

Physical Health Care of Mental Health Consumers

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Summary These Guidelines provide a framework and, where available, evidence based guidance to assist NSW Health mental health services to:

- * Recognise their role in the physical health care of consumers, including advocacy;
- * Clarify appropriate linkages with other health care providers;
- * Build stronger partnerships with key stakeholders, including GPs, mental health consumers, families and carers;
- * Establish minimum expectations for the physical health care of consumers, together with a program to improve standards; and
- * Improve the physical health care of mental health consumers.

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Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Affiliated Health Organisations - Declared, Community Health Centres, Public Hospitals

Audience Clinical, nursing, psychiatrists, emergency depts, PECCs, mental health staff

Distributed to Public Health System, Community Health Centres, Divisions of General Practice, Government Medical Officers, Health Associations Unions, Health Professional Associations and Related Organisations, NSW Ambulance Service, NSW Department of Health, Public Hospitals, Tertiary Education Institutes

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Foreword

While it has long been recognised that mental and physical health states have complex interactions, there is now a growing body of evidence that indicates the significant impact mental health can have on physical illness and disease, as well as the poor physical health that many consumers of mental health services suffer.

Such evidence confirms the importance of bringing mental health and physical health care together to provide holistic care for people with a mental illness.

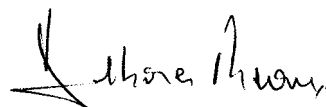
Many mental health services may already consider the physical health needs of mental health consumers through the promotion and delivery of physical health examinations and interventions. The *Physical Health Care of Mental Health Consumers – Guidelines* support the adoption of a consistent, statewide approach to these practices, and afford all mental health services the opportunity to improve the physical health of mental health consumers and prevent disease.

Early detection and treatment of illness and disease in mental health consumers, and the initiation of preventative measures for this group, will enhance both their physical and mental health and ultimately improve their quality of life. However, it should be recognised that the achievement of these goals must involve

the establishment or strengthening of collaborative partnerships between primary and secondary care providers, recognition of the role of the consumer in their own care and the provision of adequate training for mental health staff on the physical care of mental health consumers. Some attitudinal change may also be required within mental health services in relation to the adoption of a holistic care approach.

Encouragingly, there is a high level of interest and enthusiasm already within mental health services in supporting consumers to improve their physical health. Time and effort will be required to maintain this interest, and community mental health services in particular will need to think strategically and longitudinally in planning to meet the physical health needs of consumers.

The *Physical Health Care of Mental Health Consumers – Guidelines* recognises the critical role mental health services can play in improving the overall health and wellbeing of consumers with mental illness. It is a key resource that will enable these services to deliver holistic, supportive and choice-driven health care, leading to improved overall health outcomes for some of the most vulnerable, and disadvantaged, members of the community.



Professor Debora Picone AM
Director-General



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Introduction

1.1 Background

There is general consensus among the available literature, both national and international, that the physical health of people with a mental illness is poor (*Duty to Care, Holman & Jablensky 2001, Medical Disorders Among Patients Admitted to a Public-Sector Psychiatric Inpatient Unit, Koran et al. 2002, Improvement of the Physical Health of People with Mental Illness - Stefan & Kostas 2006*), and that poor physical health is associated with impaired mental health. The seriously mentally ill also have high rates of mortality and reduced life expectancy. In addition, evidence suggests that people with mental illness have reduced access to healthcare and may receive insufficient medical assessment and treatment (*Medical co-morbidity risk factors and barriers to care for people with schizophrenia, Muir-Cochrane 2006*).

In NSW, concerns regarding the completion of appropriate physical examinations in both inpatient and ambulatory mental health settings have been raised through a variety of NSW Health review mechanisms, including :

- Official Visitors, who regularly inspect hospitals and community mental health services (health care agencies) to enquire as necessary into the care and treatment of patients.
- The review conducted by InforMH, a division of the NSW Health Mental Health and Drug and Alcohol Office, on the use of the Mental Health Outcomes and Assessment Tools (Mental Health Clinical Documentation) clinical modules.
- Internal NSW Health Area Health Service audits.

In response to this feedback, the NSW Health Mental Health Program Council, which oversees the operations of the local governance structure within the NSW Health Mental Health Program, and the NSW Health Mental Health Program Clinical Advisory Council (CAC), a standing committee of the Program Council that oversees clinical practice, reviewed the current documentation and practices regarding the physical health care of the

mentally ill. This review identified that there were no clear accepted standards for the completion of physical examinations of mental health consumers in NSW and no guidelines or policy directives in existence that supported mental health services to improve the physical health care of the consumers using their service.

Accordingly, the CAC agreed at their March 2007 meeting to commence the development of the *Physical Health Care of Mental Health Consumers - Guidelines*.

This action was in line with a recommendation from the Mental Health Sentinel Events Review Committee (SERC) Tracking Tragedy 2007 report. This recommendation focused on the need for a physical examination to be considered an essential component of mental health care.

1.2 Development process

These guidelines are based on expert consensus opinion, supported by higher-level evidence where available.

1.2.1 Working Group

A Working Group was formed to facilitate development of the guidelines, and the accompanying policy, that was comprised of expert practitioners from a range of fields, including:

- Nursing
- Psychiatry
- Psychology
- Older people's mental health
- Children and adolescent's mental health
- Clinical governance

Membership of the Working Group is noted under Acknowledgements (pg ii).

Close collaboration and consultation with the Working Group was undertaken at all key stages of development, with each draft of the guidelines taking account of their input and feedback.

1.2.2 Literature Review

A literature review was undertaken encompassing national and international literature relating to the physical health of people with mental illness and the comparison between this group and the general population regarding physical health. Additionally, the review looked at strategies and models of care, both implemented and proposed, for improving the physical health of people with mental illness as well as practical advice and tools for conducting physical assessments of people with mental illness.

This information, together with advice obtained regarding the need to consider issues particularly relevant to the Australian context, such as prevalence of skin malignancies and the high rates of all illnesses in the Aboriginal¹ population, provided a framework for development of the guidelines.

1.2.3 Consultation

A consultation strategy was developed and implemented that ensured key stakeholders were able to review and provide comment on the guidelines. Stakeholders included:

- General Practice NSW
- Mental Health Coordinating Council
- Consumer Activity Network (Mental Health)
- NSW Consumer Advisory Group – Mental Health
- Carers NSW
- Transcultural Mental Health Centre
- Aboriginal Health and Medical Research Council
- Official Visitors
- NSW Health Area Health Service Area Managers of Aboriginal Health

Consultation was also undertaken with NSW Health Area Health Service mental health representatives to enable a sound process for implementation, monitoring and reporting to be developed.

1.3 Scope and Purpose

These guidelines apply to all NSW Health services providing specialist mental health care, and staff working for such services. It should be read in conjunction with the Policy Directive *PD2009_027 Physical Health Care within Mental Health Services*.

The purpose of these guidelines is to provide a framework and, where available, evidence based guidance to assist NSW Health mental health services to:

- Recognise their role in the physical health care of consumers, including advocacy;
- Clarify appropriate linkages with other health care providers;
- Build stronger partnerships with key stakeholders, including GPs, mental health consumers and families and carers;
- Establish minimum expectations for the physical health care of consumers, together with a program to improve standards; and
- Improve the physical health care of mental health consumers.

¹ In accordance with agreed NSW practice, the term "Aboriginal" in this document includes Torres Strait Islander people: See Aboriginal and Torres Strait Islander Peoples - Preferred Terminology to be Used (PD2005_319).

Mental health and physical health care

2.1 Physical Health of Mental Health Consumers

The review of the current national and international literature undertaken as part of the development process for these guidelines revealed a clear consensus that the physical health of people with mental illness is poor. Smoking, alcohol consumption and other drug use, poor diet, lack of exercise, regular use of psychotropic medication and high risk behaviours all contribute to a range of physical illnesses and conditions among this group, including:

- Coronary heart disease
- Diabetes
- Cancers
- Infections
- Obesity
- Respiratory disease
- Dental disease
- Poor outcomes following acute physical illness such as myocardial infarction or stroke.

Although the literature is less informative regarding other conditions, it is likely that consumers with significant mental health disorders also have reduced identification and interventions for other common health problems such as skin malignancies, prostatic disorders, musculoskeletal disorders, and hearing or visual deficits.

Apart from exposure to unhealthy lifestyle risk factors, the poor health of consumers is linked to reduced access to appropriate assessment and treatment. There is a diminished awareness among consumers about physical health and wellbeing issues and many suffer from self-neglect and lack of motivation as well as limited social and communication skills – all of which can impede the ability of consumers to seek medical assistance. Consumers can also have low expectations of health care services associated with previous adverse encounters and

may find it difficult to attend GP surgeries due to the cost or potentially long waiting times.

