to integrated care delivery needed to support chronic condition self management
- Organisational changes requires significant effort and time
- Working in partnership with clients to support their health needs, but leaving space to make their own choice is important
- GPs and mental health services were most appropriate to provide physical health checks
- More information provided to clients is required to support management of health care
- Disease onset can be prevented through early intervention and reduction of risk
- PDRSS standards recommended routinely measuring change in health status of clients

Key findings from similar existing programs and projects (published and unpublished):

- Sustainability of project (practice) change(s) is difficult
- It is important to utilise opportunities for collaboration with other projects rather than duplicating activities
- Client physical health screening and monitoring is current practice in some mental health settings and mandatory for clients on Community Treatment Orders (CTO) and undergoing involuntary Electroconvulsive Therapy (ECT)
- For clients on Clozapine, physical health monitoring is mandatory within AMHS

2.1.2 Existing Programs and Projects

A list of existing programs and projects that support potential collaboration, sharing of information and minimising duplication and that compliment this work was compiled, a summary is provided below.

Health Project	**Health Matters Inner South**
Mental Health Alliance shared care plan project between AMHS and PDRSS	AMHS Review Process (share review client information weekly with ISCHS)
Co-Case Management arrangement by AMHS and PDRSS in some services	Co-Case Management arrangement by AMHS and PDRSS when necessary
SRS oral health project conducted by partner Community Health services	Psychiatry Clinic at ISCHS (Alfred Psychiatry and ISCHS partnership)
CH administer the HARP psycho social stream providing care coordination for clients with complex needs	SRS Dental Project at ISCHS
Yarra Valley Community Health has an outreach team from clinical mental health services operating from their sites 4 days per week	ISCHS Mental Health Program, Client Physical Health Guide
Division of GPs Mental Health nurses are co located within Community Health Services and PDRSS	ISCHS Mental Health Program, My Wellness Plan
CH and HARP use of ' my health journal'	ISCHS Mental Health Program, Weight Management Program
Diabetes *Improving the Journey* project by EMRs PCP established an inter-sectoral response to co ordination of care	ISCHS Outreach services- Dental, Allied Health, Mental Health (ie. Healthtime at the Gatwick)
Ranges, Knox and Yarra Valley CHC all have specific EICD funding and projects	ISCHS Diabetes Model of Care (assessments conducted by Diabetes Assessment Team)
Project partners Indigenous teams have a *Healthy for life program*	Mental Health First Aid Training- available to all ISCHS staff
A EACH PDRSS has developed a partnership with a gym to provide pathways into physical health care with clients being referred and monitored by a local GP	ISCHS Chronic Conditions Project- including initial audit of systems across the organisation
Dual Diagnosis project. All PDRSS and AMHS staff now trained in use of ASSIST screening tool	SEBDA Diabetes Project- appropriate care for people with, or at risk of, diabetes through a co-ordinated model of care
EACH currently conducts the Aboriginal Health Promotion and Chronic Care partnership and the Refugee Health Nurse service	Dual Diagnosis Initiative, ISCHS Project
A previous survey on health monitoring conducted by medical students at Murnong Clinic which included a file audit	ISEMHA Care Coordination and Partnerships Project

and client and staff interviews was also used to identify gaps	

2.1.3 Chronic Care Model

The CCM and service coordination principles as endorsed by DH to inform chronic disease management within and across agencies were used to underpin the work of the project. The CCM consists of six key areas that work together to support productive interactions between care providers and clients, and encourage improved client health outcomes. The CCM components are:

1. Self Management Support
2. Decision Support
3. Delivery System Design
4. Clinical Information System
5. Health Care System
6. Community Resource Mobilisation

Effective care for people with chronic conditions involves multiple health care providers across multiple agencies and settings. To provide this care within an integrated system, health care providers must work collaboratively to coordinate and plan services and care (Wagner 1998). How the CCM links to this project is outlined in section 3.3.1 AMHS Consultation.

2.1.4 Development of Project Plans

It was recognised that the project plan needed to be locally relevant to the service system and partnerships involved but also developed and implemented with sufficient collaboration to minimise duplication of effort.

Throughout the project, a collaborative approach was taken by the two projects through constant communication and sharing of information and resources.

The two funded projects at EACH and ISCHS thus developed individual project plans which were submitted to the Central Steering Group for approval.

Key activities were identified by the projects to be undertaken:

Health Project	**Health Matters Inner South**
Conduct a needs analysis mapping existing and potential service structures	Needs analysis including ongoing consumer consultation
Further develop the clinical Treatment and Individual Recovery Plan (T/IRP) through identifying and introducing an appropriate health screening tool	Develop model of care and shared care processes based on evidence and best practice
Provide training options for mental health professionals, community health workers and other stakeholders	Provide training options
Develop a health literacy program for clients including training peer educators	Implementation of model of care, shared care arrangements, workforce development and training
Develop referral pathways and mechanisms to Primary Health Care Services and other relevant targeted services	Evaluation

Due to the number of partners involved it was decided that the Health Project would be confined to the Maroondah LGA. The services involved in the trial were Murnong Clinic (AMHS), Outer East Mobile Support Team, PDRSS services in the Maroondah Area and the EACH Allied Health (AH) site in Ringwood. Consultation was obtained

from all partners in the project including all three divisions of GP through individual discussion and feedback at the steering group.

The Health Matters Inner South project plan was developed by the project worker after initial consultations with agencies to determine current practice for addressing the physical health needs of people with serious mental illness. Consultation with partner agencies occurred through the regional steering committee meeting and individual discussion as required.

For both projects, focus groups and interviews were held with all stakeholders to identify current access to service, models of care and the gaps in accessing services needed.

3. Project Process

In August 2009 the Health Project implementation plan developed by the steering committee and the Health Matters Inner South project plan outlining key tasks were endorsed by the Central Steering Group. Due to the Health Project starting a little later than Health Matters Inner South the original project completion time was extended to mid August 2010.

3.1 Key Activities

The key activities for progression identified in the project plans were:

Health Project	Health Matters Inner South
Conduct focus groups with clients and carers	Establish consumer reference group
Conduct a needs analysis mapping existing and potential service structures	Conduct needs analysis
Consult with AMHS and PDRSS staff on existing policies and procedures and redevelopment of the T/IRP to include physical health	Agency consultations
Consult with 3 divisions of GP to determine current referral pathways and processes	Source existing training
Consult with 4 Community Health Centres to establish current role in Mental Health (MH)	Identify current practice
Identify training needs, developing and implementing a trial training package	Identify referral pathways
Develop a pathway for improving the health literacy of clients through training peer educators in health coaching	Identify realistic areas for change
Develop referral pathways and mechanisms to Primary Health Care services	Development and implementation of model of care and training

A change to project finishing time for Health Matters Inner South to align with Health Project was approved in April 2010 to enable a joint final project report.

3.2 Data Collection

Data collection and analysis was conducted through Health Matters Inner South involving:

- Identification of current client base
- Referrals to Primary Health Care Services (PHCS) from AMHS
- Referrals to PHCS from GPs
- Referrals to PHCS from ISCHS (internal to project agency)

3.3 Consultation

Based on the key activities detailed in both Health Project and Health Matters Inner South project plans, the project workers undertook a series of consultations with respective partner agencies to direct development of an appropriate model of care. This involved:

- Meeting with AMHS management
- Attending AMHS staff team meetings

- Conducting a staff survey at AMHS
- Providing feedback and setting priorities with AMHS
- Review of organisational policy
- Client consultation
- GP consultation
- Allied Health consultation
- Consultation with carers
- PDRSS consultation

3.3.1 AMHS Consultation

Both projects conducted significant consultation with AMHS throughout the project. Emphasis on AMHS was required to support the projects' target population of people with serious mental illness case managed through public mental health services.

A survey: Supporting Physical Health Needs: Attitudes and Practice Survey, Appendix 5, was conducted to provide an overview of AMHS current practice and staff attitudes toward supporting the physical health needs of their clients, identify areas for improvement, and recommend changes required to support improvement. The survey was based on one previously conducted at St Vincent's Hospital and was used by both Health Project and Health Matters Inner South.

The survey assisted development of an understanding of the range of views and some barriers AMHS staff might face in addressing the physical health needs of their clients. Specifically:

- Current role in supporting clients with their physical health needs
- Staff perceptions of what is within and external to their responsibility with regard to their clients' physical health
- What staff are prepared to do to support the physical health needs of their clients

In addition, data from this survey provided an indication of:

- Staff members' perceptions of the capacity they have to respond to physical health
- The systemic and organisational supports they need to respond and
- Particular service system areas they feel comfortable further exploring for development and improvement with regards to addressing the physical health needs of their clients.

3.3.1.1 Findings

Health Project had 31 staff complete the survey from Murnong Continuing Care Team (CCT), Chandler House CCT and Mobile Support Team (MST). With 34 staff completing the survey from Inpatient Unit, CCU and Community Services (CCT, MST, and PMHEIT) for Health Matters Inner South.

Survey findings included:

Health Project	Health Matters Inner South
Continuing Care teams expressed uncertainty around protocols and guidelines regarding physical health monitoring and who is responsible for carrying out health checks	65% of staff surveyed indicated that an established physical health monitoring protocol/guideline existed
All MST staff responded with a clear understanding of who and how health checks were to be carried out	Some staff indicated that they were responsible for coordinating physical health checks
Time constraints were cited by 83% of respondents	Time pressure is a challenge for staff, indicated by 65% stating that there was not enough time to adequately monitor the physical health of their clients, and that the required level of monitoring needed to be considered
Clinicians reported a lack of confidence in how to screen and what to screen for in health checks	More than half of surveyed staff indicated a lack of confidence about what to monitor with regards to clients physical health needs
80% of CCT clinicians had not had any training on a physical health topic in the past 6 months while all 100% MST clinicians had	74% of staff had not had any training on any physical health topic in the previous 6 months
Clinicians discussed physical side effects of medication with almost all clients but blood pressure and weight were not routinely discussed	While staff surveyed mostly routinely discussed physical side effects of medication and health habits with their clients, blood pressure, weight, waist and chronic conditions were not routinely discussed
Clinicians responded more positively to general goal setting and health habits with around 50% setting and encouraging health goals	68% of staff surveyed believed that monitoring physical health (as well as mental health) is their responsibility. Monitoring physical health was also seen as the responsibility of the team alongside the GP
Clients are not linked routinely to GP's or Allied health services for checks but rather on an as needed basis. Health information was provided more routinely and efforts to encourage clients to attend allied health services was usually recorded	Most staff have minimal regular contact with their clients' GP and other primary health care service, however would routinely encourage and support access to physical health support or services
Most clinicians agreed that communication pathways could be improved between clinics, Allied health and GP's	Most to all staff agreed that there could be improved communication pathways between GPs, Allied Health and their agency

Health Project found there were a range of perceptions expressed around the role of clinicians in physical health screening and the capacity to respond to health needs of clients. As MST already routinely ensures metabolic monitoring is carried out the

perceived responsibility for health screening was higher than that of the CCT. However concerns were raised by both teams around what health screening entailed and the confidence and skills required for conducting more extensive health checks

Health Matters Inner South discussion with AMHS staff immediately post completion of the questionnaire included defining the boundaries of Alfred Health AMHS staff roles, with staff concerns about undertaking physical health monitoring and support including, “we don’t prescribe”, legal considerations, time it would take being asked to do “more” and how it fits with Alfred Health Policy and the client’s right to refuse.

3.3.1.2 Survey Recommendations

The survey identified system and practice improvements in supporting the physical health needs of clients of both Health Project and Health Matters Inner South AMHS to be consistent with the CCM. Recommendations are provided in the following table.

Chronic Care Model Component	Recommendations
Health System Creating a culture that promotes safe, high quality care • Chronic conditions care is part of AMHS long term planning strategy. • Strategies are Management driven and support is provided through planned change and regular communication • Chronic conditions care receives necessary resources • Specific people are held accountable for chronic conditions care (audit and evaluation)	1. Physical health monitoring requirements documented in policy and work instructions 2. Staff Professional Development 3. Time allocated for physical health monitoring
Delivery System Design The delivery of effective, efficient clinical care and self-management support • Team roles and tasks are defined • Effective communication within and between multidisciplinary teams and agencies • Ensure teams are providing appropriate care pathways, care coordination and care planning	4. Existing or new systems are refined to support practice change
Decision Support Promote consistent evidence based and client preference care • Evidence-based guidelines and tools that encourage client participation • Agreed care pathways	5. Routine measurement and conversation with clients about their physical health 6. Broad client centred screening
Self Management Support Support for clients to manage their health and health care • Clients, families and carers are supported with improving self management of their health needs via- joint problem solving, goal setting, information about their condition and Individual Care Plans, self management courses and support groups • Workforce development to support self-management approaches to consulting and case management.	7. Routinely inform clients of the possible physical side effects of their antipsychotic treatment 8. Support clients to set specific goals in caring for physical chronic condition/s and to improve their general health 9. Client education
Community Resource Mobilisation Organise community resources to meet needs of clients • Build relationships and partnerships with local agencies to support coordinated and integrated care • Information resources about services to refer for social and self management support- appropriate information for clients and carers that is meaningful and that they understand	10. Document attempts to encourage and support clients to access physical health support or services 11. Provide information to clients and their carers on an ongoing basis regarding relevant physical health conditions and services 12. Formal arrangements for coordinating client care between AMHS, GPs and CH 13. Increase communication with GPs
Clinical Information Systems Organise client data and information to facilitate efficient and effective care • Systems that monitor care processes and outcomes • Feedback system of client outcomes • Integrated client pathways • Use of electronic client management systems and electronic referral	14. Effective use of electronic Client Management Systems 15. Client care feedback systems between services

Following the survey, a report of results was compiled and the Health Project, project worker met with the AMHS managers of the CCT and MST to discuss the recommendations. Both managers indicated a priority area for further development was for Eastern Health management to develop clear policies and procedures around health screening. It was felt that this area needed to be developed before looking at other recommendations from the report with staff.

Twelve key recommendations were developed from the Health Matters Inner South survey results. A report of the survey findings was presented to Alfred Health AMHS Management and it was agreed that the recommendations would be communicated to staff through further consultation and staff would support the decision and prioritisation of recommendations. Recommendations were prioritised by staff rating as high, medium and low. Six recommendations were rated as high by all staff and these became the focus of strategy development for trial.

3.3.1.3 Existing Agency Policy

A brief review of Alfred Health policy found that:

- Collection of relevant client history, including GP is mandatory upon intake
- Policy and detailed process for monitoring the physical health of clients through routine tests and observations exists
- Psychiatry Clinical Risk Screen includes physical health including falls, substance abuse, medical conditions, nutrition and hydration

It was also identified that both AMHS had current Metabolic Monitoring systems in place.

From this initial process recommendations were made regarding areas where AMHS had potential capacity to implement strategies that support the physical health needs of their clients.

3.3.2 Client Consultation

Both Health Project and Health Matters Inner South identified client engagement was vital to the development and implementation of project activities. Both projects facilitated client consultation through a group setting however with different approaches: focus groups were held by Health Project; and an ongoing client group was established for Health Matters Inner South.

Twenty-nine clients attended three Health Project focus groups held at Ringwood, Ferntree Gully and Healesville. Most identified interest in improving their physical health as high however understanding of the causes of chronic disease was reported as low with several group members having the belief that diabetes was contagious. Diabetes, asthma, emphysema and being overweight were the main chronic conditions that clients identified as having, by approximately one third of attendees.

A range of barriers to improving and maintaining good physical health were identified by clients in both projects:

- Poor communication between health professionals
- Waiting lists at Allied Health services
- Lack of services in rural areas
- Difficulties with public transport (cost, fears, lack of transport options)
- Time constraints in developing trusting relationship with health worker
- Costs associated with quitting smoking (patches)
- The need for assistance to access exercise groups and gyms
- Services being conducted in environments that are inaccessible, unfamiliar and unfriendly
- Language used by Care Providers and Health Services

- GPs often overwhelmed by clients mental health issues so physical health does not get raised at consultations

The project worker attended a meeting of a group of 14 peer mentors who are currently employed by EACH as casual workers through the PHaMs program. The aim of the meeting was to explain the project and to canvas expressions of interest to become part of the steering group as client representatives and also to take part in a trial of peer mentors supporting a small group of clients in devising and enacting a physical health plan. Several expressions of interest and resumes were received and after an interview process two peer mentors were chosen to be involved in the project. The peer mentors have attended all but one of the steering group meetings and were both involved in the physical health trial as well as assisting on the "Open Day" service access trial.

Health Matters Inner South Steering Committee determined a consumer reference group would be established to influence and guide the project activities and strategies for trial. Nine community members with current links to The Alfred, ISCHS and Prahran Mission attended the monthly meetings from July 2009 – May 2010. A range of topics were discussed at each meeting including:

- General well-being and whole of life priorities (pre and post activity conducted with project consumer reference group to demonstrate change in whole of life priorities)
- Accessing different health services
- Language used by Care Providers
- Service information
- Appointment non-attendance
- Client information sharing
- Care Coordination
- Health information and education
- Physical health screening
- The role of different Care Providers
- Care Planning
- Goal setting
- Referral processes
- Ongoing support
- Communication
- Expectations

A final Health Matters Inner South consumer group session was conducted providing members with feedback regarding how their input had been utilised throughout the project and what strategies have been trialled and what strategies are intended to be trialled, including:

- Physical health screening trial in AMHS
- GP communication and feedback trial (from AMHS)
- Training for staff (AH, AMHS, GPs)
- Service information and referral pathways (AMHS and AH)
- Medications information session for clients
- Understanding the challenges for attending appointments

A summary of key consumer considerations for the project was discussed and key considerations were provided including what is needed for long term support and sustainability of this work. Group members were invited to express their interest in being contacted in the future for consultation if further opportunities presented.

An evaluation survey was conducted with group members to provide feedback on the facilitation of the group itself, its relevance and importance. Positive feedback was received and suggestions given for further development of this work included:

- "Tracing the outcomes of people involved in [projects] like these- for better or worse (outcome)"

- "If we have greater knowledge of the management of our lives we can make better decisions", create consumer education opportunities
- "Consumer consultation embedded in practice as this is best practice"
- Funding for:
    - More resources
    - More services
    - Consumer input in delivering programs and education through consultation and evaluation

Consumer input into the project report was provided.

The perspective of clients on the development and implementation of the model of care and the tools and techniques used within the model of care was a key consideration and had direct impact on changes made for both projects.

3.3.3 GP Consultation

GP consultation for both projects occurred through the Project Steering Committee and individual meetings as required.

Within the Health Project, three Divisions of GP were project partners and members of the Health Project Steering Committee. Individual consultations occurred with staff members of each division.
Findings included:

- Fax is still the preferred method by GPs for communication with GPs
- GP's report lack of feedback of outcomes from referrals to Allied Health services and Mental Health services
- More training in mental illness and how to navigate the mental health service system is required.

During the course of this project a new mental health service navigation tool (Greater Eastern Primary Health and Eastern Health Primary Mental Health Team 2010) for GP's in the Outer East mental health region was launched and is mentioned in the training section of this report.

Through the Health Matters Inner South consultation process, it was identified that the Australian Better Health Initiative (ABHI) project worker had similar project objectives and an opportunity for collaboration was presented (Australian Government Department of Health website 2006).

The ABHI project worker identified that GPs requested Health Coaching training. It was agreed that the ABHI Project would jointly organise Health Coaching training for GPs and Practice Nurses. This is discussed in further detail in the training section of this report.

Communication with GPs was an area identified where improvement was needed. An opportunity for collaboration was identified through the Monash Division of General Practice. This involved supporting a trial of a GP Communication Feedback Form that would be trialled with recommendations provided to the Department of Health to inform further development to the Service Coordination Tool Template (SCTT).

This feedback form was designed to support improvements in communication from CH to GPs regarding relevant client information. The form was developed in consultation with GPs to encourage information to be brief (one page), timely and legible. Many divisions of general practice, community health services, and hospitals in 2009 worked to improve the quality and frequency of written feedback to GPs about clients referred for care. The outcomes of this work enabled the communication that GPs need about referred or shared clients in order to provide quality primary health needs to be defined. Support and

guidance for agencies wanting to improve their communication with GPs was provided through GP Divisions (General Practice Victoria 2010).

A document outlining the above was circulated by General Practice Victoria, with the following content (General Practice Victoria 2010):

- Why GPs require written communication
- When communication to GPs should occur
- Communication required in Team Care Arrangements
- How communication with a GP should occur
- Content of written communication
- Privacy and confidentiality

Overall, GP involvement in the development of strategies to support the work of the projects was really important; however the project had minimal capacity to increase or develop GPs' response to the needs of this client group.

3.3.4 Allied Health Consultation

Allied Health consultation occurred regularly throughout both projects via the following means:

- Membership on regional steering committee
- Individual consultations
- Email
- Attendance of the project worker at team meetings (Health Project)
- Focus groups (Health Matters Inner South)
- Surveys (Health Matters Inner South)

Through consultation with Allied Health, findings included:

- Approximately 90% of clients seen by AH professionals have a physical chronic condition
- Staff estimate of approximately 60% of clients they see have a serious mental illness
- General perception was that the physical health needs of people with mental illness were not adequately met
- Working with people with mental illness is different to working with other client groups
- There are many client barriers to accessing adequate physical health care as mentioned in section 3.3.2 Client Consultation
- There are many service provider challenges to adequately supporting the physical health needs of people with mental illness
- There are many positive examples of how AH work well with and adequately support the physical health needs of people with mental illness
- Although there are many good processes and structures in place to support this work, further support is required

The Gill & Willcox Organisational Skills Analysis Tool (OSAT): Chronic Disease Care was completed by all ISCHS staff through the ISCHS Chronic Conditions Project. Similar recommendations were identified in the OSAT when compared to the survey administered within AMHS.

From discussions with Allied Health staff, a range of recommendations were presented to support both practitioners and clients to address physical health needs. As with the role of the GPs, more detailed assessment of client need could be undertaken by Allied Health practitioners, though initial needs identification would not be their role. However additional training is required to increase Allied Health staff confidence in working with people with serious mental illness. Other recommendations included; appropriate treatment planning for people with serious mental illness; and support to engage people with mental illness to attend primary health care appointments.

3.3.5 Carers Consultation

Along with support from Central Steering Committee carer network representatives, gaining a local perspective from a carer's point of view occurred in both projects.

Within the Health Project, along with ongoing discussion of physical health needs with peer support workers in the Carers Offering Peers Early Support (COPES) team, the project worker attended a meeting of the Ferntree Gully Carer Support Group and two of the monthly meetings of the Ringwood Partner Support Group to discuss the project. COPES is a service operated in partnership with EACH, Eastern Health and Arafemi and has two peer support workers who are employed on a part time basis.

The Health Matters Inner South consulted with the Inner South Parents and Friends meeting, a community support group who meet monthly for the families and friends of people with a serious mental illness in the Inner South East region: the Cities of Stonnington, Port Phillip and Glen Eira as well as carers from outside these areas who might be seeking information and support (Inner South Parents and Friends website 2010). The meeting was attended by the project worker and subsequent contact was made by some individuals who attended the meeting.

Generally, feedback from carers in both regions was very positive with regard to the project dedicated to the issue of addressing the physical health needs of people with serious mental illness. Project discussion from carers included:

- How carers can communicate physical health concerns to health professionals
- Privacy and confidentiality of the client
- Impact on carer if physical health needs are not addressed

This carer feedback was incorporated and considered in the development of strategies to trial.

3.3.6 PDRSS Consultation

Although the target population for this project was people accessing AMHS, consultation with PDRSS was also important. PDRSS consultation included meeting with management and staff to map current practice and discuss how to best support the broader issue in a different mental health setting.

EACH PDRSS do not currently conduct routine physical health screening for clients. The Health Project has been a standing item on the management meeting agenda since the beginning of the project and the project worker attends monthly to provide updates on the progress. Two PDRSS sites were chosen to trial the health screening tool and the results are contained in section 4.4.1 Findings.

The ISCHS PDRSS Case Managers current process is to conduct physical health screening with clients. An internally developed Client Physical Health Guide (CPHG) was developed and implemented in 2006/2007. An audit of guide usage was conducted and the Client Physical Health Guide and Basis-32 audit Report (2009) of the findings presented to the Mental Health Program Manager.
It was recommended that further investigation and staff consultation was required and this occurred. The Client Physical Health Guide and Basis-32 audit Report Part 2 (2009) had the following findings:

- Overall staff response to the guide is positive
- Some staff unaware of form usage expectations and guidelines
- Various versions of the form were in use
- Format of form could be improved

- Additional items were identified for inclusion in CPHG
- Orientation processes need to include use of the CPHG
- Relevant referrals made or efforts to make referrals as a result of findings within form need to be documented and tracked to measure outcomes

The recommendations were:
Development of form procedures/business rules including:
- Timeframes for form completion (initial and subsequent)
- Regular review/audit process
- Expectations
- Reason for form use
- Communication and support from management

Re-implementation of the CPHG within the ISCHS PDRSS incorporating the recommendations has been incorporated in the 2010/2011 ISCHS Mental Health Program Plan.

As the ISCHS PDRSS current practice is to complete the CPHG, it was decided that the trial of physical health screening would be conducted by the AMHS. With the approval of the ISCHS Mental Health Program Manager, consideration for the use of the ISCHS CPHG to trial within the Alfred AMHS was discussed and agreed.

As the structure and programs offered at PDRSS varies across agencies, the role of PDRSS in the physical health needs of their clients is different across agencies and this is in part due to the program and services offered. The relationship between AMHS and PDRSS was important to consider when exploring the role of mental health services as a whole, however for the scope of this project it was appropriate to focus development within AMHS.

3.3.7 Consultation Findings

Following consultation with key partners and based on the results of the Supporting Physical Health Needs: Attitudes and Practice Survey, recommendations were made by both projects to trial physical health screening.

The consultation process clarified the current roles of care providers and indicated the following possibilities for role and practice development:
- AMHS staff have regular contact with clients regarding their mental health needs
- AMHS are required to support access to appropriate GP
- Some discussion regarding physical health is seen as “usual practice” for many AMHS staff
- GPs have limited capacity to increase responsibility and time
- GPs have processes in place to support engagement and referral to AH services
- Service information needs to be accessible and communicated between agencies

3.4 Development of Model of Care

Following consultation with AMHS management about the recommendations, a model of care incorporating physical health screening within AMHS was developed.

3.4.1 Selection of Screening Tools

The Health Project facilitated discussion regarding selection of a screening tool to trial with Murnong CCT and MST concurrently. As metabolic monitoring was already in place with the MST it was decided that the tool would ideally encompass a range of health issues such as oral health, vision, hearing and physical activity. After seeking guidance from the

steering committee and advice from regional office DH it was decided to trial the SCTT Health Conditions and Health Behaviours Profiles (State Government of Victoria 2009).

Health Matters Inner South also considered the use of the SCTT Health Behaviours and Health Conditions Profile to trial, however the AMHS preference was for the use of the ISCHS developed CPHG, Appendix 6. It was considered by the Health Matters Inner South Steering Committee that as the Health Project was trialling the SCTT, the trial of a different tool would be useful as a comparison.

3.4.2 Service Coordination

To support the development of the model of care and supporting resources, the link between the CCM and Service Coordination (SC) was mapped by the project workers (Primary Care Partnerships Victoria 2009). This provided a detailed outline of best practice processes and strategies that could be trialled within AMHS see Appendix 7.

AMHS staff prioritised recommendations from the survey supported decision for further development in the following areas:

- Broad client centred screening
- Clear referral pathways
- Service information
- Client information sharing

3.4.3 Development of Model of Care Process

The identification of these recommendations, were then mapped to form a process within AMHS that provides:

- Opportunity for discussion regarding client physical health needs
- Documenting of client physical health needs
- Opportunity for appropriate referral
- Documenting of appropriate and timely client information sharing
- Opportunity to provide appropriate service information to clients
- Appropriate follow up by AMHS staff

Both Health Project and Health Matters Inner South documented a process relevant for each AMHS agency and this became the model of care that would be trialled.

The development of the model of care considered:

- The CCM components
- Principles of SC
- “Self-care” goal setting processes
- The role of the AMHS
- The role of the GP
- The role of other PHC providers
- Broad client centred physical health screening
- Existing screening tools
- Clear referral pathways
- Service information
- Client information sharing
- Client centred approaches

3.4.4 Model of Care Objectives for AMHS Trial

The model of care objectives include:

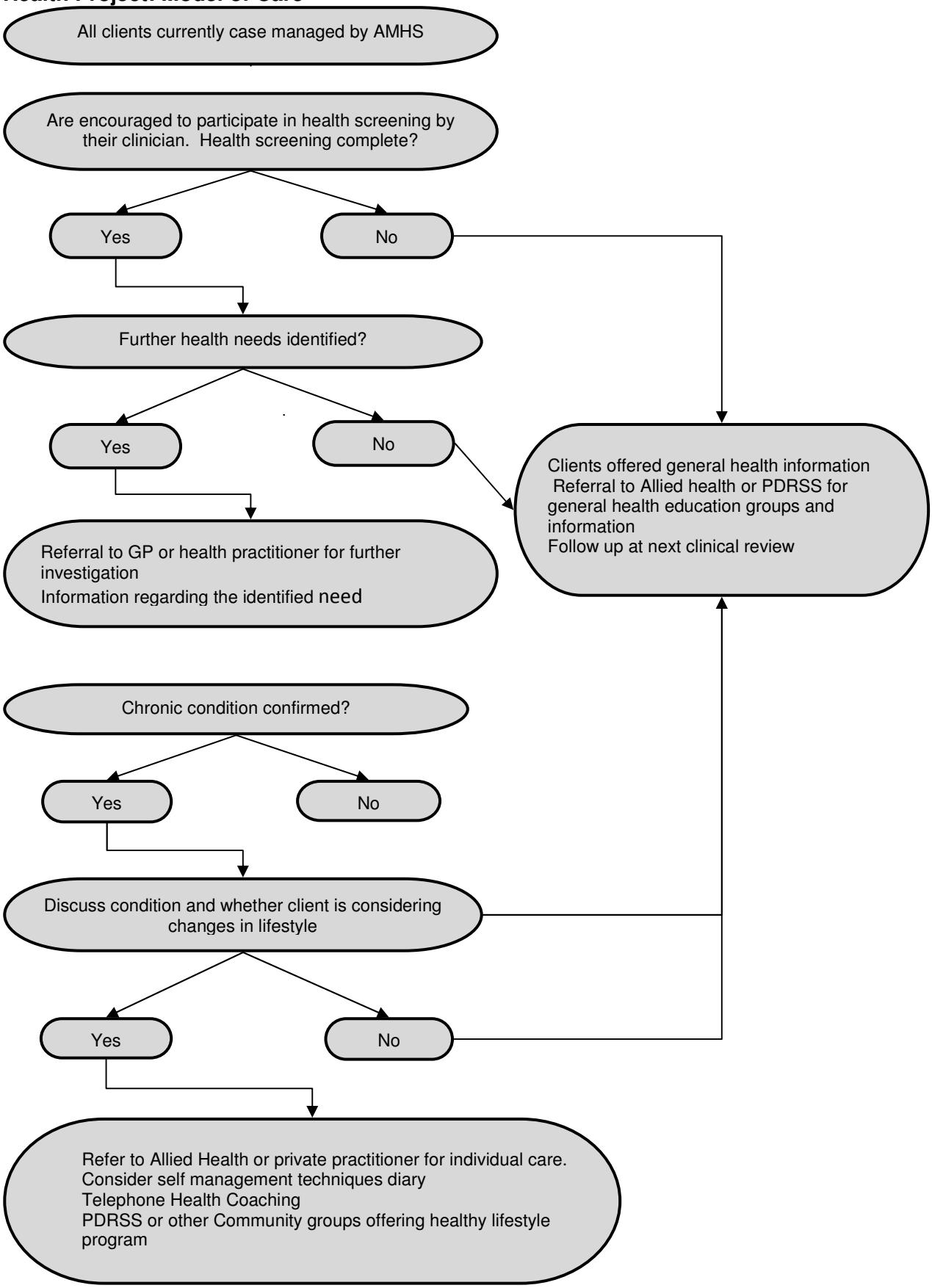
- Identify people with a mental illness, who have or are at risk of a chronic physical health condition

- Provide these clients with information, education, intervention and support as required.
- Provide a coordinated system of care for clients with a mental illness, by offering a streamlined, coordinated pathway to ensure clients are optimally supported to manage and or reduce the risk of physical chronic conditions and related complications.

3.4.5 Models of Care for Trial

The models of care developed by each project are shown below.

Health Project: Model of Care



Mental Health and Physical Health Model of Care

Introduction:
The Mental Health and Physical Health Model of Care was developed in order to provide clients with serious mental illness improved access to General Practice and Community Health Services; incorporating conversations, screening and follow up with a coordinated approach to their care.

Objectives:
- To identify people with a mental illness, with or at risk of a chronic physical health condition, and provide information, education, intervention and support as required.
- To provide a coordinated system of care for clients with a mental illness, by offering a streamlined, coordinated pathway to ensure clients are optimally supported to reduce the risk of physical chronic disease and related complications.