Health services and staff can also play a part in creating barriers to improving the health of consumers. Misinterpretation of physical symptoms as being part of the consumer's mental illness or late recognition of symptoms by health workers has a significant impact on health outcomes for this group. Failure of health professionals to refer consumers to services and stigma and discrimination towards consumers by health care staff can also be a factor. Additionally, there can be confusion around who is responsible for assessing and monitoring the physical health of consumers, and a lack of knowledge and training within mental health services regarding how to undertake this. A focus upon crisis management by mental health services can also impede a planned approach to meeting the physical health needs of consumers.

2.2 Improving health care for mental health consumers

2.2.1 Taking a collaborative approach

All consumers have the right to expect health care that is in line with the care provided to the general population. Improving the overall health and well being of mental health consumers will entail the recognition by health workers of the importance of identifying and addressing the physical health issues of this vulnerable group.

Adoption of a collaborative, longitudinal, approach by health services to dealing with the physical health needs of consumers is also required; specifically better integration between primary and secondary care, along with adequate training for mental health service staff and psychiatrists on assessing the physical health of those with mental illness. Utilisation of these Guidelines by staff and the development of formal shared care arrangements between mental health services and GPs or other health providers may assist this approach.

Other stakeholders also have a critical role to play in improving the health outcomes for consumers. These include:

- The consumer, who should be recognised as part of the care team and encouraged to participate in their own physical health care.
- The family or carer, who can provide vital support to consumers in addressing physical health issues.
- Mental health NGOs, who can provide further reinforcement regarding the importance of physical health care and may have information in relation to the consumer's health and well-being.

Further information about building or strengthening relationships with these stakeholders is provided in the 'Building Better Partnerships' section (see page 8).

2.2.2 Importance of regular health checks

Regular comprehensive physical examinations and clinical interviews that include measurement of blood pressure and weight, monitoring of respiratory and cardiac status, and targeted investigations, will provide important information about the health of consumers, which is critical to improve health outcomes for this group by ensuring:

- Misdiagnosis is reduced – patients with a physical illness can be misdiagnosed as having a mental illness or disorder or, conversely, those with a mental illness may have their physical symptoms overlooked. Consumers who are elderly, have complex medical conditions, or significant substance abuse, may have multiple active diagnoses.
- Treatment of physical health problems is commenced as soon as possible – delayed treatment has potentially serious implications for a patient's overall health, delaying recovery and increasing length of stay.
- Medication use is tailored – a competent assessment of a patient's physical health helps to tailor medication use and reduce the risk of side-effects as well as giving a clear baseline for comparison so that the clinician is alerted to the severity of the effect of a drug and of the need for action.
- Access is provided to appropriate preventative and early intervention activities – it is essential that those with a mental illness have equivalent access to these activities that have been clearly identified as very important to the health of the general Australian population.

2.2.3 Priority components of physical health care

Poor cardiovascular health has been identified as an important factor in the reduced life expectancy of mental health consumers and so should be the highest preventative health activities priority. Issues particularly relevant to this are noted in 'List A'.

List A

- Obesity
- Diabetes
- Hypertension
- Smoking
- Lack of regular exercise
- Hypelipidaemia
- Other cardiac risk factors

Other important components of physical health care for mental health consumers include:

- Regular dental and optical appointments, together with recognition and assessment of hearing deficits.
- Detection of cancer, eg following of guidelines regarding cervical smears or breast examination for women, or testicular self-examination in men.
- Identification and monitoring of potential side-effects of treatment.
- Provision of follow-up care and advice for most areas including diabetes, asthma and health promotion.
- Inclusion in preventative health management activities to address health issues such as poor diet, smoking, alcohol abuse, personal hygiene, inactivity and obesity.

2.2.4 Strategies for service improvements

There are many mental health services that are already working to improve the physical health of mental health consumers through the implementation of innovative practices. The following suggested strategies were raised within the consultation process undertaken when developing these Guidelines and some have also been adapted from *Healthy Body Healthy Mind, Promoting Healthy Living for people who experience mental health problems - A guide for people working in inpatient services* (National Institute For Mental Health In England (NIMHE) (2004) *Healthy Body Healthy Mind*. NIMHE, England).

These strategies may be useful when considering practice and service improvements that focus on the physical health of consumers. Adaptation is likely to be required to meet local resource and policy environments.

Strategies

- Assessment of staff attitudes and needs for training and support on physical health care.
- Centrally located container to hold required equipment for conducting physical examinations.
- Area Health Services promoting the importance of the physical health of mental health consumers, to staff as well as consumers and carers.
- GPs or practice nurses attached to inpatient or community services to monitor and review physical health care.
- Written information readily available to consumers and carers on general physical health issues, the links between physical health and mental health and physical health issues particularly relevant to mental health presentations.
- Achievable targets to access health services and health promotion, eg access to the dentist, podiatrist, access to smoking cessation, increased activity, increased requests for information.
- Healthy living groups in inpatient wards, covering topics such as smoking, weight-gain, exercise and relaxation.
- Specific clinics in primary care, advertised through community mental health teams and delivered with local support workers.
- A co-ordination position between secondary and primary care, based in the local community mental health service, or responsibility given to an existing position (eg Shared Care Coordinator, Clozapine Coordinator) to oversee accessing of primary care and physical health reviews.
- Liaison position within primary care to encourage groups who do not engage with primary care services specifically, including mental health consumers.
- Links with local services, such as the gymnasium or squash or tennis courts, to improve access for mental health consumers, to improve levels of social inclusion and to improve physical health.
- Effective dietitian services where mental health specialists advise service providers, support other colleagues and assess and encourage consumers individually.
- Effective physiotherapy services delivered throughout secondary care, including linking into generic services for consumers within the community.
- Software installed in each service to provide overall management of the physical health of consumers, including a prompting system that advises when investigations are due or required and enables results to be logged by various health practitioners (eg GP, optometrist, dietician etc).
- Web based module that enables GPs and other health practitioners to access clinical records offsite and record physical health examination outcomes through a single login and password.

2.3 Principles of care

Physical health care in all mental health settings needs to take into consideration the following principles:

- Mental health consumers are entitled to quality, evidence based care and treatment for all aspects of their health, including their physical health.
- Such care and treatment for mental health consumers:
 - Is delivered in a respectful, non-judgemental and culturally sensitive way, with information about their illness, physical condition and treatment options provided to enable them to make informed choices.
 - Recognises consumers as critical partners in the care team.
 - Involves their families and carers, with the consent, wherever possible, of consumers.
- The physical health of mental health consumers is considered by mental health services in the planning and provision of any mental health interventions.
- Working collaboratively with other health providers, particularly GPs, is key to providing quality physical health care for mental health consumers.
- Physical health care includes access to health promotion, screening and preventative activities.
- The provision of physical care is responsive to issues such as consumer preferences, gender, ethnicity, English proficiency and age.

Building better partnerships

3.1 General Practitioners (GPs)

3.1.1 The role of the GP

The General Practitioner (GP) has a critical role to play in improving the physical health of mental health consumers.

In Australia, the GP is often the first point of contact for people with a mental health issue or illness and will often go on to provide the mental health care for this group or provide referrals to appropriate services. This gives GPs the opportunity to provide early identification of and treatment for the physical health problems of mental health consumers. GPs are also uniquely placed to provide information and support to the consumer, as well as their family and carers, in relation to physical health or lifestyle issues, as well as to provide long-term continuity of care and monitoring of the physical health of consumers.

GPs are generally accessible health service providers that are able to deliver services from environments that are familiar to most people. However, a significant proportion of consumers with a serious mental illness do not have a regular GP. This is due to a variety of reasons, including the cost of attending a GP that does not bulk bill, difficulties in identifying a GP with an interest and training in mental health care, communication difficulties between the consumer and GP, problems associated with the consumer getting to a GP, and the stigma and discrimination surrounding mental illness.

These issues can be addressed in part by the establishment of strong working relationships between GPs and mental health services at a local level.

3.1.2 The importance of collaboration

While mental health services have clear responsibilities in relation to ensuring that consumers involved with their service receive appropriate physical health care, this would need to be achieved through collaboration with the consumer's GP or, in an inpatient setting, with appropriate health staff.

Outside of inpatient settings, GPs would, wherever possible, be the primary providers of physical health care for consumers. Mental health services need to work in partnership with GPs in this endeavour, as well as assist consumers to access appropriate physical health care, including those not engaged with a GP. This is particularly significant for community mental health services, where the GP can offer vital support in both conducting physical examinations and providing information about the consumer's physical health history.