Process Information:
1. An AMHS staff member (who has been appointed a "Physical Health" portfolio) and the Health Matters Inner South project worker, will support both the clients and staff with the orientation, implementation and trial of the "Mental Health and Physical Health Model of Care" within Alfred Health AMHS

2. Staff will be provided with training and guidelines for the "Physical Health Screening Tool"

3. Appropriate condition and service information available and accessible to staff electronically (information packs for clients to be given on USB as an option) including client information sheet "SANE Mind and Body" Factsheet (explains why it is important to talk about physical health) and "Desktop guide for Practitioners"

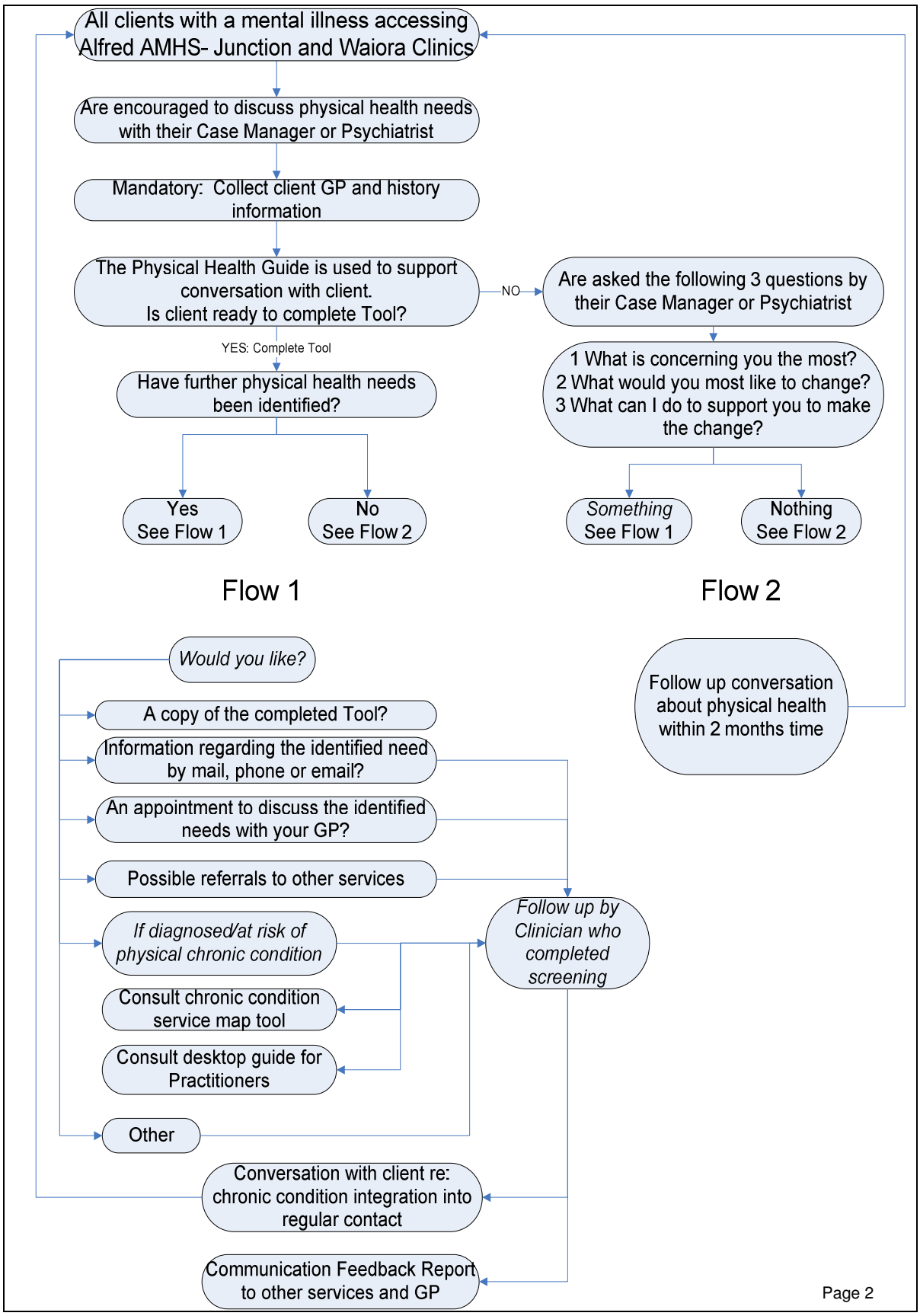
4. GP information is routinely collected to enable efficient communication and referral to clients GP. If client does not have a GP they will be supported to find an appropriate GP (this must be recorded on Physical Health Screening Tool- GP section)

5. Clear referral pathways to CHS are defined and accessible for clinicians to refer

6. Chronic Condition Service Map Tool that provides detailed local information regarding the level of care required for the client according to their level of risk: prevention, pro-active care, intensive care, intensive case management care. This tool is available and accessible to staff with the appropriate orientation to the tool

7. Communication to GP's via the Patient Feedback Report. This tool has been designed in collaboration with GP's to encourage brief and important information sharing in a timely manner. This tool is available and accessible to staff with the appropriate orientation to the tool

8. Staff will document attempts and successful engagements with their clients regarding their physical health needs


All clients with a mental illness accessing Alfred AMHS- Junction and Waiora Clinics
Are encouraged to discuss physical health needs with their Case Manager or Psychiatrist
Mandatory: Collect client GP and history information
The Physical Health Guide is used to support conversation with client. Is client ready to complete Tool?
NO
Are asked the following 3 questions by their Case Manager or Psychiatrist
YES: Complete Tool
1 What is concerning you the most?
2 What would you most like to change?
3 What can I do to support you to make the change?
Have further physical health needs been identified?
Yes See Flow 1
No See Flow 2
Something See Flow 1
Nothing See Flow 2
Flow 1
Flow 2
Would you like?
A copy of the completed Tool?
Information regarding the identified need by mail, phone or email?
An appointment to discuss the identified needs with your GP?
Possible referrals to other services
If diagnosed/at risk of physical chronic condition
Consult chronic condition service map tool
Consult desktop guide for Practitioners
Other
Follow up by Clinician who completed screening
Follow up conversation about physical health within 2 months time
Conversation with client re: chronic condition integration into regular contact
Communication Feedback Report to other services and GP
Page 2

4. Trial of model of care at AMHS

Both Health Project and Health Matters Inner South focussed the trial of the model of care incorporating physical health screening within the AMHS.

4.1 Pilot Sites

The Health Project included CCT at Murnong and EACH Allied Health who were chosen because of their close proximity and also because historically there had not been many referrals between these services.

With guidance from the Health Matters Inner South Steering Committee, it was decided that the Alfred Psychiatry Community Mental Health Service would be the main pilot site for health screening trials. Discussion between the project worker and the Community Program Manager of Psychiatric Services decided that a CC Team at Junction Community Mental Health Service would participate in the trial. Waiora Service was not chosen at this stage as Metabolic Monitoring trial was already underway.

A trial of the SCTT was also conducted within PDRSS by Health Project.

4.2 Process Development of the Model of Care Trial

Following further discussion regarding the Health Project, it was also decided to extend the trial of the SCTT to the PDRSS Lifeworks Day program (Ringwood) and the PHaMs Team also in Ringwood, because both these services had close links and some common clients with Murnong. The Outer East Mental Health Alliance members are currently working towards joint care plans for shared clients and it was envisaged that data obtained may have been of use in furthering this aim.

An information pack containing the following documents was compiled by the Health Project and approved for the trial by AMHS Manager and PDRSS Manager:

- Guidelines for trial Health Screening (Appendix 8)
- Health Screening Information Sheet (for clinicians and clients) (Appendix 9)
- SCTT Health Conditions and Health Behaviours forms
- Referral form for Allied Health Services
- SANE physical health Factsheets (for clients)
- Evaluation form (Appendix 10)

The trial process was developed for The Alfred AMHS and reviewed by the Health Matters Inner South Project Steering Committee incorporating:

- Orientation and guidelines for the “Physical Health Screening Tool” (Appendix 8)
- Appropriate condition and service information (Appendix 11) available
- Clear referral pathways to CHS are defined and accessible for referral
- Communication to GP’s via the Client Feedback Report (Appendix 12)
- Documenting attempts and successful engagements with clients regarding their physical health needs

4.3 Trial Implementation

Upon compilation of the individual packs for each clinician the Health Project, project worker attended team meetings where the documents were distributed to team members and the content and rationale were explained.

Health Project introduced the SCTT Health Condition and Health Behaviours screening tools on a trial basis at Murnong CCT, MST, Lifeworks PDRSS and Ringwood PHaMs. One week prior to the trial commencing the project worker attended each of the four nominated services team meetings. In total 10 clinicians from Murnong attended, nine from MST and four from the PDRSS. The team meeting for PHaMs was cancelled on the planned meeting day with the result that the team leader was briefed in regard to the trial and an information session was held with staff in the project workers absence on leave.

The project worker explained the purpose of the trial and the rationale for the choice of SCTT tool. The clinicians were all given packs of supporting documents which were read through and explained by the project worker. The SCTT tool was explained in detail with a practice run through of the questions. The information sheet contained the project workers contact details for anyone requiring further assistance.

The trial commenced in February 2010 for a period of one month and clinicians were requested to screen all current clients who were having their 6 monthly review. It was anticipated that 10 clients from each service would complete the tool.

Within Health Matters Inner South, the Client Physical Health Guide was introduced on a trial basis with mental health clients of one of the Alfred AMHS Junction Clinic Teams. The trial of a GP communication feedback tool was also incorporated to support communication of findings from the completion of the health screening. All current clients accessing the service within the trial period were to be asked by clinic staff to participate. It was expected that consenting clients would be contacted by the project worker within a week of completing the tool to provide feedback of their experience. Clinicians were expected to complete an evaluation also.

During March 2010, the Health Matters Inner South project worker facilitated a one hour orientation session with the nominated team for the physical health screening trial. This will be outlined further in the Training section of this report. Seven team members attended and were provided with a trial information and resource pack.

The trial commenced in March and concluded in May 2010. Target for the trial was 35 completed screening tools. Throughout the trial period, changes to the resources and the screening guide itself were required to support clinicians with the process. This occurred on several occasions with the following process:

- Project worker meeting with trial team
- Review of resources and update of number of completed screening guide to date
- Updates made to resources by project worker within 48 hours of meeting and sent back to team to support continuation of trial

4.4 Trial Results and Findings

4.4.1 Findings

In total 26 SCTT Health Conditions screening tools were returned from the Health Project trial, six from Murnong, seven from MST, ten from Lifeworks PDRSS and three from

PHaMs. Less SCTT Health Behaviours forms were filled out with one from Murnong, five from MST, 10 from Lifeworks and three from PHaMs, 19 in total.

In discussion with teams after the trial it was identified that the question "*Do you have a diagnosed chronic condition?",* on the SCTT Health Behaviours form was confusing as some clinicians and clients interpreted the question as also applying to having a mental illness. The five responses of "yes" to a chronic condition without specifying may therefore have referred to having a mental illness.

Health Conditions (26)

- 50% of respondents reported their health as 'good'
- 60 % had experienced some pain within the past 4 weeks, 10% daily pain
- 50% reported chronic health conditions including asthma, diabetes, obesity and Hep C
- 40% stated they needed dental care including broken teeth, fillings and bleeding gums
- 40% reported difficulty with vision four of whom had difficulty even with glasses
- 20% reported fear of falls

Health Behaviours (19)

- 70% reported some nutritional risk the majority being overweight
- 60% of respondents were current smokers
- 60% had undergone oral and physical health checks in the previous 5 years
- 60% rated light or very light as the hardest physical activity they could undertake (walk at slow pace or slow/medium)

Clinician/client feedback

- 11 evaluations forms were returned
- Most found the SCTT easy to understand
- Suggestion that a scale for pain be included
- A section for referral outcome to be included
- Include questions on insomnia, anorexia, illicit drugs
- Three respondents stated that referrals had taken place as a result of the trial but did not specify what action had taken place

Further examination and discussion around the low rate of return of Health Behaviours forms revealed that these were only completed when triggered by an affirmative answer to the Chronic Conditions questions.

Although referral forms for Allied Health services and contact details were included in the pack there was not an identifiable increase in referrals to EACH's Allied Health services from any of the trial sites. Without a file audit it is not possible to confirm whether referrals were made to another service or made but not on the trial referral forms.

At Alfred Health AMHS as part of Health Matters Inner South, a total of eight was achieved against a target of 35 for completed screening tools within the trial period (three of the seven participating clinicians completed one or more screening tool each).

Results for the 8:

- For all completed screening tools, on average 61% of the tool is utilised. Fields that are being completed less frequently include: full GP details, full GP review information, sexual health
- Many fields are not required to be completed if a certain response is given by a client- however this has not been clearly documented at times
- 75% of clients had a GP review within the last 6 months (as at the time of the trial period)
- 25% clients had findings communicated to GP

- 87.5% of clients refused referral to services for reported concerns, however 37.5% of clients are already accessing services for other reported concerns

Client needs identified:
- 50% of clients reported weight issues (one reported rapid weight loss recently)
- 25% were identified as having poor diet
- Although 0% reported having Diabetes, only 37.5% have been tested
- 25% reported problems with sleep
- 50% had not seen a Dentist for several years
- 25% had feet and nail concerns
- Difficulty with their eyesight
- Balance concerns
- 87.5% of clients smoke cigarettes
- 25% reported regular alcohol consumption
- Illicit drug use and other drug use

Clinicians Feedback:
- 3 of 7 clinicians completed the evaluation
- Uncapped case loads and time pressure remain issues for uptake
- Average time taken to complete was 15-20 minutes, comment made that further time is required for follow up and referral. Clinicians felt that the length of time taken to complete seemed reasonable to long
- Action was taken as a result of completing guide
- Liked most: prompt questions to ask; clear and easy
- Least liked: seemed long whilst doing it; finding the time
- Improvement suggestions: more space per question for comments
- All responded that they did think the guide is a good tool for supporting clients to think about their broader health needs
- Positive response to use of tool in future and support for further implementation is important
- Decision support tools important including referral and service information
- Further support with GP communication is needed; comment "Was confused with information to be supplied, it felt like we were telling the GP his/her role"

No client feedback was obtained for either trial but would be useful for future analysis.

4.4.2 Findings

- Clients are at the centre of their own health care
- Clients are seen by service providers to be at the centre of their own health care
- The CCM is appropriate and useful to apply in a mental health setting
- Physical health screening is appropriate within AMHS
- Training in behaviour change techniques is beneficial
- Processes may need to vary across different teams within the one agency
- AMHS Clinicians are specialist mental health workers and capacity to respond to physical health needs can be limited due to other AMHS screening requirements

4.4.3 Strengths of the model of care

- Commitment by AMHS to trial physical health screening
- Commitment to trial GP communication feedback form at Alfred Health AMHS
- All clients are offered health screening
- Clients are offered support to access health information
- Identified health needs are referred on to appropriate care e.g. GP or other health professional
- Model provides for follow up at next review

- Current positive relationship between partner agencies ensured efficient collaboration
- Management support to drive improvements
- Physical close location of partner agencies (Health Matters Inner South)
- Consultation with partners throughout the project enabled continuous improvements in project activity development
- Ongoing client consultation ensured client voice is heard
- Collaborative approach between project sites supported minimising duplication of efforts and strengthened project findings

4.4.4 Challenges of the model of care

- Aspects of the model of care were not utilised by clinicians:
  - Alternate approach- conversation regarding what is concerning client if not agreeing to complete health screening
  - Use of desktop guide for practitioners
- Clinicians assuming responsibility when a client refuses referral when a physical health need has been identified
- Inconsistent perceived time to complete health screening amongst clinicians
- Some confusion by clinicians over how to administer the SCTT Health Conditions and Health Behaviours forms
- Health screening tool needs to include action taken and referral feedback
- Monitoring use of tool
- Introduction of policies and procedures and embedding into practice
- Ensuring timely and appropriate access to Allied Health
- Physical distance of location between partner agencies (Health Project)
- Engagement with privately funded GPs was a challenge for both projects

4.5 Trial Recommendations

Recommendations:

- The screening tool should include broad health questions, be clear and no longer than two pages
- Orientation for the use of the screening tool is required
- Further develop referral pathways between services
- Time is given to allow practice and attitude change to occur as this is a slow and challenging process
- Auditing and monitoring is vital
- Agency policy is developed to document agreed commitment, responsibility and role regarding the physical health of clients accessing AMHS
- A project worker or dedicated staff member is required to support the establishment and sustainability of processes
- Communication pathways between AMHS and GPs require further development
- Policies and procedures regarding physical health screening for AMHS are considered by PDRSS
- AMHS Clinicians are adequately supported to ensure that physical health screening can occur either through AMHS or GP/other linkages

5. Training

A range of training for primary health care services and mental health services around improving access and identification of physical health needs and providing health care services to people with serious mental illness was trialled and outcomes reported on.

The training aimed to:

- Increase knowledge, confidence and skill of AMHS to discuss physical health needs of their clients
- Increase knowledge, confidence and skill of AMHS to refer their clients to appropriate PHCS
- Increase knowledge, confidence and skill of GPs and CH Allied Health staff working with people with serious mental illness
- Increase knowledge, confidence and skill of GPs and CH Allied Health staff to support meaningful and realistic goal setting for physical health needs

Based on best practice guidelines for chronic condition care and in response to training gaps identified, both project workers arranged training to be provided in the following areas:

- Behaviour change and motivation
- Physical health
- Mental health
- Client education

Sourcing of existing training for trial was preferred by both projects and DH rather than creating new training options from the onset. This was due to sustainability of training programs to allow access to recommended training for other services in the future due to cost, availability and flexibility.

Training was offered to the partner agencies involved in the Health Matters Inner South Project and offered in the EMR primarily for partner agencies in the Maroondah.

As a project deliverable, this section outlines:

- The training that was trialled (for AMHS, GPs, CH)
- Outcomes of the training (what worked/didn't, was it relevant, did it meet needs)
- Other findings and recommendations
- How the training that was trialled links in with the screening tool and physical health conversation approaches
- Sustainability: resources made available to further support training needs of agencies, new staff and refresher for trained staff

5.1 Health Coaching

Health Coaching (HC) training (Health Coaching Australia Pty Ltd 2008) was offered as part of the Health Project and Health Matters Inner South in response to training needs analysis identifying that support for practitioners in behaviour change would be beneficial. The aim of the training was to provide professionals with behaviour change techniques to identify and improve a clients readiness and capacity to engage in health treatment options particularly clients with a mental illness. Further information regarding Health Coaching and workshop evaluation has been provided in Appendix 13.

Other behaviour change training options are available and relevant including Flinders Self Management Programs and Motivational Interviewing however Health Coaching training was chosen to trial. Motivational Interviewing training had been identified as training to

support the Dual Diagnosis Initiative within mental health services therefore would not be useful to duplicate this same training. Finding time to attend training for many practitioners, particularly GPs and AMHS staff needed to be considered and although the Flinders Programs and Motivational Interviewing training would be appropriate to offer, Health Coaching Australia were able to offer a half day condensed version of their full two day program. Previously GPs from parts of SMR had attended the half day HC workshop in 2009 through the ABHI Project Multidisciplinary education and training for health professionals: Chronic Disease Self Management small grant, and provided positive feedback and those who were unable to attend were requesting another workshop.

Training approach for Health Project and Health Matters Inner South:

Health Project results of the AMHS survey indicated that staff at PDRSS and Eastern Health AMHS lacked confidence in approaching clients about their health needs and was an area for further development. Health Coaching Australia was contracted to provide a 5 hour session on health coaching which was open to AMHS clinicians, PDRSS and other Allied Health staff. Promoted through email and included on the training calendar. A total of 28 workers attended including six staff from MST, one from CCU, one from CCT, a GP, 16 PDRSS staff and three from other agencies. The project worker also attended the session.

The HC workshop was organised by the Health Matters Inner South project worker in collaboration with the ABHI worker based within Southcity GP Services.

GPs and Practice Nurses within the Southcity GP Services division, Alfred Health AMHS staff, ISCHS Dental staff and ISCHS Chronic Conditions Project staff were invited to attend a half day Health Coaching workshop.

Twenty-two registered for the workshop with 17 attending on the day with representation from all agencies invited. Both the ABHI worker and the project worker attended the session. An evaluation of the workshop was undertaken by the facilitator, ABHI worker and project worker. An immediate post training questionnaire was provided and a second questionnaire was sent to participants two months later to assess practice application and opportunity to give a case example demonstrating this.

Results:
For the EMR, as a result of informal networking during the session several workers including the GP attending expressed interest in setting up a Health Coaching peer support group as a means of implementing the principles of Health Coaching. The project worker sent out an expression of interest to all participants at the workshop and 5 responded with a request to be involved. EACH Allied Health site will commence a one day a week health coaching clinic later this year with the GP mentioned and once the clinic is established an interest group will be convened.

Overall the workshop was very relevant and useful, positively received by participants and some client outcome success was achieved, however implementation challenges are apparent. In summary:

- The half day work shop may not be adequate for supporting confident application to practice
- Further support post training is required for practice application

Barriers to Health Coaching training:

- Cost, some agency training budgets are very small and HC does not currently allow opportunity for appropriate staff to be trained and accredited to deliver HC
- Difficult to dedicate two days training in health to participate in longer course, also not affordable for some agencies

- Policy not currently in place to support routine health screening and health coaching

Other considerations:
- The project worker believes that the day of the Health Matters Inner South training (Saturday) may have negatively influenced interest and therefore attendance numbers
- Sharing training between agencies provided a space to meet and discuss service and referral pathway information

Findings:
- Health Coaching is an appropriate training for all PHC and Mental Health Service professionals to support behaviour change
- Half day training is preferred by agencies, however may not be enough to support practice change

Recommendations:
- All Primary Health Care and Mental Health Services participate in behaviour change training where possible including Health Coaching
- Health Coaching training cost is funded or part-funded by DH for AMHS, PDRSS and CH staff
- Physical health policies developed for AMHS and PDRSS staff include the provision for behaviour change training for staff
- Physical Health portfolios with nominated 'champions' at all AMHS services and PDRSS are established
- Health Coaching principles are included as part of the induction training for new workers to AMHS and PDRSS

5.2 Mental Health In-service for Allied Health staff

Part of the Health Project training trials included the Primary Mental Health team providing a three hour training session to Allied Health staff. This session had emphasis on mental illness and dealing with difficult behaviours in response to identified needs of staff.

Twelve staff attended this session including a GP, three physiotherapists, a dietitian, two intake workers, three occupational therapists and two managers. The session was conducted by a senior clinician from the Primary Mental Health Team and a senior clinician from Eastern Health AMHS.

Objectives were:
- Identify why it is important to see the interrelationships between clients physical and mental health issues
- Increase ability to identify clients with mental health presentations
- Practical management issues
- Basic risk assessment and risk management
- Referrals to the mental health system

Key points arising from evaluation:
- How to identify anxiety, depression and psychosis: 91% responded they were much more confident in identifying MH issues
- Managing challenging situations: 64% responded somewhat more confident, 36% a lot more able
- How can I work effectively with clients with a mental illness? 54% responded quite a bit more able, 45% responded somewhat more able

Key points and comments arising from training:

- Allied health staff regularly deal with clients who have a mental illness but who may not always disclose as such
- Some clients with mental illness are unable to participate fully in their treatment e.g. tolerate an hour long session, carry out recommended exercises, diet or other lifestyle modifications without support. Clinicians (some) respond by practicing opportunistic interventions, as the first appointment may well be the only one a client attends
- It is important that reception and intake staff are included in future training
- "Small group discussion and practical exercises would be useful"
- "More advice on managing mental illness"
- "Be good to have a follow up in six months"

Recommendations:
- Increase formal opportunities for Allied Health and Mental Health workers to undertake joint training
- Primary Mental Health team funded to provide education to CH. As they are also engaged with GP's they are in an ideal position to further relationships between AMHS, PDRSS, Allied Health and Divisions of GPs
- The training role of the Primary Mental Health Team is expanded to include implementing training in physical health by utilising Allied Health staff
- Training in mental health is provided on a regular basis to Allied Health staff

5.3 "Mind the Gap" training for GPs

Mind the Gap training for GP's in the EMR was expected to be rolled out by the three divisions of GP but due to other training being offered in mental health diagnosis and low registrations this has not occurred. The next training in this area is planned for September.

In May 2010 a mental health service navigation tool (Greater Eastern Primary Health and Eastern Health Primary Mental Health Team 2010) for use by GP's was launched
The service navigation tool is web based and has been developed by a partnership between the Primary Mental Health Team and Greater Eastern Division of GP. This tool will assist GPs to quickly locate relevant mental health services and some allied health services. The tool also included referral forms but not feedback forms. The tool also has application for use by Allied Health and PDRSS.

Introduction of the recently developed electronic service navigation tool in EMR may assist to increase knowledge of services offered and referral pathways as electronic referral forms are included in the tool.

Recommendations:
- The Greater Eastern web based tool is expanded to include referrals to CHS and feedback forms to referring bodies
- Training for GP's in physical health is combined with diagnostic training and service navigation
- The role of the Primary Mental Health team in linking GP's, AMHS and CHS is explored and developed

5.4 Health Literacy

Health Project held an education session on diabetes for clients aimed at improving health literacy. The session was conducted by an accredited diabetes educator and covered topics such as the causes and treatment of diabetes and lifestyle changes to prevent diabetes. Forums held with clients at the beginning of the project indicated a low level of understanding of the causes of diabetes and its treatment by some clients

Seventeen clients and five staff from PDRSS attended the two hour session. Two clients were assisted with transport the remainder attended unassisted. Fifteen of the seventeen were from the adult program and two were from the over 65 home based outreach. Two clients identified themselves as having a diagnosis of Type 2 diabetes. A simple impact evaluation was conducted with nine evaluations completed. Clients reported a higher than anticipated level of understanding of diabetes pre workshop. Many asked relevant questions or provided information during the session and several approached the educator at the end of the session for further discussion. Post session evaluation indicated an increase in knowledge of causes, treatment and prevention of diabetes and eight out of nine reported feeling comfortable with discussing diabetes with their GP as a result of the session. During the afternoon tea following the session the project worker was approached by several clients asking for follow up sessions particularly with a dietitian. One client commented that the dietitian he had been sent to by his GP was unable to spend very much time with him and he had not fully understood recommendations as a result.

Recommendations:
- Sessions in health education for clients are appropriate and should be held regularly in a time, place and format that clients can readily access

5.5 Physical Health Information Sessions for Mental Health staff

Health Matters Inner South arranged for Allied Health staff from ISCHS to present a range of chronic condition health topics, service and support and how to refer. The presentations were given during Alfred Health AMHS regular team meeting.

The aims of the sessions were:
- Learn about specific chronic conditions
- Provide referral information and best client access pathway
- Interagency relationship building
- Opportunity to discuss specific case studies

The topics presented included:
- Inactivity and physical activity
- Lung health and respiratory disease
- Diabetes

The Diabetes session was co-facilitated by the ISCHS Dietitian and The Alfred Psychiatry Dietitian. The other sessions were facilitated by ISCHS Physiotherapists.

Staff evaluations indicate the sessions were positive and useful. The average satisfaction rating response for the sessions were 8.5 (1 being unsatisfied and 10 being very satisfied). The information provided was most liked by staff. Topic relevance to clients was rated on average 8.5 (1 being not relevant and 10 being relevant). All staff indicated that the session did give practical ideas and suggestions about improving their clients' health and wellbeing with the exception of two that did not respond. With regard to the session to run in the future for refresher or for new staff, 100% responded "yes".

Comments provided by staff included:

- "Great opportunity for more collaboration with ISCHS"
- "Would like more information on strategies regarding working with people with mental health"
- "Further introduction to orientate staff for example, survey of general health information completed by case manager's to inform education"

Unfortunately an evaluation was not completed for the Diabetes session due to oversight. Feedback from the presenting ISCHS Dietitian was positive.

Recommendations:

- Allied Health (or others from Community Health) continue to deliver presentations at Alfred Health AMHS to provide service, condition and referral information on a regular basis

5.6 Physical Health Screening Tool Orientation

Health Matters Inner South conducted training in the use of the CPHG with the nominated Junction Alfred Health AMHS Continuing Care Team. Seven staff attended the session. The one hour session was facilitated by the project worker.

The session included:

- Introduction and outline to purpose of physical health screening
- Overview of trial information, resource packs and supporting tools
- Explanation of Mental Health and Physical Health Model of Care
- Orientation to the CPHG
- Role play demonstrating administering CPHG
- Orientation to GP Feedback Report
- Trial targets and timelines
- Opportunity to discuss changes to tools used during trial and final clarification
- Orientation to GP Feedback Report
- Discussion regarding changes to be made to GP Feedback Report

Participants were provided with an information and resources pack to support the Physical Health Guide Trial containing:

- Information sheet for clinicians regarding health screening and the trial (Appendix 9)
- Guidelines for the trial
- Information sheet for clients participating in the trial (Appendix 9)
- SANE Mind and Body Factsheet (information for clients)
- CPHG
- Patient Feedback Report for communicating with GP
- Mental Health and Physical Health Model of Care
- Chronic Condition Self-Management Guidelines- Desktop Guide for Practitioners (Royal Australian College of General Practitioners 2003)
- Primary Care service and support information
- Service information
- Evaluation for clinicians (Appendix 10)

Recommendations:

- Adequate orientation to physical health screening is vital
- Physical health screening should be built into new staff orientation processes
- An appropriate orientation program is attended by all staff intending to use physical health screening see Appendix 14 and Appendix 15 for proposed session outline

5.7 Mental Health First Aid Training

In response to a training needs survey administered through the Health Matters Inner South Project to 38 ISCHS Allied Health staff, 100% indicated that learning about mental illness is important to their work. Surveyed staff were asked to identify topics they would like to learn more about with regard to mental illness, more than one response could be given. Staff indicated that all topics would be valuable.
The topics most requested by staff included:

1. Managing challenging behaviours
2. Effects of medication on clients' physical health
3. Physical health problems being associated with mental illness
4. The psychological symptoms

Seven of 17 responded that of existing mental illness training that they aware of, the Mental Health First Aid (MHFA) training would be valuable to attend. Others mentioned training regarding working with people with personality disorders.

Verbal comments made in response to survey:

- Allied Health staff were not aware of what the MHFA training was. A misconception that this was physical First Aid training for Mental Health clients.
- The MHFA training would be good for all Allied Health to attend but the two day duration and frequency of how often this training is offered pose challenges*

**Note: 1) For management to support staff to take time from service provision responsibilities over two consecutive days;*
2) Maximum course numbers limit staff attendance (up to 16 participants)

It was decided that training in MHFA would be conducted for ISCHS Allied Health staff only as ISCHS has two current staff members accredited to run the Mental Health First Aid training and the existing training outline provides the topics identified with the structure of the course allowing for tailoring to meet individual needs of participants.

MHFA (Kitchener, Jorm & Kelly 2010) is a training program for members of the public in how to support someone in a mental health crisis situation or who is developing a mental disorder. MHFA training can assist in early intervention and in the on-going community support of people with mental illnesses. It is useful for people employed in areas which involve increased contact with mental health issues. MHFA runs under the auspices of Orygen Youth Health Research Centre, University of Melbourne and has been adapted and implemented internationally.

Training aims:

- To support staff to feel more confident in working with people with serious mental illness through the understanding of certain diagnoses and the behaviours that may be associated with certain diagnoses
- Gain an understanding of the physical side effects of medications prescribed to people with serious mental illness

Mental Health First Aid training was provided for ISCHS Allied Health staff. The two day training was held over consecutive days. Sixteen attended the training (including the Health Matters Inner South project worker). A pre and post training evaluation was administered to participants.

Results:
Of the 15 who completed the survey, 11 were able to be used to measure changes in knowledge, skills and behaviours. All participants reported a positive increase in knowledge, skills and behaviour across all 12 evaluation questions. The largest change across all participants was in regard to the question:

"To what extent do you feel confident talking to clients about how mental illness may be impacting on physical health needs and how physical health needs may be impacting on mental illness?"

Verbal comments post training included:

- "It was good to have the two days of training and have the appropriate time given to the topic"
- "It would be good to have follow up session where Allied Health staff can bring examples and case studies to discuss any issues things that arise since first aid course- treatment specific i.e. how to approach in assessment, how to discuss self harm, anxiety and exercise"
- "Has been valuable being in like group"
- "I feel much better after hearing practical strategies that I can use"

Findings:

- MHFA is appropriate training for Allied Health staff
- Delivery of training could be broken into four half days over time to mitigate time taken from usual responsibilities

Recommendations:

- All Allied Health staff should be trained in MHFA
- Further support for staff through case review meetings to consolidate learning is recommended. Cross discipline case review or secondary consultation processes formalised and in place for regular and ongoing opportunity.

5.8 Working with clients Motivation

Promoting Positive Behaviour Change presented by Dr Ron Findlay exposes participants to behaviour change therapies such as Single Session Work, Narrative Therapy, Motivational Interviewing, Health Coaching and Solution Focused Approach. This session was arranged by the Health Matters Inner South project worker and provided twice as a three hour workshop for Alfred Health AMHS staff.

Training aim:

- To provide professionals with techniques to promote motivation and positive behaviour change through a variety of theories and approaches

A total of 11 staff attended the workshops from the AMHS from a range of disciplines and roles including: Occupational Therapist; Registered Nurse; Psychiatry Registrar; Case Manager; Provisional Psychologist; and students. The project worker also attended the first session. An immediate post training evaluation and post training review (sent one month after training) were provided to participants.

Results:
Overall the workshops were rated above average (n=6) by participants with 5 rating excellent. With all attendees stating that they would recommend this workshop to colleagues. Comments included:

- "I found it useful and gained some new ideas to try"
- "Really useful!"
- "So refreshing to have narrative framework introduced in clinical setting"
- "I'm a student so it's wonderful to have such relevant info!"

Content, relevance and usefulness of workshop was excellent as responded by 55% of participants with the remaining responses being above average. For 73% of participants, learning needs were met to a large extent. More role playing and practical application was requested by many participants when asked what they would like to see more of.

Suggestions from participants regarding further support to implement these techniques into practice included:

- Further workshops
- By educating more staff on these techniques
- Provide and encourage more training
- Regular refresher sessions, supervised practice
- Lower case loads to have more time with clients
- Another practice workshop

The one month post training review was returned by two of the participants. One had a case study included that demonstrated the use of the techniques and how the techniques supported change in long term behaviour of a current client. Various approaches over several years have been attempted by the Case Manager, however with limited success.

Half day training is preferred by AMHS, however may not be enough for some training courses.