3.1.3 Strengthening relationships with local GPs

GPs should be considered an integral part of the mental health care team, particularly in terms of improving the physical health of mental health consumers. Developing shared care arrangements with a consumer's GP, or linking consumers with a GP in the area, should be a priority for mental health services. To support this, a strategy should be developed, at either a local or Area Health Service level, to strengthen relationships with local GPs.

Factors to consider when developing such a strategy include*:

Communication

GPs often have significant time pressures which impact on their ability to liaise with other services. Mental health services can assist by being aware of this and giving consideration to the types of communication strategies that might support productive liaison and information sharing. Valuable information to be aware of at an early stage includes:

- Constraints on the availability of GPs
 - What is the best time to phone?
 - Will face-to-face meetings be possible?
 - What are the practice hours?
- Effective means of communication in particular situations

* Adapted from Sharing the Care - General Practitioners and Public Mental Health Services, Department of Human Services, VIC Health

- Are letter, fax and phone all possibilities?

The proforma letters at Appendix 1 and 2 (pages 27 and 29) provide an example of communicating with a GP to request a physical examination for a consumer. A phone call to explain this process to the GP, or to check its appropriateness for the GPs practice and how it will work when implemented, may assist in its success.

Confidentiality

Both the GP and the mental health service providers are bound by confidentiality requirements. Confidentiality relating to clinical records and personal information is subject to both ethical and legal protection, and managers of mental health services must ensure that staff are aware of their obligations under the Mental Health Act 2007 and the Health Records and Information Privacy Act 2002.

While the requirements allow for information in connection with the further treatment of a patient to be exchanged, it is important to ensure that respect for confidentiality of personal information acquired by service providers in the course of their business is given the highest priority and, whenever necessary, consent is sought from the patient for disclosure of information.

Key Personnel

While the GP is in many cases a sole practitioner, mental health service staff work in multidisciplinary teams and more than one team member may contribute to the service response for a particular patient. Relevant staff for the GP to be aware of in mental health services includes:

- Case manager/Care coordinator (all patients are allocated a mental health worker).
- Treating doctor or psychiatrist.
- An emergency contact in the event of an emergency and where the Care Coordinator and/or treating doctor are not available.

Including GPs in Mental Health Networks

Directors of Clinical Services, managers of community mental health services, team leaders and coordinators and the GPs themselves, will all be important players in the development and maintenance of effective networks.

Strategies to ensure that GPs are included as part of an area mental health network might include:

- Development of a mailing list of GPs in the local area.
- Distribution of up to date information describing the range of mental health services in the area and their organisational structure.
- Establishment of lunchtime or evening forums for networking, information exchange and educational initiatives for GPs and mental health workers in the area.
- Involvement in local research initiatives.
- Liaison meetings between the community mental health service and the local GP Division to identify barriers to cooperative working relationships or to develop cooperative initiatives.

Establishing Professional Linkages

Professional linkages can be effectively developed and maintained by:

- Knowing which GPs in the local area have an interest in seeing individuals with mental health related problems and take an active involvement with people who have a mental illness.
- Providing regular and up to date information to all GPs in the area about the organisation and delivery of the mental health service.
- Seeing GPs as important users of the mental health service and providing them with a prompt service response.
- Building linkages with bilingual GPs or those who have close practice links with specific ethnic communities.
- Always giving timely and regular feedback to GPs by phone, fax or letter about shared or referred patients.
- Recognising the importance of negotiating clear roles and responsibilities with GPs when entering into shared care arrangements.
- Empowering GPs to be more active in the provision of care to people with mental health problems.

3.2 Mental Health Consumers

3.2.1 The role of the consumer

Consumers are the most appropriate people to judge when they need intervention or treatment for a physical health complaint. Accordingly, they need to be active participants in their own physical health care to determine their own health outcomes, be involved in, and as far as is practicable make decisions about, their own care and to assess the benefit of different treatment options.

Studies have indicated that consumers often feel that once they have received a diagnosis, their physical health is neglected (Sayce 2000, Dean et al 2001). However, these same studies note that many consumers have a high level of interest in and commitment to improving their physical health and accessing information about health related topics. While some consumers may need a level of support and encouragement to address their physical health issues, it is important that services engage consumers and encourage their participation in their health care rather than see them as passive recipients of such care.

This is especially relevant given the high rates of smoking and poor diet among people with mental illness – action and commitment by the consumer combined with encouragement and support from the service is essential to address these health issues.

3.2.2 Empowering consumers

Health services and clinicians need to respect the voices of consumers and their capacity to be independent and self-reliant if they are to participate in their own physical health care.

Such participation requires involvement, sharing or interaction with clinicians and other health staff, with consumers afforded the opportunity to speak out, have an opinion and be listened to.

To empower consumers to play a greater role in determining their own health outcomes, they should also be provided with information and advice about their rights and the obligations of the service regarding their physical health care, as well as:

- Details of the consumer's physical health diagnosis.
- Treatment options, including risks, benefits and potential side effects.

- How such treatment may interact with any prescribed medication for the consumer's mental illness.
- The agreed treatment plan.
- Planned follow up care.

This information will help consumers to know what to expect of the service, be involved in decisions about their own care and more readily see the benefit of treatment.

3.2.3 Helping consumers to help themselves

Apart from advice regarding any existing health conditions, consumers need to be targeted with health promotion information on topics such as smoking cessation, diet, and nutrition and weight control. They also need basic information about:

- The physical health risks that are prevalent for consumers.
- The connection between good physical and mental health.
- The importance of consumers having a regular GP.
- The need for consumers to have a regular physical examination.

An example Information Sheet has been provided at Appendix 3 (page 31) that provides some guidance regarding how to communicate these important points.

Services can also offer direct support to consumers to enable them to address their physical health issues by:

- Helping consumers make an appointment with their regular GP.
- Putting them in contact with a local GP that is experienced in treating people with a mental illness.
- Providing consumers with a reminder regarding health care appointments.
- Offering to accompany consumers on their health care appointments to support them to communicate about their health issues and articulate their symptoms.
- Organising transport for consumers to enable them to attend health care appointments and return home or to the service.
- Encouraging consumers to share information about their physical health with their family and carer/s so that they can receive their support.

- Establishing or linking consumers with a weight management group to support healthy eating as well as developing other skills such as nutrition awareness, shopping and cooking.
- Checking that consumers are receiving adequate meals, and arranging help with this where necessary, including recommending a suitable diet.
- Linking consumers with appropriate education programs or services regarding smoking cessation or organising information sessions within the facility to encourage consumers to take this step.

3.3 Carers and Families

3.3.1 The role of the carer

The majority of care for people with a mental illness occurs in the community, making carers and families of a consumer an integral part of the care team.

The partnership that generally exists between a carer and the consumer they support enables carers to provide timely, significant and detailed information regarding the physical health of the consumer. Carers can also play an important role in supporting the general health and wellbeing of the consumer, often arranging appointments and liaising with health care professionals, administering medication, preparing special diets, assisting with therapies and treatments and dressing wounds.

Critical emotional support provided by carers and families can help consumers adhere to medication regimes and encourage them to make healthy lifestyle changes, such as cessation of smoking.

Accordingly, carers should be acknowledged as partners in care and included in every stage of assessment and care planning, with the agreement of the consumer. Advice regarding the inclusion of carers when dealing with consumers who are children or adolescents is provided in section 6 of these Guidelines entitled "Special Populations" (page 23).

3.2.2 Recognition of carers

The NSW Government has formally recognised carers and the critical role they play in improving the quality of life and the health outcomes, both physical and mental, for consumers through the development and implementation of the NSW Carers Action Plan. This

plan outlines a whole of government policy commitment to recognising and supporting carers and requires Area Mental Health Services to develop Area Health Service Carer Action Plans that demonstrate implementation.

The Mental Health Act 2007 also outlines the requirement for services to include carers by giving them greater access to information about the consumer while still allowing consumers to have some control regarding who is to be provided with information about them. The new Act achieves this by:

- Enabling consumers to nominate a particular person to be their 'primary carer' so this person can receive information and be involved in treatment planning.
- Establishing a process for identifying who will be the primary carer when the consumer is not able to or does not nominate a particular person.
- Enabling consumers to exclude a person or persons who they do not wish to receive information about them or their treatment.

Further information regarding the Mental Health Act 2007 can be found on the NSW Health website at <http://www.health.nsw.gov.au>

3.2.3 Engaging and informing carers

Services that respect and value carers, and work closely with them, ultimately provide a better level of care to the consumer. To engage carers at a local level regarding physical health issues, mental health services need to consider how to provide adequate information that is easy to read and understand. The example Information Sheet at Appendix 3 provides text that services may wish to use in developing their own information for carers.