Recommendations:

- All PHC and Mental Health Services participate in behaviour change training where possible including Promoting Positive Behaviour Change, HC and other appropriate techniques (Motivational Interviewing).

5.9 Consumer Medication Workshop

In response to feedback from the Health Matters Inner South Project Consumer Reference Group (PCRG) for ISCHS to run an information session for clients on medications, a two hour workshop was held for clients of the ISCHS Mental Health Program, members of the ISCHS Mental Health Consumer Reference Group and members of the PCRG. The session was facilitated by two ISCHS Mental Health Program Registered Psychiatric Nurses.

Aim:

- To provide education and information to clients regarding psychiatric medication, their side effects, the importance of the relationship with prescribing doctor and looking after physical health

Seven people registered for the workshop with five attending on the day. The project worker and one case manager also attended. Promotion of the workshop was via case managers and flyer sent to PCRG.

Results:
The session was positive and well received by attendees with evaluation responses reflecting this. The average response for overall impression of the session was above average with 100% indicating they would recommend the session to others. All participants responded that the topic was both relevant and important to them. Comments indicated that the information and discussion was a positive aspect of the session and appreciative of the opportunity, however others felt that they still had some knowledge gaps that were not addressed within the session. Facilitation was respectful and rated above average and excellent equally. Eighty percent of participants said they would attend this session in the future, 20% were not sure.

The project worker observed the session as positive, interesting and interactive for both participants and facilitators. All who attended asked questions of the facilitators and experiences and knowledge was shared between the participants.

Other considerations:

- Attendance numbers were less than expected by the project worker. It was thought that as this was a client suggested workshop there would be high interest. Verbal feedback from staff promoting the workshop identified that the workshop was not being offered to all clients. Some staff were reviewing client lists and then offering to clients who they thought would benefit from attending. A mail out to clients directly promoting the workshop may have been a more effective strategy to increase attendance.
- Although attendance numbers were few, this allowed for more participant discussion whereas a larger group would need to be contained much more strictly to keep within workshop time frames.
- The project worker found the session to be useful and applicable potentially for other care providers who work with people taking antipsychotic medication for example, Allied Health Care Providers.

Recommendations:

- Regular information sessions made available for clients and topics identified by clients at least twice yearly or more
- Promotion of sessions provided to all clients so they can make their own decision to attend or not

6. Access Strategies

Literature and client feedback tell us that inability to access services remains one of the barriers to achieving best possible physical health. To explore some of the barriers a range of access strategies were trialled by both projects.

6.1 Health Project

Health Project consultation with staff at CCT and Murnong indicated a low level of knowledge of the range of services offered at CH and the referral process. Strategies that support referral to CH and attendance to appointments that were identified and trialled include:

- Meet & Greet at Allied Health
- Open Day at Allied Health site
- Peer Mentor Support

Staff were interested in the concept of an open day but wanted an opportunity to become better informed about services to enable them to encourage their clients to attend.

6.1.1 Meet & Greet at Allied Health

In response to clinicians at clinical services indicating a low level of knowledge of Allied Health services an opportunity was provided for AMHS clinicians from Murnong CCT to tour the EACH Allied Health site at Patterson Street. The aim was to improve the level of knowledge of services offered and present an opportunity to network with the Allied Health staff.

Six clinicians and the manager attended as well as a PDRSS team leader and one worker. Six Allied Health clinicians attended as did the manager. Mental Health clinicians were given a brief description of each service offered and were able to visit all program areas on the site. Program brochures and referral documents were also provided and explained. At the conclusion of the tour staff from both services met in the staff room for informal discussion and refreshments. Feedback from the tour was positive with some clinicians having not been aware of many of the services offered on the site or the referral pathways.

Summary of key points from meeting:

- Provided a networking opportunity that had not previously existed which enabled discussion of services and referral pathways for both Mental Health and Allied Health staff
- Was time effective – one hour at the end of the day
- Provided information both verbally and in hard copy of services available
- Provided mental health clinicians with a base level of knowledge of services available and geography of site
- Provided mental health clinicians with information about referral criteria and pathways
- Clinicians reported finding this opportunity useful and there has since been a request by another team (CCU) to have a similar meeting with Allied Health

Recommendations:

- Staff of Allied Health and AMHS are provided with an opportunity to meet regularly to keep a focus on the health of clients with a mental illness and update their knowledge. This can be achieved by informal meetings or through more formal channels such as presenting at professional development sessions at both Allied Health and Mental Health sites

6.1.2 Open Day at Allied Health site

Following the success of a trial 'Open Day' held for the Indigenous population at the Patterson Street Allied Health site it was decided in consultation with management to conduct a similar trial for this project. The project worker attended a team meeting to explain the project and its aims. A date was chosen some months in advance and Allied Health staff cleared their appointments for the morning. Staff present included physiotherapist, occupational therapist, dental, dietitian, podiatrist, community health nurse, Well Women's clinic nurse and a specialist GP.

Workers from Murnong clinic, CCU and Halcyon and Lifeworks PDRSS were invited via email, phone and printed flyers to bring their clients or invite clients to come along themselves to the open day. Thirteen clients and six staff attended on the day, three clients from CCU and 10 from PDRSS. The three clients from CCU left after the introduction. Further investigation of the reason for their departure revealed a combination of being unwell on the day and the workers accompanying them not being clear about the nature of the session which they believed was to be a simple tour

The clinical services manager and allied health staff were introduced to mental health staff and clients. Clients were then invited to have a brief informal discussion of their needs with allied health staff in their offices. Two peer mentors were on site to assist clients with finding rooms and making appointments. When clients had visited all the practitioners of their choice they were invited to stay for an informal morning tea.

A pre and post visit impact questionnaire was conducted with reported levels of knowledge and comfort with visiting the site increasing significantly following the visit. Appointments were made for nine clients following a brief assessment by the clinician. Two were rated as urgent and saw clinicians within a week. Others were classified as priority of which four clients had appointments that they attended. The other three clients also had appointments made with various Allied Health clinicians but did not attend. When followed up they had either forgotten, did not feel well enough on the day to attend, or had difficulty with motivation.

Results from the session can be viewed in Appendix 16.

Summary of key points from 'Open Day':

- Clients and workers reported enjoying the informal nature of the open day and valued finding out more about services offered.
- Clients felt valued by being able to spend time with clinicians of their choice and discuss their particular needs
- Several clients made appointments with Allied Health staff on the day after a brief assessment
- Several clients who made appointments did not keep them
- Some clients from CCU who attended were unable to participate even through the introduction component (leaving after 15 minutes) due to high levels of anxiety and general mental un-wellness
- Trial of the Open Day' was valued by clients and clinicians and could be a useful tool combined with follow up to ensure appointments made are kept

Recommendations:

- Block bookings for groups of clients at Allied Health sites where transport and a support worker are provided would ensure less ' no shows'
- Allied Health services are outreached to sites clients are already comfortable and familiar with such as MH clinics and Day Programs

6.1.3 Peer Mentor support

Following the 'Open Day", subsequent appointments were made whereby a number of clients did not attend these appointments, the steering group discussed possible causes and how this could be reduced.

It was decided that the two peer mentors who were part of the steering group would be employed to assist four clients with formulating and enacting a personal health plan. Both peer mentors had attended the Health Coaching training and it was decided to use the Readiness, Importance and Confidence (RIC) tool (Health Coaching Australia Pty Ltd 2008) as a basis for developing a health plan and as a means of evaluating changes over the eight week period. Three of the clients selected had attended the 'Open Day' and one was a client of the Lifeworks Day Program. All had a current case manager or key worker. The clients met regularly (weekly or fortnightly) with their mentor assisted with keeping appointments, finding resources and provide support and encouragement. The trial will take place over an eight week period and will be evaluated with a self evaluation process using the HC RIC tool. This trial will address some of the barriers identified by clients and is based on evidence from several reports (see Appendix 17) on the value of peer mentors identify the procedure of involving clients.

- All clients involved in the 'Open Day' were contacted by phone by the project worker and invited to participate in the peer mentor trial. The project worker explained the nature of peer support and obtained permission for the peer mentor to contact the client and make an initial appointment to discuss the project and decide whether to participate
- Following the initial meeting with the peer mentor clients completed a RIC tool with the peer mentor, were given information on the nature of health coaching and selected a goal to work on
- The selected goal was written into an action plan and a copy was retained by the client, peer mentor and case manager
- The peer mentors met regularly with the project worker to discuss progress and receive supervision

Summary of key points from peer mentor interview:

- Clients valued the lived experience of the peer mentor and were easily able to establish rapport
- Knowing extra support was available if needed was sufficient for clients to be able to enact parts of their health plan unassisted
- The support of peer mentors rekindled existing strengths in clients with all four coming up with strategies of their own
- Small steps and slow change needs to be respected by mental health and Allied Health clinicians when clients are managing both a mental and physical chronic condition
- Goals need to be flexible and able to be modified depending on clients mental health at the time
- The role of peer mentor is very broad and boundaries need to be very clear
- More training in health coaching would be useful in role
- More of an explanation of the role of peer mentors at the start is needed as there was some confusion at the beginning by clients who thought peer mentors were experts in health

Comments from clients in response to phone interview and written response at end of trial:

- Much greater knowledge of interaction between mental and physical health. I could see it in process
- Keeping a journal was successful especially for reflection to keep motivated
- While the overall goal to lose weight for two clients was not achieved significant specific goals were achieved – returning to water exercise weekly, continuing

walking, increase water intake to 1 litre per day, cut down on tea and coffee to 3 cups per day
- Having a progress review weekly was helpful
- "Went to visit my GP for a check up at start of program- seemed timely"
- "Peer mentor helped motivate me and provided me with resources"
- "Kept a hunger and food intake diary. This was useful to look at the interaction between emotions, mood, thoughts and food and drink consumption"
- "Identified that when I was busy I didn't pay attention to my physical health"
- "Walked with peer mentor weekly and also joined a walking group weekly"
- "Having the peer mentor gave me something to look forward to"
- "Bought a bike to exercise more, walked more, exercised more"
- "Made an appointment with dietitian"
- "Cut my smoking down by more than half"

- **Recommendations:**
- The role peer mentors can play in providing a link between clients and health care professionals should be considered
- Peer mentors or other support workers are trained in behaviour change to assist clients in implementing their personal health plan
- In developing health plans clinicians take into account the impact of mental illness on the clients ability to enact the plan and ensure support is in place

6.2 Health Matters Inner South

Health Matters Inner South consultation with Allied Health staff identified areas where further support could be trialled to decrease barriers to accessing physical health care. This involved:
- Trial of Telephone Health Coaching service; and
- An audit: exploring barriers to client attendance at appointments

6.2.1 Telephone Health Coaching

Telephone health coaching is an additional free program provided through the "Go for your life" Infoline (Victorian State Government 2006) that facilitates self management of healthy eating and physical activity behaviours for individuals. The service is provided by trained health coaches, upon referral by health professionals.

With the support from the ISCHS Health Promotion Working Group, Health Matters Inner South conducted a small trial of this service.

The target group for trial was people with a mental illness with a diagnosed chronic physical health condition/s or at risk of chronic physical health conditions. Involved in the trial were ISCHS staff who have appropriate clients for referral to the service and clients who are interested in the service and consent to participating in the trial.

Participating staff were asked to complete a data collection form when referring a client to the service, to complete a clinician evaluation and support the client to complete a separate evaluation at the end of the trial. Completion of the evaluation forms was not consistent with discharge from Telephone HC service as time did not permit.

Nine clients were referred to the Telephone HC service.

A range of reasons for referral were provided including:
- Low level of motivation
- Client has chronic conditions

- Client would benefit from improving physical activity behaviours
- Client with schizophrenia and diabetes, would benefit from improving physical activity behaviours and more regular follow up
- Obesity and weight management
- High blood pressure
- High cholesterol
- Sedentary lifestyle
- Weight management
- Improve sleep

Evaluations were completed by both clients and clinicians with seven from clients and four from clinicians.

Summary of feedback:

Client Feedback	**Clinician Feedback**
Generally clients feedback regarding what they liked most about Telephone HC was the approach of the Health Coach.	Clinician feedback regarding what they liked most about Telephone HC was the added encouragement and motivation support for clients.
Clients least liked the infrequency of calls, phone not being ideal and the general nature of the service	Clinicians least liked the infrequency of the calls
A rating of 7 was the average response to "How helpful was this service for you?" with 1 being not helpful and 10 being very helpful	Clinicians general response to their perception of how the service supports improving client health and wellbeing was that it has potential to support clients however response may need to be tailored to individuals needs and complexity
71% would recommend the service to others	33% would recommend to others with 33% indicating suitable for some and 33% no response
An increase in the amount of calls provided to clients was favourable	An increase in the frequency of contact with clients and referring clinician was suggested by clinicians

Recommendations:
- Telephone Health Coaching support is offered (where available) to clients in assisting behaviour change and self management of physical health conditions
- Further development and investigation regarding effectiveness of Telephone Health Coaching support for people with mental illness is required

6.2.2 Exploring barriers to client attendance at appointments

There was little documentation available, but a range of anecdotal evidence regarding the barriers for mental health clients in keeping appointments, prompted exploration of the issue as part of this project. The exploration by the Health Matters Inner South project involved an audit and follow-up of non-attendance over a period of a week for a specified range of services. This exercise was considered normal service follow up and thus did not require research approval. Approval was obtained from ISCHS Management.

This exercise aimed to:

1. Document reasons given by clients with a mental illness at ISCHS for not attending centre-based Allied Health appointments or groups
2. Document client feedback on what, if anything, would help them to attend appointments
3. Utilise this information in the planning of services

Audit sample included people described in this audit as a "known mental health client" were defined as those:
a) Having an open or current "Mental Health" episode in TrakCare*, or
b) Dental clients booked into the Mental Health Dental Clinic Program. (To be eligible for specific mental health Dental clinics, a client must have a signed form from a Case Manager. This form also establishes fee exemption).

Results:
The results showed the total number of clients booked into appointments was 224 and the total number of clients who did not attend was 69 **(31%)**.

Service	Count Booked	Known MH Client	Others	Overall DNA	DNA MH client count/ rate	DNA others count/ rate
Total	*224*	*66*	*158*	*69*	*16 (24%)*	*53 (34%)*

For the barriers identified by clients to attending appointments and groups, the three most common responses were: having the incorrect appointment date; issues with transport (cost, timetable, access); and being too unwell to attend.

The findings indicate that:

- Approximately one third of all clients do not attend appointments and groups at ISCHS
- Services that are targeted to a MH population appear to have a more positive attendance rate than general services.
- Of the 69 clients who did not attend in the audit period, approximately one third had a known mental illness with the remaining 70% who did not attend being a client who does not have a known mental illness
- When considering all appointments and groups booked, 24% of clients with a known mental illness did not attend and 34% did not have a known mental illness did not attend, indicating that people with a known mental illness are less likely to miss their appointment. This could be because the clients identified as being a known mental health client were being case-managed which may have included some level of support to attend appointments.

Discussion:
The barriers to attending appointments or groups identified by clients are consistent with those discussed in literature (Bertakis et al 2000; Cleary, Mechanic & Greenley 1982;

* TrakCare is an electronic Client Management System endorsed by the Victorian Government and has been implemented in several CH agencies

Collins, Santamaria & Clayton 2003; Dyer et al. 1998; Kruse & Rohland 2002; Martin, Perfect & Mantle 2005; Mitchell & Selmes 2007); Murdock et al. 2002); Paterson, Charlton & Richard 2010). The most common responses for barriers to appointment attendance were:

1. Incorrect date, transport and being sick
2. Forgot appointment, unaware of appointment and work or other commitments

The most common response from clients asked to suggest strategies to support their attendance was that nothing would have helped. The second most common response indicated a reminder call or text message would help which was also reported by participants involved in the study by Martin, Perfect & Mantle (2005). Murdock et al. (2002) however reviewed the effectiveness of telephone reminders and considered this strategy to be only partially successful because not everyone has access to a telephone where a message could be provided.

Further to discussions regarding reminder systems, Collins et al. (2003) make mention of other findings and strategies from similar studies including the association between forgetfulness and length of waiting time from referral. Other strategies discussed in Martin, Perfect & Mantle (2005) have focussed on relationships between the client, their GP (potential for application with other professionals) and reception staff, also choice of care provider and making it easier to cancel appointments. Martin, Perfect & Mantle (2005) also discuss an acknowledgement of non-attendance being "inevitable and that punitive measures directed at the patient would have little impact on attendance rates".

The audit identified four main limitations that can be reviewed in the full report: Exploring barriers to client attendance at centre-based appointments and groups at ISCHS (2010).

The audit concluded that the DNA rate for people with mental illness who are Case Managed at ISCHS was lower than the DNA rate of others.

Barriers to attending allied health centre based appointments, wellbeing and exercise groups are many and varied. No clear priorities overall were identified by clients for strategies to support appointment attendance.