Services should also ensure that they gain the consent of the consumer to advise a carer regarding:

- Possible physical side effects of any medication the consumer has been prescribed.
- Outcomes of their physical examination.
- What treatment has been recommended for any physical health issues.
- When the next physical examination is due and who will conduct it.

3.4 Mental Health Non-Government Organisations (NGOs)

Mental health NGOs can play a pivotal role in improving the physical health of mental health consumers through a range of interventions - from promotion and prevention to early intervention, family and peer support, mentoring and counselling, community awareness activities and education and training.

Through their delivery of practical and innovative services to both consumers and their families and carers, NGOs often have first hand knowledge and understanding of the physical health issues experienced by consumers. In many cases, an NGO can be a consumer's primary non-clinical service provider. This makes NGOs important stakeholders whose capacity to support and encourage consumers to focus on their physical health needs should not be undervalued.

NGOs can also provide advice to mental health services in terms of service planning and delivery as well as appropriate approaches to effectively engage consumers. Working collaboratively with NGOs at an Area Health Service level can help to ensure a complementary approach is taken to raising awareness about physical health issues for consumers, which avoids duplications, provides continuity of care and more efficient use of limited resources.

Clinical guidance for all mental health settings

4.1 Chaperones

For physical examination that requires removal of clothing, or palpation of more than limbs, (such as initial examinations), two staff members will need to be present unless a requirement for urgent care prevents this, or the consumer specifically requests this does not occur. In such situations the reason for not using a chaperone must be documented. Issues of sensitivity, age, consumer personal history, gender, and ethnicity should be considered. The second staff member may be a qualified healthcare interpreter if they are agreeable to this role. Staff availability requires consideration, but usually one staff member should be of the same gender as the consumer. It may sometimes be appropriate for a family member, friend or carer to be present during the examination.

4.2 Equipment

Inpatient setting

All mental health inpatient units should have, or have ready access to, the following equipment:

- a private, warm, well lit area with an examination couch or bed suitable for conducting of physical examinations, together with sheets or towels.
- stethoscope
- sphygmomanometer
- thermometer
- tendon hammer
- non-stretchable measuring tape
- tuning fork (256 Hz)
- weighing scales
- urinalysis sticks
- Auriscope and ophthalmoscope
- Examination torch

- Snellen chart
- Height measure
- Disposable gloves
- Examination lubricant
- Neurological testing pins
- Peakflow monitor
- Glucometer
- Alcometer/ breathalyser
- Oximeter
- X-ray box or electronic substitute
- Pathology venipuncture and associated collection equipment
- Pathology specimen containers.

Community setting

Community mental health services should have a clear mechanism for accessing the above equipment for consumers whose need for physical examination cannot be met through collaboration with GPs. This mechanism could involve strategies such as organising to transport the consumer to an appropriate facility that has the required equipment.

4.3 Initial Physical Examination

- Physical examination should occur in the context of obtaining an appropriate medical and drug and alcohol history.
 - Such history should be recorded in Mental Health Clinical Assessment Documentation and include information regarding family history of heart disease, diabetes or other major medical conditions and major health related behaviours such as exercise, diet and smoking.

- Wherever possible such history should be informed by a review of previous records and, with appropriate consent, collaborative history from the consumer's GP or other appropriate person.
- Note that older consumers have increased risk of significant medical co-morbidity. A raised index of suspicion should therefore occur for consumers > 65yo.
- Note that Aboriginal consumers have increased risk of medical comorbidity, to the extent that it may be regarded as the norm (Kowanko et al, 2003).
- For all admitted consumers >65 yo, or otherwise considered at increased risk of falls, a falls risk assessment consistent with *PD2005_353 NSW Health Management Policy to Reduce Fall Injury Among Older People* should occur. The need for such assessments for consumers in community care should be considered.
- It is expected that the Mental Health Clinical Documentation Physical Examination module be completed, or an entry made in the Assessment documentation explaining its omission (under 'Physical Examination Summary') (eg 'not applicable because...'). 'NAD' or other acronyms or ticks without comments are inadequate entries. Core components of a physical examination of a consumer admitted to inpatient or community mental health care are:
 - Observations - BP, pulse and respiratory rate, temperature.
 - Weight and waist-hip ratio or waist measurement.
 - Height (if not already recorded from previous contact).
 - Examination of respiratory, cardiovascular and gastrointestinal systems.
- Initial examination of the neurological system including at least notation regarding presence or absence of marked abnormality of key features such as:
 - equality of pupil size, or eye movement.
 - facial symmetry
 - limb and hand power
 - gait
 - limb tone
 - orientation and alertness
 - involuntary movement or akathisia (the Abnormal

Involuntary Movement Scale may be used to assist this if clinically appropriate).

- It is preferable to measure the weight and waist-hip ratio of consumers, however if this is not considered appropriate, weight and waist measurement may be used. See Appendix 5 for further information.
- A more complete neurological examination should occur at some stage for community consumers if there are any concerns regarding neurological issues raised from history or initial examination; and in the inpatient admission of all consumers admitted for the first time, or if this has not occurred within the last 12 months.
- For all inpatient admissions, physically distinguishing features (eg scars, physical deformities) and evidence of physical injury (bruising, lacerations, pressure sores, fracture, signs of drug abuse etc) shall be examined for and documented. Any limitation on the examination (eg unwillingness to be uncovered) should be documented. Such an examination should occur for community admissions if clinically indicated.
- The documentation of additional physical assessment information should be undertaken as clinically indicated. This may include more complete neurological examination, notation regarding nutritional status, or examination of other systems such as lymphoid/haemopoietic, musculo-skeletal systems, genito-urinary examination or breasts.
- Physical examination should be conducted by appropriately trained staff. Most frequently this will be medical or nursing staff, but other disciplines may be involved.
- Local policies will need to clearly delegate responsibility for completing aspects of physical examination and relevant Mental Health Clinical Documentation.
- Services must establish a program to progressively improve their compliance with the specific physical health needs of consumers. Sources of further information to assist this are provided in Appendix 6.

4.4 Investigation

Investigations should be guided by history and physical examination and so none should be considered to be mandatory and few 'routine'. Given the increased health risks faced by mental health consumers, their known common co-morbidities, and known risks of psychotropic medications, the table on page 15 provides guidance on the investigations that may be appropriate to conduct, or access recent results of, whilst in the care of mental health services.

TABLE: Investigations that may be appropriate to conduct, or access results regarding, association with mental health care

Investigation	Acute inpatient care	Non-acute inpatient care	Community care	Comments / Variation
Most new admissions to care				
EUC	+	+	+	
LFT	+	+	+	
FBC	+	+	+	
Serum levels of relevant psychotropic drugs	+	+	+	
Urinary Drug Screen	+	+	+	Adults < 65yo
ECG	+	+	+	Adults >45yo, or if clinical indications
Urinalysis	+	+	+	Adults > 45yo, or if clinical indications
ESR or CRP	+	+	+	Adults > 65yo
BSL	+	+	+	Adults
Lipid profile (within 6 months)	+	+	+	Adults
Beta HCG if adult female and potentially sexually active	+	+	+	In community, if considering commencing new medications
Other investigations as clinically indicated	+	+	+	
Additional investigations for first presentations or major change in mental health presentation				
Thyroid Function Tests	+	+	+	
Serum calcium/phosphate	+	+	+	
B12/folate	+	+	+	
Cerebral CT or MRI	+	+	+	
CXR (esp. adults >55yo or smokers)	+	+	+	
MSU	+	+	+	In community if female or >65yo
Other investigations as clinically indicated	+	+	+	
If indicated by clinical presentation or history				
Syphilis serology	+	+	+	
HIV serology	+	+	+	
Other serology eg Hepatitis A, B or C	+	+	+	
ANA, other immunological investigation	+	+	+	
Urinary catecholamines	+	+	+	

TABLE: Investigations that may be appropriate to conduct, or access results regarding, association with mental health care (continued)

Investigation	Acute inpatient care	Non-acute inpatient care	Community care	Comments / Variation
If indicated by clinical presentation or history				
EEG	+	+		
Investigations associated with long term health risks				
Cardiovascular				
BSL or fasting BSL	+	+	+	Minimum 3-6 monthly on antipsychotics, annual for adults > 65 yo
Lipid profile	+	+	+	Minimum 12 monthly adults on atypical antipsychotics or >= 65 yo
Hb A1C	+	+	+	If confirmed diabetes and not conducted within last 3 months
Other				
Pap smear				
		+	+	Potentially sexually active females 18-70 yo if not conducted within 2 years. >70 yo- as decided by GP
Mammogram		+	+	Females aged 50-70 years if not conducted within 2 years
Faecal haemocult blood		+	+	Consumers >= 50 yo if not conducted within 12 months *
Bone mineral density scan		+	+	If clinical indications

- Risks associated with potential interventions should be considered in decisions.
- Appropriate consent (including consideration of duty of care, Mental Health Act 2007 and/or Guardianship Act issues) must be obtained for investigations.
- In inpatient care it is the primary responsibility of the mental health service to ensure appropriate investigations occur.
- In all settings, where consent allows, such investigation should occur in the context of liaison with a consumer's primary healthcare provider (usually GP) to prevent duplication and encourage appropriate ongoing care strategies. Clinical judgment should be used in determining if a previous investigation has occurred within a relevant time-frame.
- If clinical decisions are made to not conduct investigations, or that it is not feasible to conduct certain investigations, these should be documented.
- The primary responsibility of community mental health care is to ensure that appropriate investigations have occurred prior to entering the service, or as part of a new assessment. This should occur, with appropriate consent, by accessing appropriate hospital records and/ or communication with previous service providers and the consumer's GP.
- Referral to secondary care shall occur if a positive result occurs in the absence of oral iron supplementation for an identified condition.