Recommendations:

- A range of strategies need to be in place to increase the rate of attendance
- Further investigation is required to look at both the service and client factors that may influence clients to not attend appointments or groups
- Further investigation is required regarding how to best support attendance for people with mental illness who do not have a Case Manager as not all people can, or want to engage with, or are eligible for Case Management services

7. Key Findings

7.1 Service Access Barriers

This project explored a range of strategies that aimed to address the barriers for people with mental illness accessing adequate services for physical health needs. These included:

- People with serious mental illness are often defined solely by their mental illness
- Lack of integration between mental health and medical health
- Primary care providers confidence in working with this client group and lack of professional support
- Mental health providers tend to overlook physical health concerns
- Inability to receive timely access to primary health care for mental health clients
- Difficulties with information sharing related to electronic systems, confidentially and privacy
- Client concerns – including transport, isolation, cognitive impairment, attention difficulties or other behavioural factors or previous negative experience with providers or stigma associated with disclosing a mental illness

7.2 Overall Findings

AMHS

- Physical health screening of AMHS clients is best placed to be undertaken by the AMHS
- This responsibility needs to be reinforced by agency and government policy
- Agency drivers, supports and resources are vital to the success of this work
- Practice and attitude change is a slow and challenging process for all change in workplaces, and has held true in this project

Clients

- Choice and opportunity is important to clients; high cost, limited range and lack of choice of services create barriers for clients
- Health services need to be provided in a place and manner accessible and acceptable to clients
- Relationships with case managers/professionals are important and take time to build and establish trust
- Practitioner engagement with clients allowing clients to be ‘heard’ is critical to client outcomes

Primary Health Care

- Effective strategies for improved communication with GPs requires further process refinement
- Feedback processes to GPs need to be embedded
- Service providers should communicate relevant information to each other (with consent) to reduce multiple referrals and ‘telling the story’ many times
- Health Coaching training was well received by GPs who attended

8. Recommendations

Project Funding

1. Funding should continue in order to:
   - Develop and embed the system and process outcomes of the demonstration projects
   - Evaluate the impact of access to Primary Health Care Services for people with serious mental illness

Project Consolidation within AMHS

2. Further development to consolidate projects within trial AMHS agencies including:
   - Providing information to clients regarding the purpose of physical health screening within AMHS
   - Clinicians take into account the impact of mental illness on a client's ability to enact the developed health plan
   - Definition, agreement and communication of referral pathways between GPs, CH and mental health services
   - Development of communication pathways between AMHS and GPs
   - Development of agency policy to document agreed commitment, responsibility and role regarding the physical health of clients accessing AMHS
   - Behaviour change training for all staff
   - Monitoring and reporting back on actual implementation outcomes i.e. percentage of clients screened and referred where required

Model of Care

3. The Department of Health roll out a model of care in mental health settings, as trialled by the projects, that responds to the physical and broader health needs of clients

Training

4. All Allied Health staff should be trained in Mental Health First Aid
5. All Primary Health Care and Mental Health Services participate in behaviour change training
6. Mental Health and Community Health services provide regular information sessions for clients, on topics identified by clients

Health System

7. The role of peer mentors in providing a link between clients and health care professionals should be explored
8. Further development of the relationship between AMHS, PDRSS, GPs and CH, including joint team meetings and service development, to increase staff knowledge and confidence in working with this population group
9. Further investigation to look at both the service and client factors that may influence clients to not attend appointments or groups, and identified strategies trialled.
10. Explore and develop the role of the Primary Mental Health team in linking GPs, AMHS and CH

8.1 Consolidating this work

It is recommended that a commitment to further development is required, for both projects, to support consolidation and sustainability of project activities within the trial AMHS agencies.

Health Project Specific Recommendations

- Further work is required to develop a health screening tool for Eastern Health AMHS
- Further training for staff in use of the tool and how and when to refer
- Referral pathways are further developed between Eastern Health AMHS, PDRSS and Allied Health services

Although some aspects of the SCTT were viewed positively the general consensus was there is a need for a simpler version which included similar questions on physical health issues in the one form. Some confusion arose around completing the Health Conditions and Health Behaviours forms and this may be addressed through further training and support should the SCTT continue to be used. Eastern Health AMHS have undertaken a process of reviewing policies and procedures in relation to physical health screening including training and support of staff

The project worker has developed a draft health screening tool which Eastern Health AMHS management is examining as part of its overall development plan for physical health monitoring. As metabolic monitoring is already conducted regularly by MST and there is already an approved form and process in place it was decided not to include these components in the draft health screening form. The draft incorporated the following clinician feedback:

- Health Screening tool should include questions around general health needs including dental and levels of physical activity
- The need for a simple and easy to administer one or 2 page form
- Training for staff
- Referral pathways require further development

Note: Eastern Health have since developed draft policies and have entered into a three year funding agreement with Pzifer to employ a project worker to further develop and implement health screening for AMHS clients.

Health Matters Inner South Specific Recommendations

- Further work is required to support implementation of physical health screening within Alfred Health AMHS. Staff commitment to the physical health needs of their clients exists, how this is achieved requires further development to support sustainable practice change and achievable implementation across the agency
- AMHS communication with GPs also requires further work and support. Communicating appropriate client information to GPs needs to be re-introduced into the Alfred Health AMHS and embedded into practice. Use of GP communication tool or other mechanisms could support this
- Resources to support this work require further development

Model of care incorporating physical health screening within Alfred Health AMHS further development could include:

- Support to review format of guide incorporating clinician feedback
- Support to review process with AMHS clinicians and management for completing guide
- Support to train staff (orientation to tool)
- Support to re-trial modified guide within AMHS
- Collect client feedback regarding their experience of physical health screening
- Evaluate re-trial of modified guide
- Further investigation and development of resources and support for clinicians
- Feedback mechanisms especially monitoring and reporting

Further improvements to GP Communication could involve:

- Review of GP communication processes
- Direct GP contact (or presentation to staff) to support AMHS staff
- Follow-up-trial of GP communication tool (or consultation regarding other ways to appropriately communicate to GPs)

Resource development to support this work should consider:

- Resources developed are relevant and useful to the audience and choice is provided
- Orientation to existing online service directories
- Training (including training resource kit)

8.2 Broader roll out of Model of Care

It is recommended that a model of care responding to the physical and broader health needs of clients is rolled out more broadly in mental health settings

8.2.1 Principles for broader roll out of Model of Care

- Primary Mental Health team is an existing resource to utilise as a link between AMHS, Division of GP, CH and PDRSS to further develop referral pathways
- Barriers identified by clients and service system barriers need to be addressed concurrently
- Implementation of model of care needs to be flexible to allow for local service system

- Practice and attitude change take time and energy to embed as well as management support and the identification of champions
- Physical health screening training is provided to all AMHS and PDRSS staff at induction and on a routine basis
- Behaviour change training with regard to physical health needs is provided to all AMHS and PDRSS staff at induction and on a routine basis
- Agencies will need considerable time, effort and support to be able to implement change
- Not all agencies will be ready to participate in this level of commitment

8.2.2 Recommendations for approach to broader roll out of the Model of Care

Area	Activity	Professional Development
AMHS	▪ Implementation of model of care incorporating physical health screening tool ▪ Monitoring use ▪ Policy and procedure development and embedding into practice (with sustainability considered)	▪ Orientation for AMHS staff in physical health screening ▪ Capacity building with Management and Team Leaders ▪ Behaviour change training
PDRSS	▪ Service mapping to explore capacity and needs of PDRSS	-
GPs	▪ Implementation of GP communication processes	▪ Orientation for AMHS staff in GP communication and use of GP feedback form
CHC	▪ Allied Health staff are provided with appropriate support to increase confidence and service access for people with serious mental illness ▪ Joint Allied Health/ Mental Health case review processes are developed and implemented	▪ MHFA training ▪ Behaviour change training ▪ Across program/ discipline joint case review
Clients /Carers	▪ Physical health screening process is supported by client feedback and client outcomes	▪ Health education sessions for clients

10 Appendices

Appendix 1. Reviewed Literature

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Appendix 2. Description of Mental Health Services

AMHS Area Mental Health Services

All specialist mental health services are required to provide a range of components so that clients have access to similar service responses and functions wherever they live. However the health services and hospitals deliver their public specialist mental health services differently depending on the local service environment and catchment area. Some services have separate teams for each component function; others operate 'integrated teams' which perform a number of functions by rostering staff to undertake the required activities for a given period. The critical factor is that all area mental health services provide the full range of functions (Victorian Department of Health 2010).

PDRSS Psychiatric Disability Rehabilitation and Support Services

PDRSS provision is a specialist function. Services are underpinned by a commitment to the principles of psycho-social rehabilitation and a philosophy of providing programs for people with psychiatric disabilities that are not available to them through generic community services.

PDRSSs assist service users to regain or develop skills they may need to actively participate in daily life, in personal and social interactions and in community life and activities. Services also seek to address the environmental factors that can have a negative impact on people with a psychiatric disability living in the community (Metropolitan Health and Aged Care Services Division 2004).

Appendix 3. Description of Project Settings

EMR project context

The Outer East region encompasses three local government areas, City of Maroondah, City of Knox and the Shire of Yarra Ranges which cover a large geographical area including semi rural. Project partners therefore included four Community Health Centres, three Divisions of GPs and several AMHS sites.

It was decided through consultation with the steering group and DH that the bulk of the consultations and trials would take place in Maroondah LGA. Maroondah was chosen because of the relatively close location of the primary partners – Eastern Health AMHS (Murnong Clinic and MST), EACH Allied Health site and PDRS services.

SMR project context

The Inner South East Region local government areas include City of Port Phillip, City of Stonnington and parts of Glen Eira. Project partners included one Community Health Centre, one Division of GPs and one AMHS.

Appendix 4. Project Timeline

	PROJECT ACTIVITY TIMELINE															
	2009								2010							
	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
Consultation																
Development of Model of Care																
Trial of Model of Care																
Telephone Health Coaching																
Exploring Barriers to client DNA																
Meet and greet Allied Health																
Peer Mentor Support																
Open Day at Allied Health																
Screening Tool Orientation																
Health Coaching																
Mental Health In-service																
Health Information Sessions																
Working with Clients Motivation																
Medication Workshop																
Health Literacy																
MH First Aid Training																
Final Project Report Due																

Appendix 5. Supporting Physical Health Needs: Attitudes and Practice Survey

Physical Health and Mental Health
Staff Questionnaire

This questionnaire relates to the physical health needs of people with serious mental illness. There are no right or wrong answers, your responses will simply help us to understand your views and some barriers you may face.

For each question below please tick one box	Yes	No
1. *Do you* have established physical health monitoring protocol/guidelines in your work place?	☐	☐
2. *Do you* have a clear understanding who (within your team) is responsible for ensuring adequate monitoring is undertaken (please mark NA if not applicable)	☐	☐
3. *Do you* believe monitoring physical health (as well as mental health) is your responsibility?	☐	☐
4. *Do you* have enough time to adequately monitor the physical health of your clients?	☐	☐

	None	Some	Most	All
5. *Do you* feel confident about what to monitor with regards to clients physical health needs?	☐	☐	☐	☐
6. *Do you* routinely inform your clients of the possible physical side effects of their antipsychotic treatment?	☐	☐	☐	☐

In how many of your clients do you routinely ask about or measure their:	None	Some	Most	All
7. Blood pressure	☐	☐	☐	☐
8. Weight	☐	☐	☐	☐
9. Waist circumference	☐	☐	☐	☐
10. Health habits	☐	☐	☐	☐
11. Chronic condition/s	☐	☐	☐	☐
12. Setting specific goals in caring for physical chronic condition/s	☐	☐	☐	☐
13. Setting specific goals to improve their eating or exercise	☐	☐	☐	☐
How many of your clients routinely have:	☐	☐	☐	☐
14. General GP physical health checks	☐	☐	☐	☐
15. Appointments with other primary/allied health services	☐	☐	☐	☐

For how many of your clients do you:	None	Some	Most	All
16. Encourage and support their access physical health support or services?	☐	☐	☐	☐
17. Provide information to them and their carers on an ongoing basis regarding physical health?	☐	☐	☐	☐
18. Complete a client physical health screening tool on a regular basis?	☐	☐	☐	☐
19. Record your efforts to encourage them to seek assistance for their physical health needs?	☐	☐	☐	☐
20. Consider it to be appropriate for you to arrange metabolic monitoring?	☐	☐	☐	☐

21. Have formal arrangements for coordinating client care between GP's, Allied Health and your agency?	☐	☐	☐	☐
22. Think there could be improved communication pathways between GP's, Allied Health and your agency?	☐	☐	☐	☐

The following questions relate to interface with primary care	Yes	No
23. Do you have a clear system for agreeing responsibility for monitoring of patients between primary and secondary care?	☐	☐
24. Do you have a clear system for sharing results/information between primary and secondary care?	☐	☐

	None	Some	Most	All
25. With how many of your clients do you have contact with their GP?	☐	☐	☐	☐
26. With how many of your clients do you have contact with other primary health services?	☐	☐	☐	☐

	Yes	No
27. Is there a clear understanding between primary and secondary care, about who is responsible for acting on abnormal results?	☐	☐

28. Have you attended a workshop/educational seminar etc on any physical health topic in the last 6 months?	☐	☐

29. What support would you need to adequately address the physical health needs of your clients?

30. Where do you work primarily?

☐ Inpatient ☐ CCU ☐ Community ☐ Other please specify

31. What is your professional status

☐ Nurse ☐ Medical ☐ OT ☐ Social Worker ☐ Psychiatrist ☐ Other please specify

Other comments

Thank you very much for completing this questionnaire.

Improving Access to Primary Health Care Services for people with serious Mental illness

Based on and adapted with permission from St Vincent's Mental Health-Monitoring Metabolic Side Effects of Antipsychotics survey, 2008 (this survey was adapted with permission from Barnes TRE, et al. A UK audit of screening for the metabolic side effects of antipsychotics in community patients. *Schiz Bull 2007).*

Appendix 6. Client Physical Health Guide

Client Physical Health Guide	Client Name: Date of Birth: dd/mm/yyyy / / Sex: UR Number:

GENERAL INFORMATION

GP Details: Name/Clinic:	Address: Phone:
Medical History:	
Current Medication:	
Allergies:	

PHYSICAL REVIEW

1. Has the client had a **GP Review** in the last 6 months? Has the following been checked: ▪ Blood Pressure ▪ Pulse ▪ Temperature **GP review** please request a full physical examination and ▪ <u>For Females, suggest discussion/tests:</u> - Mammogram - Pap Smear ▪ <u>For Males, suggest discussion/tests:</u> - Prostate Investigations Reminder: - Check client's kidney function if client on Lithium - Check blood levels have been done if client on Sodium Valproate or Thyroxine or Anticoagulation's (Warfarin) - Also Full Blood Count/U&E,s/ Liver Function Test/ Cholesterol Level	Yes☐ No ☐ Unknown ☐ If yes, when was Review? Suggest GP review if response is "No" Comments:
2. Consider the clients **weight** ▪ Diet Risk: Less than 2 serves of fruit/vegetables p/day and more than 2 serves of "fatty" meals/foods p/week ▪ BMI (If known): 18.50 and under (underweight) 25 and over (overweight) refer for further investigations ▪ Waist circumference (if known): Over 80cm refer for further investigations If the client is **overweight,** please request following to identify possible early onset of Diabetes: ▪ fasting lipids ▪ glucose **Discuss referral to**: GP, Dietitian, Physiotherapy	Comments:

Adapted from ISCHS Mental Health Program Client Physical Health Guide, with permission from Inner South Community Health Service, Australia 2009

Client Physical Health Guide	Client Name: Date of Birth: dd/mm/yyyy / / Sex: UR Number:

3. Does the client have **Diabetes?** ▪ Speak/refer to Alfred Psychiatry Dietitian if you need more support with obtaining information on Diabetes ▪ Discuss with GP referral to diabetes educator, if appropriate. If client does not have **Diabetes**, have they been tested? ▪ If no and presenting with risk factors for diabetes, discuss referral to GP for tests Risk factors can include: family history of diabetes, taking high blood pressure meds, smoke, poor diet, little or no physical activity, waist measurement of more than 90cm **Discuss referral to**: GP, Dietitian, Podiatry, Physiotherapy, Diabetes Educator	Yes☐ No ☐ Yes☐ No ☐ Comments:
4. Does the client **exercise?** ▪ 30 minutes or more 5 days p/week? **Discuss referral to**: Physiotherapist (assessment for) exercise programs, gym, walking groups	Yes☐ No ☐ Yes☐ No ☐ Comments:
5. Does the client have problems with **sleep?** ▪ If less than 3 hours p/night or ▪ more than 8 hours p/night **Discuss referral to**: GP, Sleep specialists, Dietitian, exercise programs, relaxation/meditation programs, consider medication review	Yes☐ No ☐ Yes☐ No ☐ Yes☐ No ☐ Comments:
6. Discuss with client **oral hygiene** and care ▪ Does the client have access to a toothbrush and toothpaste ▪ Are their teeth in poor condition? Do they need to be reviewed by the dentist? ▪ Does the client require dentures or education regarding denture care? ▪ Has the client been referred to the ISCHS Dental Program or private Dentist? **Discuss referral to**: Dental Service	 Yes☐ No ☐ Yes☐ No ☐ Yes☐ No ☐ Yes☐ No ☐ Comments:
7. **Feet and Nail Care - Discuss** and if appropriate have a look at client's feet. ▪ Do they have any in grown toenails? ▪ Any signs of infection? E.g. redness, soreness, inflammation ▪ Thickened toe nails difficult to cut with regular clippers **Discuss referral to**: Podiatrist	Feet viewed: Yes☐ No ☐ Yes☐ No ☐ Yes☐ No ☐ Yes☐ No ☐ Comments:

Client Physical Health Guide	Client Name: Date of Birth: dd/mm/yyyy / / Sex: UR Number:

8. Has the client had their **eyes** checked within the last 12 months? ▪ Are they experiencing difficultly seeing? ▪ Have they had a problem in the past with sight? **Discuss referral to**: Optometrist	Yes☐ No ☐ Yes☐ No ☐ Yes☐ No ☐ Comments:
9. Does the **client have a history of falls** or **balance problems?** ▪ Liaise with Treating Doctor detailing **falls** and explore possible causes, recent increase in **medication?** **Discuss referral to**: ISCHS Falls and Balance Program, GP, Psychiatrist	Yes☐ No ☐ Comments:
10. Does the client have **recurrent chest infections**? ▪ Discuss with client and GP correct use of respiratory medication E.g. reliever used before preventer (Ventolin before seretide) ▪ Do they need to be on a spacer? If already on one, are they using their spacer correctly? **Discuss referral to**: Nurse Respiratory Educator, Physiotherapist, Cigarette Cessation Programme	Yes☐ No ☐ If yes, refer to GP for management plan Comments:
11. Does your client have a history of **Urinary Tract Infections**? ▪ Note frequency to the toilet, incontinence, and confusion, burning sensation **Discuss referral to**: GP	Yes☐ No ☐ If yes, refer to GP for management plan Comments:
12. **Constipation -** Is the client experiencing constipation. ▪ How often are they going to the toilet? Are they on particular medication which causes constipation e.g. Clozapine, Iron tablets, Cogentin ▪ Encourage client to drink water 1-1.5 Litres ▪ Increased fruit and vegetables in diet ▪ Encourage exercise **Discuss referral to**: Dietitian	Yes☐ No ☐ Comments:
13. Discuss **safe sex** ▪ Is safe practice inconsistent or nonexistent? ▪ Do they know where to get free condoms/lube? **Discuss referral to**: GP, Sexual Health Nurse, Sexual Health Clinics, ISCHS - STI tests - Sexual health advice	Yes☐ No ☐ Yes☐ No ☐ Comments:

Adapted from ISCHS Mental Health Program Client Physical Health Guide, with permission from Inner South Community Health Service, Australia 2009

Client Physical Health Guide	Client Name: Date of Birth: dd/mm/yyyy / / Sex: UR Number:

14. **Drug and Alcohol Information:**	Quantity	Frequency/Duration	Action
▪ Cigarette Use			
▪ Alcohol intake			
▪ Illicit Drug Use: If injecting, no. of injections/day			
▪ Other e.g. benzodiazepines, cannabis, psycho stimulants, heroin			
Discuss referral to: alcohol and drug service			

Referred to	**Date/ Details Referred**	**Date/ Details Reviewed**
GP		
Dietitian		
Diabetes Educator		
Dentist		
Optometrist		
GP		
Occupational Therapist		
Physiotherapist		
Podiatrist		
Respiratory Educator		
Alcohol & Drug Service		

Date Completed:

Planned Date of Next Physical Health Screening Review (every 6-12 Months):

Name of Clinician:

Signature:

The above tool is to be used as a guide to physical health management of mental health clients. Clinical judgement must always be used and medical advice sought when clinically judged appropriate. Always seek medical advice if unsure.

Appendix 7. The Chronic Care Model and link to Service Coordination

	Delivery system design	Decision support tools	Self management support	Clinical information systems	Community
Access & initial contact	Clear referral pathways	Service information and eligibility. Directory for chronic condition care	Provision of service information and other health information	Effective use of referral systems including electronic information system- S2S (e-referral)	Referrals from external agencies are through coordinated and integrated care processes
INI	Broad client centred screening	Agreed care pathways	Provide choice of services/supports available	IT resources allow for efficient access to client and service information	Services are available for referral on from agencies
Assessment	Assessment system: - Comprehensive - Common - Holistic - Builds over time	Common assessment form Written assessment protocol	Process geared toward gathering information AND assisting client to identify and understand key issues	IT system allows efficient recording and access of assessment information for the whole care team	Relevant and appropriate assessment information is communicated to referring agencies
Care planning	Care plans are a routine part of client care	Intra-agency care plans Inter-agency care plans Written care plan protocol	Care plans are written by clients with support of care provider	Care plan information is documented to facilitate ease of access for reference, follow up and review	Appropriate care plan information is communicated to external care providers

Care delivery	Multidisciplinary teams AND communication within these teams and between other teams and disciplines	Encourage client participation throughout care	- Routine conversations with clients about broader health needs - Shared decision making with client	Record conversations, decisions, actions, encouragements and referral etc in client file	Provide community information resources about services to refer for social and self management support- appropriate information that is meaningful and clients understand
Monitoring & review	Review processes are routine and integrated into procedure	Agreed client outcome measurement tools are completed at beginning of care and regularly throughout	If changes or new goals are identified, this is discussed with clients who are supported with altering goals and strategies	Review, completion of outcome measures, conversations and goal adjustment are all recorded in the client record including attempts to complete any of the above with client	As progression is made or goals change review information resources about services referred for social and self management support. Further provide appropriate information that is meaningful and clients understand
Transition & Exit	Discharge procedure documentation exists and accessible	Discharge processes are clear and pathway and steps are available	Discharge processes are discussed and understood by client	Document necessary conversations, referrals and plans regarding discharge	- Ensure resources and service information are provided to client in preparation for discharge - Communication with other services to ensure adequate support in place
Proactive recall	Recall procedures exist and accessible	Recall processes are clear and steps are available	Recall processes are discussed and understood by client	Electronic Health Record supports automated recall systems	Routine review of other services involved in care and referral/ re-referral as required

Appendix 8. Guidelines for Model of Care Trial

Health Project:

The SCTT Health Conditions Screening tool is to be introduced on a trial basis with mental health clients of Murnong Mental Health Clinic CCT, MST, Lifeworks (EACH) Psychiatric Disability Rehabilitation and Support (Day Programs) and a PHaMs team from EACH.

The trial will commence in February 2010 for a period of 1 month and all current clients who are having their 6 monthly review (3 monthly for EH Clinical Service Consumers) will be asked to participate. It is anticipated that 10 clients from each service will complete the health screening tool. There will also be a brief feedback form for clinicians and clients to complete with responses to their experience of completing the tool. Clinical services will run the trial over a 1 week review period to obtain a sample of 10.

All workers in AMHS, PHaMs and PDRSS have previously completed a health screening survey asking whether client physical health screening is carried out on a regular basis. The responses to this question will be used as baseline data to measure change after the introduction of the trial.

- The project worker will attend team meetings to outline the Health Project and explain the purpose of the trial
- All clients will be given a brief information sheet outlining the purpose of the Health Project.
- The clinician will then complete the 2 page Health Conditions Screening Tool with the client using the tool template code set.
- If a chronic health condition is indicated the clinician/support worker may also complete the Health Behaviours Screening Tool.
- Any issues identified during the screening process will be discussed and a referral may be made to the clients GP for further investigation or to EACH Allied Health Services for an appointment.(referral form supplied) or to other health care provider as required
- Mental Health Clients have been identified as a priority group for service access to Allied Health Services
- For clients of clinical services any issues requiring follow up will be address in the Individual Recovery Plan and discussed at Clinical Review
- Urgent issues identified to be addressed with the psychiatric registrar immediately
- The clinician and client will complete the feedback form
- A copy of the completed forms will be kept in the clients file along with case notes on any action taken
- A copy of the completed forms (de identified) will be placed in a collection box at admin for the project worker or Team leader to collect and collate
- Intake at Allied Health at Patterson Street will be asked to monitor the number of referrals received from the services participating in the trial
- Every client will also be given a copy of the SANE Mind and Body factsheet with information on health matters and contact details to obtain further advice on specific conditions

Health Matters Inner South:

Guidelines for trial Physical Health Guide

The Physical Health Guide screening tool is to be introduced on a trial basis with mental health clients of Alfred Community Area Mental Health Service Junction Clinic.

The trial will commence in March 2010 for a period of 2 months or 5 clients per clinician. All current clients who will be accessing the service within the period will be asked to participate. There is a brief feedback form for clinicians to complete with responses to their experience of completing the tool. Clients will be asked if the project worker can contact them within a week of completing the tool to provide feedback of their experience.

Workers from Alfred Community AMHS have previously completed a physical health screening survey asking whether client physical health screening is carried out on a regular basis. The responses to this question will be used as baseline data to measure change after the introduction of the trial and implementation to the broader organisation.

- The project worker will attend team meetings to explain the purpose of the trial and provide an orientation for staff participating in trial
- All clients will be given a brief information sheet outlining the purpose of the Health Matters Inner South Project and trial.
- The clinicians will then complete the Physical Health Guide with the client
- Any issues identified during the screening process will be discussed and a referral may be made to the clients GP for further investigation or to ISCHS Allied Health Services for an appointment (via the Information and Referral Service) or to internal service clinics (Dietetics)
- For clients of clinical services any issues requiring follow up will be address in the Individual Recovery Plan and discussed at Clinical Review
- Urgent issues identified to be addressed with the psychiatric registrar immediately
- The clinician will complete the feedback form
- For clients consenting to participate in the feedback process, contact information will be provided to the project worker
- A copy of the completed forms will be kept and scanned into the clients electronic file along with case notes on any action taken
- A copy of the completed forms (de identified) will be placed in a collection box for the project worker or Team leader to collect and collate
- The project worker will monitor the number of referrals received from the AMHS staff participating in the trial (audit- TrakCare)
- Every client will be given a copy of the SANE Mind and Body factsheet with information on physical health and contact details to obtain further advice on specific conditions
- Feedback- results will be collated at the end of the trial period and feedback and future directions will be provided to staff at Team Meetings by the project worker.

Appendix 9. Health Screening Information Sheet

Health Project:

Health Screening Trial Information Sheet for clinicians and clients

What does health screening mean?

Health screening is a way of checking how your physical health is going. There are a series of questions designed to make you think about any health problems you may be currently experiencing. If there is something that you and your clinician decide needs attention then you can be referred to your doctor for further checks or a Community Health Service for further advice.

Why the trial?

The State Government has identified the physical health of people with a mental illness as a priority area for them to address. The information below tells you a bit about the physical health rates of people with a mental illness generally. The government is interested in finding ways for people to have regular health checks and also ways of getting easier access to doctors and Community Health Centres when you need it. By taking part in this survey you will be helping to provide recommendations for changes to the health system.

Where does the information go?

A report is being written for the Government with information collected from a variety of sources in the Outer East. All information in the report will be in a de identified manner respecting the privacy and confidentiality of all taking part.

Background information

People with a severe mental illness often do no have the same access to treatment for physical health conditions nor do they experience the same life expectancy as other people in the community. The Western Australia *Duty to Care* report launched in 2001 reported on a health study of 240,000 mental health service users between 1980 and 1998. The report compared hospital admission rates, cancer incidence rates and death rates between this population and that of the general West Australian population. Among the findings were:

- The overall death rate of people with a mental illness was 2.5 times higher than the general population
- Despite a downward trend in the death rate due to heart disease in the general population the death rate in people with a mental illness due to heart disease had increased in women and remained steady in men
- Cancer rates were about the same as the general population despite the high incidence of smoking but once a cancer was diagnosed there was a 30% higher death rate

People with mental illness often suffer poorer nutrition, dental decay and are vulnerable to chronic conditions like diabetes and the negative health effects of weight gain due to medication

Victorian Government Recommendations

The Victorian Mental Health Reform Strategy 2009-2019 'Because Mental Health Matters' identified Physical Health as a priority area. As a result the government has funded 2 demonstration projects 'Improving Access to Primary Health Care Services for people with serious mental illness'

The aims are to improve

1. Access to service (through screening and identification of physical health needs)
2. Access to models of care that support identified client needs

The target population for this project is people with a serious mental illness who are case managed through public mental health services

If you have any questions or concerns about this survey please contact the Project Officer Sharon O'Boyle at EACH (Lifeworks) on 9879 4699

Physical Health Guide Trial
Information Sheet for clinicians

What does health screening mean?

Health screening is a way of checking how your client's physical health is going. There are a series of questions designed to make you think about any health problems your client's may be currently experiencing. If there is something that you and your client decide needs attention then you can refer to their doctor for further checks or a Community Health Service for further advice.

Why the trial?

The information below tells you a bit about the physical health rates of people with a mental illness generally. Government policy has outlined an interest in finding ways for people to have regular health checks and also ways of getting easier access to doctors and Community Health Centres when needed. By taking part in this trial you will be helping to provide our service with information about how we can best identify the physical health needs of our clients by using screening tools.

Where does the information go?

The information will help our service decide if health screening is the best way of supporting our clients. All information collected and collated by the project officer will be de-identified respecting the privacy and confidentiality of all taking part.

Background information

People with a serious mental illness often do no have the same access to treatment for physical health conditions nor do they experience the same life expectancy as other people in the community. The Western Australia *Duty to Care* report launched in 2001 reported on a health study of 240,000 mental health service users between 1980 and 1998. The report compared hospital admission rates, cancer incidence rates and death rates between this population and that of the general West Australian population. Among the findings were:

- The overall death rate of people with a mental illness was 2.5 times higher than the general population
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- Cancer rates were about the same as the general population despite the high incidence of smoking but once a cancer was diagnosed there was a 30% higher death rate

People with mental illness often suffer poorer nutrition, dental decay and are vulnerable to chronic conditions like diabetes and the negative health effects of weight gain due to medication

Victorian Governments recommendations

The Victorian Mental Health Reform Strategy 2009-2019 'Because Mental Health Matters' identified Physical Health as a priority area. The Integrated Chronic Disease Management initiative also recognises this as a priority. As a result the government Department of Health has funded 2 demonstration projects 'Improving Access to Primary Health Care Services for people with serious mental illness'.

The aims are to improve:

3. Access to service (through screening and identification of physical health needs)
4. Access to models of care that support identified client needs

The target population for this project is people with a serious mental illness who are case managed through public mental health services

Physical Health Guide Trial
Information Sheet for clients

What does health screening mean?

Health screening is a way of checking how your physical health is going. There are some questions to help you think about you health. If there is something that you and your clinician decide needs attention then a referral can be made to you doctor for further checks or a Community Health Service for further advice.

Why the trial?

By taking part in this trial you will be helping us see if using physical health screening can support our clients, if it works well we will keep on using it!

What will we do with the information?

The information will help our service decide if health screening is the best way of supporting our clients.
Your information is private and will not be identified. Your results and experiences will help us decide whether to continue.

Background information

People with a serious mental illness often do no have the same access to treatment for physical health conditions nor do they experience the same life expectancy as other people in the community. The Western Australia *Duty to Care* report launched in 2001 reported on a health study of 240,000 mental health service users between 1980 and 1998. The report compared hospital admission rates, cancer incidence rates and death rates between this population and that of the general West Australian population. Among the findings were:

- The overall death rate of people with a mental illness was 2.5 times higher than the general population
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- Cancer rates were about the same as the general population despite the high incidence of smoking but once a cancer was diagnosed there was a 30% higher death rate

People with mental illness often suffer poorer nutrition, dental decay and are vulnerable to chronic conditions like diabetes and the negative health effects of weight gain due to medication

Victorian Governments recommendations

The Victorian Mental Health Reform Strategy 2009-2019 'Because Mental Health Matters' identified Physical Health as a priority area. The Integrated Chronic Disease Management initiative also recognises this as a priority. As a result the government Department of Health has funded 2 demonstration projects 'Improving Access to Primary Health Care Services for people with serious mental illness.'

Appendix 10. Health Screening Evaluation

Health Project:

Evaluation SCTT Health Conditions Trial

1. Was the form easy to understand? Yes most some No

2. Were there areas of your health that were not covered ? **(if yes please explain Clients only for this question)** Yes most some No

……..

3. Was there anything else you would like to see included? **(Clinicians only for this question)** Yes most some No

……

4. Was there any action taken as a result of filling out the form. If so what was the action? Yes most some No

……..

5. Was the information sheet useful? Yes most some No

6. Was the SANE factsheet useful? Yes most some No

7. Any suggestions for changes or improvements to the Health Screening?

…….....
.....

Thank you for completing this questionnaire

Health Matters Inner South:

Clinician Evaluation: Physical Health Guide Trial

Thank you for participating in the Physical Health Guide Trial. We value you opinion about the use of this tool and would like to hear about your experience. We would appreciate you taking the time to provide us with your feedback on what you found useful (or not) and how we might be able to improve this tool.

Role: _____

1. Did you complete one or more of the Physical Health Guide? Yes No

1a. If yes, how many _____ (please go to question 2)

1b. If no, what were the challenges or barriers for completing the guide with your clients?