4.5 Ongoing Physical Health Care

- Setting specific issues are addressed in the 'Specific Mental Health Setting' section of these Guidelines (see page 19).
- In all settings, attempts should be made to contact, with appropriate consent, the GP or other primary healthcare provider, of all consumers.

- In all settings, care plans for all consumers must address physical health needs, including alerts, special precautions, and plans to address acute and/or ongoing physical health issues.
- In all settings, all mental health clinical staff have some responsibility with regards to the continuous assessment of the physical health care needs of patients. This is achieved by observation and direct enquiry and must be documented in the patient's medical record. Medical and nursing staff are particularly expected to apply their professional knowledge in this regard.
- Unless the consumer specifically declines, all consumers must have their weight and/or waist-hip ratio (WHR) measured by the mental health service at least every 6 months. This will need to be more frequent if the consumer is identified as over-weight (BMI>25 or WHR >1). It is preferable to measure the waist-hip ratio of consumers, however if this is not considered appropriate, weight and waist measurement may be used.
- Health interventions that have been identified as particularly relevant to the long term health status of mental health consumers are listed below. 'List A' includes those that are particularly relevant to cardiovascular health and 'List B' are other potentially indirect interventions.
 - List A**
 - Smoking cessation (if relevant).
 - Weight control interventions, including dietary and life-style advice, if BMI > 25 or WHR > 1.
 - Regular exercise.
 - BP monitoring.
 - List B**
 - Contraceptive advice (if of reproductive age) and sexual safety advice.
 - Visual acuity and clinical hearing evaluation, with referral to secondary care if any abnormalities.
 - Dental review if not conducted in previous 12 months or a need is identified prior to this.
 - Education on breast (women) or testicular self examination and symptoms of prostatism (men over 55 years).
 - Provision of information regarding HPV vaccination (females <27yo).
- Influenza vaccination when indicated.
- Examination for skin malignancies.
- Contraceptive (if of reproductive age) and sexual safety advice.
- Education on risks related to alcohol and illicit drug abuse.
- The *Physical Health Mental Health Handbook* provides additional relevant information that can be used to assist identifying such needs and considering management options. Refer to Appendix 6 (see page 36) for information on where this resource can be accessed.
- In all settings, Mental Health services will need to:
 - Have clear criteria for when nursing or allied health staff should notify medical staff of concerns about the physical health of consumers.
 - Have clear protocols for identifying and responding to medical emergencies.
 - Ensure rehabilitation and recovery programs include activities relevant to physical healthcare.
 - Ensure that for consumers receiving ongoing care (>3 months inpatient, >6 month community) there are clear protocols to identify and develop consumer management plans that address consumers' needs related to chronic health conditions and preventative health care. These must:
 - Ensure the issues in 'List A' have been discussed with the consumer, provided/conducted if appropriate, or reasons for not taking this step documented. Once a service has a system to ensure investigations or interventions in 'List A' occur, they should aim to improve the access of consumers to interventions in 'List B'.
 - Address any physical health needs identified relevant to mental health interventions they are receiving. Appendix 6 provides useful references to assist this and the proforma table found in Appendix 4 may assist in monitoring the provision of ongoing health needs in non-acute settings.
 - Identify the role of mental health services and other service providers. Where other service providers are nominated for roles the mental health service should ensure these are appropriately negotiated and agreed to.

4.6 Inability To Cooperate

In circumstances where a consumer is unable to cooperate, there should be a record in the appropriate Mental Health Clinical Documentation (eg Physical Examination, Assessment module/s) of:

- Why the consumer was unable to co-operate.
- What can be observed with regards to their physical health.
- What has been attempted or advised.
- Strategies or plans to meet the consumer's physical health needs, including examination, at the earliest opportunity.

4.7 Actions At Discharge

- If any physical health care issues are identified, follow up mechanisms must be identified and arranged in conjunction with the consumer (and/or their primary carer, as outlined in the Mental Health Act 2007). This must include providing guidance, where required, in managing physical health issues that may arise from psychotropic medications or other mental health interventions.
- Opportunities to involve family or carers in such discussions are encouraged. Details of discussions and arrangements must be documented in the consumer's clinical record.
- Wherever possible these should also be discussed via phone with the consumer's GP or other primary healthcare provider, and details of the communication documented in the consumer's clinical record.
- The Mental Health Clinical Documentation Transfer/ Discharge Summary must include documentation of relevant investigation results, physical examination findings (including patient weight), significant physical health interventions and their outcomes, physical health issues at discharge and follow up arrangements that are confirmed or require arrangements.

Clinical guidance for specific mental health settings

5.1 Inpatient mental health care

5.1.1 Responsibilities

Within this setting mental health services have the responsibility for ensuring that:

- The acute physical health care needs of inpatients are identified, assessed and managed in a timely and effective manner.
- Access to medical or surgical support for inpatient mental health consumers is equivalent to such support available for non mental health inpatients.
- Access is available to appropriate mental health care for consumers with co-morbid physical health disability. Mental Health Service policy shall define any limitations in inpatient units' ability to meet physical health care needs, and identify mechanisms for access to mental health care for consumers with such needs.
- Consumers in non-acute inpatient units have their ongoing physical health needs identified, assessed and managed. This includes appropriate access to health promotion, screening and preventative activities and incorporating physical health goals and activities in rehabilitation and recovery programs.
- Follow up mechanisms are identified and arranged for identified physical health care needs, and appropriate information is communicated at discharge to support this.

5.1.2 Timing

- All admissions should receive a physical examination at the time of admission, or at least within 24 hours of admission, where this delay is deemed clinically appropriate. This should be noted in the patient's notes, giving reason for the lack of physical examination and plans for when it should occur.
- If the Mental Health Clinical Documentation of an adequate physical examination from within the previous month accompanies the transfer of a

consumer between mental health units then a repeat physical examination may not be required unless considered clinically indicated by the responsible consultant medical officer or delegate.

- All consumers in non-acute care should have a physical examination and focussed interview consistent with standards described for 'initial examination', plus examination for movement disorders, no less frequently than every 12 months. For patients who are 65 years or older, or whom are known to have significant active physical illness or disability, this should be no less frequently than every three months.
- A more comprehensive physical assessment than it is reasonable to routinely expect of Emergency Department staff is required for consumers admitted to mental health inpatient units. Unless there is an agreement for satisfactory completion of the Mental Health Clinical Documentation Physical Examination in the Emergency Department, patients must be re-examined within 24 hours upon admission to a mental health unit from an Emergency Department.

5.1.3 Observations

- All patients should have their physical observations taken and recorded on admission by the admitting nurse. Admission observations include: TPR, BP (lying and standing), oxygen saturation, height, weight, BMI, waist-hip ratio, urinalysis, BSL (if indicated). These should be undertaken as soon as possible.
- Weight and waist hip ratio should be compared with the last recorded weight and the medical team notified if there has been a significant change.
- Unless there are specific contraindications, all patients require daily monitoring of BP and TPR for three days, and more frequently as clinically indicated or as directed by the treating team. After three days the frequency of observation may be reduced, to a minimum of weekly in acute settings or monthly in non-acute care. However, patients 65 years old or older, or with active co-morbid physical health conditions, should usually

have at least twice daily observations for three days then continue to have at least daily observations during acute care or weekly in non-acute care.

- All patients in non-acute care should continue to have at least monthly weight and waist-hip ratio measurements. It is preferable to measure the waist-hip ratio of consumers, however if this is not considered appropriate, weight and waist measurement may be used.
- Additional physical observations and monitoring will be determined and reviewed by the treating team.

5.1.4 Ongoing Physical Health Care

- Mental health inpatient services should negotiate clear protocols for accessing assessment and interventions from other healthcare providers (eg medical or surgical consultation, allied health services not provided directly by the mental health service). Services must advocate for such access if there appears that this is not equivalent to that available to non-mental health consumers.
- If chronic or preventative health care needs are identified during an acute admission then appropriate follow up arrangements should be arranged in consultation with the consumer and their nominated primary carer.
- Additionally inpatient units providing care for consumers for periods greater than three months must ensure that interventions and investigations relevant to ongoing health care have been discussed with the consumer, provided/conducted if appropriate, or reasons for not acting documented.

5.2 Community mental health care

Physical healthcare of mental health consumers in the community relies upon effective partnerships between mental health services and other healthcare providers.

5.2.1 Responsibilities

Within this setting mental health services have the responsibility for:

- Ensuring that the physical health of a consumer is considered in the planning and provision of any mental health interventions.
- Ensuring a process occurs to exclude physical causes in consumers at increased risk. Physical causes may include pharmacological causes.

Notable groups in this regard are:

- Consumers with first presentations of mental illness or major changes in their mental health presentation.
 - Those who are aged 65 years or older.
 - Those with known complex pre-existing medical conditions.
 - Aboriginal people.
- Minimising the risk of adverse physical health outcomes due to the provision of mental health interventions.
 - Actively seeking to improve partnership arrangements with providers of physical health care most relevant to the consumers who use their services.
 - Assisting consumers to access:
 - Physical health care equivalent to the general population.
 - Appropriate inclusion in health promotion, screening and preventative activities.
 - Physical health care needs arising from mental health interventions or their mental illness.
 - Advocating for improvement in such access, if required.
 - Identifying consumers who, due to the severity of their mental illness, have a persistent inability to access mainstream primary health services; and identifying specific mechanisms to meet their physical health needs.
 - Incorporating physical health goals and activities in rehabilitation and recovery programs.

5.2.2 Timing

- Where a mental health clinician believes that the consumer may have a delirium or poorly controlled medical problem with immediate risks, they should facilitate urgent medical assessment. Where possible the consumer's GP should be contacted to determine their desired involvement. If the GP is not able to provide timely care, measures should be taken for the consumer to be appropriately transported to an Emergency Department.
- The need for physical examination and investigations needs to be considered as part of all initial assessments. If considered required, these may occur through the mental health service conducting them

directly or communicating appropriately with other health professionals involved with the consumer.

- An example of a proforma that may assist with communication with other health care providers is at Appendix 1.
- For consumers admitted to community mental health care, all attempts must be made to have a physical examination and consideration of investigation as soon as feasible. This must be conducted within 1 month of a new admission to community mental health care. Note 'Initial Physical Examination' section (see page 13) regarding who may conduct this examination.
- All consumers in community mental health care must have a physical examination consistent with standards described for 'initial examination' no less frequently than every 12 months. Wherever possible this should be conducted in the same manner as described for the initial examination.
- For consumers who are 65 years or older, or whom are known to have significant physical illness or disability, this should be no less frequently than every six months.
- All consumers taking antipsychotic medications, or who are otherwise identified as being at increased risk of movement disorder, shall have an annual examination for movement disorders by the mental health service (see Appendix 5 for pro-forma).

5.2.3 Assisting access to physical health care*

- When a consumer is referred to a community mental health service, strong efforts should be made, with appropriate consent, to communicate with their nominated GP.
- The service should liaise with the consumer's nominated GP within the community when:
 - The consumer is admitted to or discharged from an inpatient unit.
 - The mental status of the consumer significantly alters.
 - The physical health of the consumer significantly alters.
 - Medication is significantly altered, especially where there is a significant risk of physical side-effects (eg Clozapine).
 - Physical treatments such as Electroconvulsive Therapy (ECT) are being considered.

- If a consumer in the community is not accessing medical health care, the mental health service should make reasonable efforts to link the consumer with an appropriate health care provider. Where this is not achievable, such as for a severely paranoid consumer who refuses to access services, this should be documented in the clinical record and the consumer's condition monitored for an opportunity to successfully refer them.
- There may be a need to link a consumer to specific services such as specialist outpatient clinics or dental services. Some consumers will require support to help them keep the appointment. This should be provided by non-government support organisations where available, but may sometimes require the direct involvement of mental health staff.
- Where a mental health clinician believes that the consumer may have a poorly controlled medical problem and may be at significant risk due to their medical condition, reasonable steps should be taken to ensure prompt physical assessment. Such steps may include physical assessment by a medical practitioner from the service or ensuring the consumer is conveyed to their GP or an emergency department.
- Services will need to take actions to identify GPs or other health providers who have a particular willingness to provide primary healthcare services to consumers of mental health services.
- Services may assist communication with primary healthcare providers if physical health care needs are identified. This should include communication regarding healthcare needs arising from mental health interventions.

5.2.4 Physical examination

Initial physical examination

- Initial physical examination may be by a staff member of the mental health service, or by another health professional (such as the consumer's GP).
- When discharged from inpatient care, a copy of the Mental Health Clinical Documentation Physical Examination module with details of a completed physical examination should accompany the consumer.

* (Adapted from Physical Examination, the Annual Examination and Attention to Clients' General Medical Health Needs, Office of the Chief Psychiatrist, Victoria 2002).

- Staff should also ensure they have access to information regarding medications and medical history from the Mental Health Clinical Documentation Assessment module. If this occurs, a repeat examination is not required unless clinically indicated.
- Where examination is conducted by another health professional, then the mental health service should ensure that there is a record that such an examination has occurred, and any reported significant findings or proposed subsequent action. If any gaps between the examination conducted and the Guidelines for initial physical examination are identified the service shall make attempts to remedy these.

Ongoing physical health care

- Ongoing monitoring for the emergence of physical health care needs of consumers is the responsibility of all clinical staff, particularly medical and nursing staff. This is achieved by observation and direct enquiry and must be documented in the consumer's medical record.
- Where consent allows, such monitoring and investigation should occur in the context of liaison with a consumer's primary healthcare provider (usually GP), preventing duplication and encouraging appropriate ongoing care strategies. If a consumer has a regular GP, it is reasonable for the mental health service to request that the GP takes responsibility for the ongoing general preventative health care of the consumer. However the mental health service should communicate with the GP regarding the above Guidelines, and continue to follow the advice in the section 'Assisting access to physical health care' (see page 21).

Special populations

6.1 Family and/or primary carer

A key component in improving the physical health of mental health consumers is the involvement of the consumer's family and/or primary carer. Mental health staff need to keep the family and/or primary carer informed, with the permission of the consumer, of the consumer's physical health status. Family and carers have an important role in supporting consumer's to take care of their physical as well as their mental health and should be equipped with practical strategies, knowledge and skills to help them with this role.

Family and/or primary carer involvement in physical care and treatment planning should be a priority, enabling their direct input into planning for the short and long term. Where required, interpreters should be used to explain any identified health issues and how they will be addressed to families and/or the primary carer. Age appropriate information should be provided for children and young people who are in the care of, or have contact with, a consumer with mental illness.

6.2 Consumers who are children or adolescents

At initial assessment of a child or adolescent consumer, physical examination may include developmental assessment and specific issues such as screening for sensory deficit in developmental delay. It is also important to be aware of potential issues, such as physical or sexual abuse, and to remain alert for physical signs.

Things to consider when conducting a physical examination of children or adolescents include:

- a) Organisation – having a planned approach and ensuring equipment is in good working order and close to hand will help children and adolescents to feel confident and support the examination to run smoothly.
- b) Flexibility – this is a critical element in the physical examination of children and adolescents and should be adopted in the overall care and treatment of this group. For example, the presence of a parent or the use of a doll (to explain a procedure) may be appropriate.
- c) Safety – be careful of fittings and equipment in the examination area. Reviewing the environment from a “child’s perspective” (ie below adult eye level) may assist in this process.
- d) Communication – explaining what is happening in age-appropriate language and reassuring the child or adolescent is vital. Obtaining feedback from them to assess their understanding of procedures is recommended and is likely to improve their co-operation.
- e) Privacy – younger children may prefer the parent/carer to be in the room but modesty will still be important; older children are often extremely sensitive about their bodies and may prefer privacy while taking a history and/or conducting a physical examination – this should be respected and will foster a more relaxed atmosphere.