Guide was too long	☐	Feeling anxious about this and other trials that are currently underway- so I didn't complete guide	☐
Didn't have enough time	☐	It's not my responsibility	☐
I didn't feel confident to talk about physical health	☐	The guidelines for completion were not clear	☐
All my clients declined participating	☐	I didn't feel confident once a physical health issue was identified that I would know what to do- so I didn't complete guide	☐
I don't know how this could work in the future- so I didn't complete guide	☐	This needs to be in policy before we do anything- so I didn't complete guide	☐
Other (please specify) (please go to question 4)			☐

2. On average, how long did it take you to complete the guide with your clients?
_____

2a. Did this length of time seem Good Reasonable Long Not Realistic

3. Was there any action taken as a result of filling out the form. If so what was the action?
_____

<u>The following questions can be answered even if you did not complete with clients</u>

4. How relevant are the questions to your clients?
1 _____ **10**
(not relevant) (relevant)

5. Were there areas of your client's health that were not covered? (Please provide details if possible)
_____

Please turn over

Page 1

6. What do you like most about the physical health guide?

_____

7. What do you like least about the physical health guide?

_____

8. Do you have any suggestions for changes or improvements to the physical health screening guide?

_____
_____

9. Do you think the physical health guide is a good tool for supporting clients to think about broader health needs? Yes No

10. Do you think physical health screening could be implemented more broadly in your organisation? Yes No

11. Did you find the GP Communication fax sheet (1 page) useful? Yes No

11a. Do you think the GP Communication fax sheet could be implemented more broadly? Yes No

11b. Do you have any comments regarding the GP Communication fax sheet?

_____
_____

12. Was the information sheet useful? Yes No

13. Was the SANE factsheet useful? Yes No

14. Was the Service Information (2 page service directory) useful? Yes No

15. What could The Alfred do to support broader implementation of physical health screening? (please note this decision has not been made or discussed)

_____
_____

16. Do you have any other comments you wish to make regarding the trial or any thoughts for recommendations and future considerations?

_____
_____

Thank you for completing this evaluation

Appendix 11. Service Information

Services

Information to support referral and follow up upon completion of the Client Physical Health Guide
Please consider the GP involved in the clients care for referral, consultation and communicating findings and referral

Health issue/need	Service Provider	Agency
Weight, nutrition	Dietitian	Alfred Psychiatry Dietitian (can book straight into Powerchart) ISCHS Dietitian* Private Dietitian (find a Dietitian on association website) http://www.daa.asn.au
Diabetes	Dietitian	As above and ISCHS Dietitian also provides Diabetes assessment and support group*
	Podiatrist	ISCHS Podiatry* Private Podiatrist (find a Podiatrist on association website) http://www.podiatryvic.com.au/
	Physiotherapist	ISCHS Physiotherapy* Private Physiotherapist (find a Physiotherapist on association website) http://www.physiotherapy.asn.au/index.php
	Diabetes Educator	Baker IDI **92585000** (this number will change in May 2010) http://www.bakeridi.edu.au/diabetes_services/education/
Exercise	Physiotherapist	As above and ISCHS Physiotherapist can assess and provide further information regarding exercise programs, aquatic groups, walking groups, gym groups*
Sleep	Sleep Specialists	Refer to GP for specialist referral http://www.sleepaus.on.net/sleepserviceslists.html
	Relaxation/ meditation	ISCHS Standing Up to Anxiety group* ISCHS Women's Wellbeing Group* Gentle Yoga at Kilbride centre http://www.portphillip.vic.gov.au/default/Yoga.pdf Yoga in the park, Prahran (free) http://www.stonnington.vic.gov.au/www/html/4341-yoga-in-the-park.asp For other services: http://www.naturaltherapypages.com.au/
Oral care	Dentist	ISCHS Dental program: **95203177** Other Dental services available http://www.dhsv.org.au/ Private Dental services (find a Dentist on association website) http://www.adavb.net/Default.aspx#lfO1SeWcQmsL
Feet and Nail care	Podiatry	As above
Eyes	Optometry	Sacred Heart Mission St Kilda http://www.sacredheartmission.org/Page.aspx?ID=67 Australian (formerly Victorian) College of Optometry http://www.aco.org.au/clinical-services/metro-service-information.htm

Falls or balance	Falls and Balance Program	ISCHS Falls Prevention Education Program* ISCHS Tai Chi Exercise*
Lung health, breathing, chest infections	Nurse Respiratory Educator	ISCHS Pulmonary Rehabilitation Program* http://www.alfredhealth.org.au/Page.aspx?ID=454
	Smoking cessation program	Refer to clients GP Quitline **137848**
Urinary Tract Infections	GP	Refer to clients GP
Constipation	Dietitian	As above
Safe sex	GP	Refer to clients GP
	Sexual Health Nurse	ISCHS Sexual Health Nurse*, ISCHS has an self serve Needle Syringe Program (NSP) at each site where people can access free condoms and lubricants
	Sexual Health Clinic	Melbourne Sexual Health Centre http://mshc.org.au/Default.aspx?alias=mshc.org.au/general
Alcohol and drugs	Counselling	ISCHS Drug and Alcohol program* Windana 95297955 http://www.windana.org.au/home.php/ The Bridge Program St Kilda **95212770** http://www.salvationarmy.org.au/SALV/STANDARD/PC_60135.html Access Point Health **83411600** http://www.accesspoint.org.au/
	Withdrawal	Windana as above, The Bridge as above, Access Point Health as above

Services listed are generally low cost or free services however please check fees and waitlist information upon referral

*For more information or referral to service contact the **Information & Referral Worker**.
A dedicated worker is based at each of our sites and the service is available: Monday – Friday 10:00-1:00 and 2:00-4:30
Prahran: 95251300, South Melbourne 96909144, St Kilda Mitford St 95340981.
St Kilda Inkerman St operates as an afternoon drop in service (also known as Rhed) with a range of different services available, for more information contact the Information & Referral Worker available from 1pm on 95348166.
Or go to http://www.betterhealth.vic.gov.au/ to search for GPs and other Health Professionals and services available.

Appendix 12. GP Feedback Form

ALFRED PSYCHIATRY
Junction Community Mental Health Services
2-12 St Kilda Road
St Kilda 3182

Phone: 9076 9888 Fax: 9076 9855

TheAlfred

Dear Doctor

This report is to provide you with information about your patient who has been attending Alfred Health Community Psychiatry Services. I would welcome the opportunity to discuss the patient with you, or to provide any further information you may require. My contact details are at the bottom of this report.

Yours sincerely

Patient Details	Date:
Name:	GP Details:
Address:	Clinic:
Date of Birth:	Address:
Client consent to share information obtained?	Phone: Fax:

Mental Health Case Manager completed physical health screen with patient and have discussed needs and referral options.

Patient concerns identified:

Follow up arranged so far:

Patient may benefit from further GP follow up:

Further comments:

Service Provider details: Junction Community Mental Health Services
Name:
Phone: 9076 9888
Fax: 9076 9855
Best times to contact:

PLEASE NOTE: If you have received this facsimile in error, please notify us immediately

Adapted with permission from Monash Division of General Practice, Patient Feedback Report 2009

Appendix 13. Health Coaching Australia

"The HCA Model of health coaching is a system of evidence-based behaviour change principles and techniques designed to be used in any clinical encounter where a client is asked to take action to manage an aspect of his or her health. It is a cognitive behavioural model that aims to help health practitioners to assess and improve client readiness, willingness and ability to adhere to medical and lifestyle treatment recommendations, in a time efficient manner. In particular, the HCA Model addresses behavioural, emotional, situational and cognitive barriers to health behaviour change" (Health Coaching Australia 2008).

Summary of key points from both projects Health Coaching Evaluation:

- 100% of respondents from both projects training said they would recommend the workshop to colleagues
- 84% responded that the content was relevant and useful to their current work and rated the workshop in the high to excellent range
- All participants who responded indicated that their learning needs were met to a large extent and learning objectives outlined by HCA being entirely met by 75% (or more) of participants for all seven objectives
- Comments from participants included a recommendation that all mental health workers would benefit from this training
- Many comments around the simplicity practicality and usefulness of the tools particularly the RIC (readiness, importance and confidence tool)
- Participants found that they would have liked more case examples and time spent on practice application.

Summary of SMR second evaluation questionnaire:

- 91% that responded indicated that they have applied the health coaching techniques to their practice since the workshop.
- On average 25-50% of patients on whom the techniques have been used, reached a successful outcome (only five responded to this question)
- In response to satisfaction in managing non-compliant patients, 36% experienced an increase in satisfaction, 18% had not had an increase, 10% were unsure and 36% did not respond
- Three case studies were provided to demonstrate application of techniques to improve patient outcomes. Two cases were to support clients with changes to weight and the other was regarding transfer of residency.
- When asked if the techniques have become embedded into current practice, 55% responded "Yes".

Participant responses to what support is required to implement the principles of Health Coaching to clinical practice include:

- Arrange some supervised practice sessions
- Further health coaching session - maybe the 2-day course and reading material
- Liaise with PHC coordinator regarding implementation of GP care plans
- Provide session(s) to more local health care workers in area
- Looking at physical health is new to the mental health sector so the training would be beneficial for all mental health workers
- More practical exercises and role plays in other sessions to embed knowledge gained
- Provision of a handbook rather than handouts to refer back to easily
- Training in how to apply principles in group settings

Appendix 14. Session Outline for Suggested Orientation

Improving access to Primary Health Care Services for people with serious mental illness

Workshop Outline – Orientation

Physical Health Screening Orientation
For Area Mental Health Service

Time	Duration	Item	Description	Notes for trainer	Outcome
9:30	5 mins	**Welcome and introduction**	Welcome and introductions	Introduce yourself and participants Acknowledgements for those who helped organise the course for the day	Welcome and understanding of the context for today's session.
9:35	10 mins	**Ice breaker**	3 things with examples from your current case load, that you already do well with regards to the physical health of your clients	- Participants talk to person sitting next to them - Have approx 5 mins each to talk about their practice - No feedback to group	Opportunity to meet others attending session Opportunity to identify existing strengths with regard to current practice for supporting physical health of clients
9:45	20 mins	**Background/ Why are we here**	- Present the health statistics of people with serious mental illness - Policy - Wagner: framework (diagram) - Best practice (1 slide) - Client centred approaches (SANE DVD 2010)	- More information in resource folder for people who are really interested - Self management support capabilities document (Flinders) - Evidenced based, international, its relevance to the you (them) and this is what drives health dollars (Wagner is BP and possibly talk about the core capabilities for workers for self management support) - Provide definitions, statistics or food for thought statements or talk about ways of framing questions with clients	Participants have an understanding of the issue, policy context, best practice and evidenced based approaches to improving care for people living with or at risk of chronic conditions
10:05	10 mins	**Activity**	3 areas where my practice could improve with supporting the	- Participants talk to the other person sitting next to them (or at least someone different)	Opportunity to identify improvement areas with regard to current practice for

			physical health needs of clients	- Have approx 5 mins each to talk about their practice - No feedback to group	supporting physical health of clients
10:15	30 mins	**Screening Tool**	- Introduce screening tool - Have AMHS person talk about their experience with the screening tool	- Each participant will have a copy of the screening tool - AMHS- (would be good if they talked about it from a practice change perspective- at first wasn't sure about it, but I felt it was my responsibility, but didn't know how it would go etc)	Opportunity to see the screening tool and hear about actual experience of physical health screening within AMHS
10:45	30 mins	**Screening Tool activity**	- Participants have a go at completing the screening tool	- Separate into groups of 3 - Allocate: Client, Clinician and Observer - Provide: Screening tool to work through - Groups get through as much of the tool as they can in 20 mins - 10 mins for group members to feedback how they experienced the tool and provide feedback to group members that they might have for each other	Opportunity to experience the screening tool from the clients or clinicians perspective and be provided with feedback regarding experience
11:15	5 mins	**Needs Identified and Referrals**	- Brief information regarding once the tool has been completed with clients, needs and referral options will have been identified	- Pathways and referral and service information in resource folder	Participants are provided with service and referral information to support findings from completing screening tool
11:20	10 mins	**GP Communication**	- Background: GPV report (feedback tool trial), - Why should I as a mental health worker be thinking about GP?	Q: could get a GP to deliver this? - Evidence that clients do better when there is coordinated care - Therefore, there is a proforma as a result of trials and feedback - More information about this is in resource folder	Participants are provided with information regarding appropriate communication with GPs and a tool to support this work
11:30	15 mins	**GP Communication Activity**	Participants complete the GP communication form	- In the same group of 3 as before - Allocate roles: client = client, clinician = clinician, observer = GP - Clinician has a go at completing feedback form (with help from both client and GP)	Participants are provided with opportunity to experience completing GP feedback from to support findings from completing screening tool

				- Consider the information from your roles perspective eg. For the GP, client would be seen under Medicare only fee, would have 10 mins to see the client, is likely to have 1000's of patients, if you were GP what information would you need? - An example of a completed feedback form is in your resource folder	
11:50	10 mins	**Behaviour Change**	Health Coaching - Brief overview of HC - Present RIC technique	- More information on HC in resource folder	Participants are provided with overview of Health Coaching in context of behaviour change theories
11:55	5 mins	**RIC Activity**	Individual activity	- Worksheet for participants to write on - Think about a physical health related needs that you have personally that you are finding hard to commit to and make change - Apply the RIC technique to your health need	Participants are provided with opportunity to apply the RIC technique
12:00	5 mins	**Implementation**	Things that need to be considered as part of implementation	- Pose questions (that don't need to be answered there and then) - Reflect back to Wagner and how some of the components are decisions that may not be yours to make, however we hope you discuss with your Managers how you can address physical health needs of clients and that you feel you can start somewhere	Participants are provided with information to support implementation of physical health screening into their agency
12:05	5 mins	**Wrap Up**	- Key messages - Thank you(s)		
12:10	10 mins	**Questions**			
12:20	10 mins	**Evaluation form**	Participants are provided with evaluation form		An evaluation of the session is available for development of future sessions
12:30	**LUNCH**				

Appendix 15. Suggested Orientation Participant Outcomes

Physical Health Screening Orientation Participant Outcomes

This orientation supports participants by being:

- Provided with information regarding the physical health risks for people with serious mental illness
- Provided with a basic introduction to Wagner Chronic Care Model
- Clearer about their role in physical health of their clients
- Confident about their role in the physical health needs of their clients
- Provided with physical health screening tool and its use
- More likely to discuss physical health needs with clients
- Feel more confident with supporting clients to access physical health services
- More likely to provide clients with information about physical health services and general health information
- More likely to refer to GP or other health services
- More likely to communicate with clients GP and other health services about clients physical health needs
- More likely to discuss physical health needs of clients with team
- Provided with useful resources to read further and support practice in this area

Appendix 16. Results of "Open Day"

First name	Previous visit To site	Knowledge level pre	Comfort level pre	Knowledge level post	Comfort level post
Client1	Yes	2	5	8	10
Client 2	No	1	5	10	9
Client 3	Yes	7	9	8	9
Client 4	No	1	5	8	10
Client 5	Yes	5	7	9	9
Client 6	Yes	7	9	10	10
Client 7	No	2	5	10	8
Client 8	Yes	3	8	8	7
Client 9	No	0	10	6	10
Client 10	Yes	4	8	9	9
Client 11	No	0	7	10	10

Name	Follow up 1 month post
Client 1	Placed on wait list for dental and podiatry, Assigned peer mentor to assist with appointments and health plan devised to quit smoking
Client 2	Missed first physio appt. Attending with case manager for 2nd appointment
Client 3	Have not been able to determine if client had appointments
Client 4	Had appointments with Dietitian and physio which she did not keep. Key worker Lifeworks to assist with new appointments
Client 5	Had appointment with Dietitian and attended appointment
Client 6	Dental appointment made for dental hospital due to special needs. Outreach worker to assist with transport and support
Client 7	Made appointments with well women's clinic and GP. Peer Mentor to assist with these appointments and health plan to improve physical activity
Client 8	Attended podiatry appointment himself and had repeat appointment. Allied health team assisted with reminder calls
Client 9	On waiting list for physio. Engaged with peer mentor to work on exercise and healthy eating plan
Client 10	On waiting list for podiatry
Client 11	No response

Appendix 17. Peer Mentor Support WA Trial

In WA the HealthRight Peer Advocacy and Support Service Trial in 2007 demonstrated the difference to physical health that working with a Peer Mentor demonstrated. Peer Mentors were employed on a six month contract to work with 5 clients each. Of the 23 clients in the trial 37.5% were diagnosed with previously unknown health problems during the trial, six reported having given up smoking, nine were losing weight and 13 reported they were exercising more frequently.
Clients also reported that would be far more likely to make changes with support from someone 33.3% said they would give up smoking, 71.4% would exercise more and 57% would lose weight. 42% said they would be more likely to attend GP appointments if someone went with them (Bates & Kemp 2008).
Other reports such as:

- PEAR Project peer mentor evaluation EACH (2009 unpublished)

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