If a young person under 16 years of age is an inpatient of an adult mental health unit, it is good practice to discuss their physical health care needs with the local Child and Adolescent Mental Health team.

If under 14, it is mandatory to involve the young person's parents or guardians in decision-making and care and treatment planning. Young people 14 and over may elect to make independent decisions, but it is recommended that their parents or guardians remain involved. Under the Mental Health Act 2007, young people between 14 and 18 years of age can nominate a primary carer that is not their parents or guardian, but cannot elect to exclude their parents or guardians.

If there are circumstances that make it unclear if the involvement of a young person's parents or guardians is safe or practical, consultation with Child Protection Services should be sought. In circumstances where the consumer is a young person for whom the Minister or Director-General of Community Services has parental or care responsibility, a Department of Community Services caseworker should participate in the planning process.

6.3 Consumers who are older persons

The physical healthcare of consumers who are older persons should be consistent with these Guidelines. Older persons more frequently suffer from interrelated medical, psychiatric and social issues. Accordingly, the initial assessment should have particular focus upon physical health.

It should be remembered that older persons are particularly at risk of problems related to:

- a) Falls
- b) Multiple medication use
- c) Malnutrition
- d) Pressure areas (if they have reduced mobility)
- e) Musculo-skeletal limitations and pain
- f) Constipation

Assessment and management must take this into account. *PD2005_353 NSW Health Management Policy to Reduce Fall Injury Among Older People* provides relevant guidance. Additional challenges to obtaining an accurate and complete history may exist in some older people. These may include hearing or visual impairment, memory impairment, and minimisation of symptoms or conditions due to perceived social attitudes or in order to please the health staff. Consent to examination and treatment can also be a complex issue with the elderly.

In new presentations and in relapse of established illness in older persons, it is important to take delirium into account and to communicate closely with community practitioners. The possibility of elder abuse should also be considered in situations of trauma.

6.4 Pregnant consumers

If a consumer is pregnant, it is critical that her physical health is monitored and any health issues or disease identified early. Health staff should also:

- a) Carefully weigh the potential risks and benefits of any medication the consumer may currently be taking and discuss these findings and treatment alternatives with the consumer.
- b) Ensure the consumer is connected with antenatal services and assist with booking if required.
- c) With the consumers consent, liaise with appropriate maternity services (perinatal psychiatrist/perinatal mental health coordinator).

After the birth, early childhood nurses can provide, or facilitate access to, psychosocial support, guidance and monitoring of the infant's progress. If there are concerns about the health and safety of the child, consideration may need to be given to making a prenatal risk of harm report to the Department of Community Services Helpline (13 3627).

6.5 Consumers from culturally and linguistically diverse backgrounds

Physical care and examinations for consumers from Culturally and Linguistically Diverse Backgrounds (CALD) requires a culturally sensitive approach. Health professionals should be aware of their own values and beliefs. It is recommended that, when working cross-culturally, staff approach CALD consumers with sensitivity and respect for the social context of the consumer's problems. It is important to understand the personal meaning of the illness for the consumer, their family and their community. The process should take into account the following factors:

- a) Lack of proficiency in English.
- b) Impeded access to health services due to language difficulties and cultural expectations.
- c) Lack of awareness of available community services.
- d) Stressors experienced during the process of adapting to mainstream Australian culture.

CALD consumers and their families should have access to interpreter services to facilitate the treatment planning process where appropriate, including three-way telephones or conference phones for use with telephone interpreters. Health staff should refer to *PD2006_052 Standard Procedures for Working with Health Care Interpreters* for guidance on use of interpreters. Where complex or unknown cultural dynamics are involved, cultural advice should be sought from the NSW Transcultural Mental Health Centre (Phone: 02 9840 3800, Fax: 02 9840 3755, Email: tmhc@swahs.health.nsw.gov.au).

6.6 Aboriginal consumers

The specific historical, cultural, spiritual and social factors of Aboriginal people must be taken into consideration when identifying and addressing their physical health needs. Many Aboriginal people's contact with government services may have been negative, which can cause suspicion and mistrust. This may be acutely important for Aboriginal people with mental health problems and disorders.

It is recommended that mental health staff dealing with Aboriginal consumers should familiarise themselves with the National Aboriginal Community Controlled Health Organisation/Royal Australian College of General Practitioners' *National Guide to a Preventive Health Assessment in Aboriginal People*, available on-line at www.racgp.org.au/aboriginalhealthunit/nationalguide. Another recent source is the Third Edition (2007) of Couzos & Murray, *Aboriginal Primary Health Care*.

Physical examination and care and treatment of physical health needs should reflect the key principles for working with Aboriginal communities, including:

- a) Services working in partnership.
- b) Holistic approach to mental health.
- c) Flexibility
- d) Accessibility of services.
- e) Ability to follow people across areas.
- f) Respect and sensitivity for indigenous people.
- g) Involvement of family and others in care.
- h) Treating an individual as part of a family and the community.
- i) Provision of education and training.
- j) Illness prevention.

Health staff should liaise with specialist Aboriginal health representatives in their area (eg Aboriginal Mental Health Workers or Aboriginal Medical Services) to ensure that their approach to providing physical health care for Aboriginal consumers is consistent with the needs of the local Aboriginal community.

The process should also:

- a) Provide the consumer and family with relevant 24-hour contact numbers for assistance.
- b) Identify community liaison contact(s) who can engage additional support for the consumer such as extended family, elders and community members.
- c) Ensure actions are taken to resolve precipitating events and other life stressors.
- d) Refer the consumer to Aboriginal health or medical services whenever possible.
- e) Ensure, where possible, that the family is present at time of physical examination.

6.7 Consumers with intellectual disabilities

Cognitive and communication difficulties can make it hard for people with intellectual disability to recognise and communicate pain or other symptoms of ill health. Involving family members or other support workers will support the identification of health issues and the provision of a medical history. However, these support people may be unaware of symptoms, and an accurate history may be difficult to obtain. It should also be noted that:

- a) Physical examination may be difficult due to anxiety or challenging behaviours in the person with intellectual disability.
- b) The combination of difficulties with communication, accurate history taking and physical examination may mean that assessments are lengthy, so adequate time should be allocated for this.
- c) There is a risk of "diagnostic overshadowing", where physical or behavioural symptoms may be ascribed to the intellectual disability, and a physical or mental health disorder overlooked as a result.

The specific medical conditions and risk factors that prevalence studies have identified occur more frequently in people with intellectual disability should be considered.

The International Association for the Scientific Study of Intellectual Disability (IASSID) has made recommendations for the detection and management of these conditions in people with intellectual disability (see <http://www.iassid.org>).

The IASSID Health Guidelines for Adults recommend action in the following areas:

- Dental health
- Sensory impairments
- Nutrition
- Constipation
- Epilepsy
- Thyroid disease
- Gastro-oesophageal reflux disease and H.pylori
- Osteoporosis
- Medication review
- Immunisation status
- Physical activity and exercise
- Comprehensive health assessments
- Genetics
- Women's health.

Key messages

For all stakeholders

- Mental health consumers have the right to receive the same standard of physical health care that is provided to the general public.

For mental health consumers

- A regular physical examination is important for mental health consumers.
- Consumers should have a regular GP. If a consumer doesn't have a regular GP, they should talk to their mental health service, which may be able to link them with one in their locality that has an interest in or experience with mental illness.
- Consumers are encouraged to give consent for the mental health service to contact their GP regarding their physical health and to share information about their physical health needs.

For families, carers and friends of mental health consumers

- Carers can provide important support to consumers to help them improve their physical health.
- Consumers generally have a level of interest in improving their physical health and need to be encouraged to participate in their own physical health care.

For mental health services

- Mental health services have a responsibility to ensure consumers involved with their service have access to appropriate care for their physical health.
- Mental health services need to encourage mental health consumers to have regular physical examinations

- Mental health services should support mental health consumers to take preventative action and make lifestyle changes to improve their physical health, such as giving up smoking
- It is important for mental health services to develop strong partnerships with GPs in their locality and help mental health consumers to connect with a local GP.

For General Practitioners (GPs)

- A collaborative partnership between GPs and mental health services is a vital component of the consumers care. This partnership is particularly significant for community services, where consumers do not have access to medical care.
- GPs can conduct physical examinations of consumers and provide information about the consumer's physical health history.
- The *Physical Health Mental Health Handbook*, available from the Better Health Centre or General Practice NSW, can help GPs work with and treat consumers.

Proforma: communication with GPs - initial physical health assessment

This is provided with the intention that mental health services adapt it for their local circumstances.

Date:.....

Dear(name of GP)

Re: Initial Physical Health Assessment of Mental Health Consumer

MRN.....

.....was seen by on ... /.../.....
(name of consumer) (name of service)

He / she has the following symptoms:

.....
.....

The provisional diagnosis is of:

.....
.....

(Mental Health services may wish to insert space for other information here eg differential diagnosis, management plan, medication details)

We now know that mental health can have a significant impact on physical illness and disease and physical illness can present with symptoms suggestive of mental illness. Additionally, many people with mental illness suffer, or have an increased risk of, poor physical health. This confirms the importance of taking a holistic approach to health care for people with a mental health issue. The General Practitioner (GP) is a critical member of the care team for people with a mental illness and has an important role to play in improving the physical health of this group.

An appropriate physical health examination is an essential part of the assessment of a person with symptoms of mental illness and your assistance in conducting such an examination of the individual listed above would be greatly appreciated.

Certain physical examination and investigations are particularly relevant to people with a mental illness and the attached form has been provided to enable you to record details of any of these you believe appropriate. Written consent has been obtained from the above individual to share this information with our service. Once completed, this form can be faxed or emailed as per the contact details provided below. Alternatively, you may choose to fax or email copies of the results themselves.

Thank you in advance for your support and please do not hesitate to contact the service if you have any queries regarding this process, or our assessment.

Service contact details:

Phone:..... Fax:..... Email:

Manager:

Yours sincerely

Physical Examination

Observations	BP	Pulse	Resp	Height	Weight	BMI	Waist/Hip Ratio
CVS							
			Resp				
GIT							
Rectal examination (>50 yr)							Other, eg Genitourinary / Musculoskeletal / Haemopoietic / Dermatological / Breasts
Neurological							
Investigation	Date	Results (or attach)					
EUC							
LFT							
FBC							
Thyroid Function Tests							
Serum calcium							
phosphate							
B12							
folate							
Cerebral CT or MRI							
Other investigations (instigated by GP or proposed by mental health team)							

Proforma: communication with GPs - ongoing physical health care

This is provided with the intention that mental health services adapt it for their local circumstances.

Date:.....

Dear (name of GP)

Re: Ongoing Physical Health Assessment of Mental Health Consumer

MRN.....

..... is currently in contact with on ... /.../.....
(name of consumer) (name of service)

The major problems we are trying to assist with currently are:

.....
.....

(Mental Health services may wish to insert space for other information here eg differential diagnosis, management plan, medication details)

We now know that mental health can have a significant impact on physical illness and disease and physical illness can present with symptoms suggestive of mental illness. Additionally, many people with mental illness suffer, or have an increased risk of, poor physical health. This confirms the importance of taking a holistic approach to health care for people with a mental health issue.

The General Practitioner (GP) is a critical member of the care team for people with a mental illness and has an important role to play in improving the physical health of this group. GPs can support early intervention and monitoring of physical health issues as well as involvement in recommended health promotion and screening activities – all essential for a person with a mental illness. Advice for GPs regarding specific health issues for people with a mental illness can be found in the *Physical Health Mental Health Handbook*. This resource can be accessed from the Better Health Centre (02 9887 5450) or downloaded from the NSW Health website at www.health.nsw.gov.au.

Your assistance in providing information about the physical health of the individual listed above would be greatly appreciated.

Certain physical examination, activities and investigations are particularly relevant to people with a mental illness and the attached form has been provided to enable you to record details of any these you believe appropriate. Written consent has been obtained from the above individual to share this information with our service. Once completed, this form can be faxed or emailed as per the contact details provided below. Alternatively, you may choose to fax or email copies of the results themselves.

Thank you in advance for your support and please do not hesitate to contact the service if you have any queries regarding this process, or our assessment.

Service contact details:

Phone:..... Fax:..... Email:

Manager:

Yours sincerely

Name:..... Title.....
 Patient name Date of completion.....

Physical Examination

Observations	BP	Pulse	Resp	Height	Weight	BMI	Waist/Hip Ratio
CVS							
			Resp				
GIT	Other, eg Genitourinary / Musculoskeletal / Haemopoietic / Dermatological / Breasts						
Rectal examination (>50 yr)							
Neurological							
Investigation	Date	Results (or attach)					
EUC							
LFT							
FBC							
ECG							
Bood glucose							
Lipid profile							
Other investigations (instigated by GP or proposed by mental health team)							
Other Actions (if relevant)	Date	Comment					
Smoking cessation support							
Weight control intervention							
Other Health promotion or screening activities							

Proforma: promoting physical health care of consumers to stakeholders (consumers, family or carer of consumer and relevant NGOs)

This is provided with the intention that mental health services adapt it for their local circumstances.

Linking physical and mental health care... it makes sense

Improving the physical health of people who use mental health services is a priority. By working together, we can make this happen.

What does physical health have to do with mental health?

There is now quite a substantial amount of research that tells us that physical health and mental health are critically linked. If you feel well physically you often feel better mentally, and sometimes the symptoms of a physical illness can suggest a mental illness where one doesn't exist.

Unfortunately, many people with a mental illness also suffer, or have an increased risk of, poor physical health. Smoking, alcohol consumption and other drug use, poor diet, lack of exercise, regular use of psychotropic medication and high risk behaviours all contribute to a range of physical illnesses and conditions for those with a mental illness.

Why does it make sense to link physical and mental health care?

It's important that people with a mental illness or disorder receive good quality physical as well as mental health care. People with a mental illness, including those that are involved with a mental health service (consumers), have the right to expect health care that's in line with the care provided to the general population.

It makes sense, then, that mental health services take a 'holistic' approach to providing care for the consumers that use their service, considering both the physical and

mental aspects of their health.

Linking physical and mental health care in this way will have real benefits for consumers, including:

- Reducing the number of consumers with a physical illness being misdiagnosed as having a mental illness.
- Identifying and treating physical health issues for consumers earlier, meaning consumers recover quicker.
- Recognising side effects from medication in consumers more easily, so that action can be taken as soon as possible to lessen them.

What role can mental health services play in supporting consumers to improve their physical health?

Mental health services can support consumers who use their service to improve their physical health by assisting them to identify and seek early medical aid for physical illnesses or disease, reducing the severity and length of the illness and the number of deaths that may otherwise have occurred.

Mental health services can also encourage consumers to take preventative health measures, such as giving up smoking or losing weight. These measures will help to improve their general wellbeing and ultimately their quality of life.

However, services cannot work in isolation to address the physical health issues of consumers. General Practitioners (GPs) and consumers and their families or carers all need to work together to ensure physical health care for consumers is recognised as a vital part of their overall care and treatment.

Where does the GP fit in?

The GP is a key person within the consumer's care team. They are often the first point of contact for someone with a mental illness or disorder and are the best qualified to conduct physical health examinations and investigations for consumers. If a consumer does not have a regular GP, mental health services can link them with a GP in their locality who has knowledge of or experience with mental illness.

What physical health care will mental health services provide?

Mental health services have a responsibility to ensure that consumers involved with their service receive appropriate physical health care.

This includes making sure that:

- All consumers are supported to receive a physical health examination.
- The consumer's mental illness or disorder isn't due to a physical illness.
- Careful consideration is given to how any treatment the consumer receives for their mental illness will affect their physical health.
- Consumers are put in contact with a GP or other health providers for required health reviews or tests.
- Care plans for consumers take account of physical health needs and ongoing physical health issues.
- Consumers can attend activities and are given information that will help to improve their physical health and wellbeing.

Guidance and advice to help mental health services meet their obligations in this regard are provided in the *NSW Health Physical Health Care of Mental Health Consumers – Guidelines* as well as the Policy Directive *PD2009_027 Physical Health Care within Mental Health Services*.

What steps can a consumer take to improve their own health?

Consumers are the best people to judge when they need treatment for a physical health complaint. This means they need to be active participants in their own physical health care. They can do this by:

- Having a regular GP.
- Getting regular physical health examinations.
- Asking for help from their mental health service to make and/or travel to and from physical health appointments.
- Giving consent for the mental health service to contact their GP or other health providers so they can work together in addressing the consumer's physical health concerns.
- Asking questions about their physical health diagnosis to ensure they understand both the complaint and the treatment.
- Sharing information about their physical health with their family or carer so they can receive practical and emotional support.
- Reading information about health and nutrition and making changes to their diet and exercise routine.
- Taking part in healthy lifestyle programs or activities that will help them to make better health choices, such as giving up smoking or reducing the amount of alcohol they drink.

Taking these steps will help consumers to take charge of their physical health and support their own road to recovery.

How can a consumer's family or carer help?

Apart from being able to share important information about the consumer's current physical health and health history, if the consumer consents to this, carers can also provide real practical support to consumers. This might entail arranging appointments with health providers and accompanying consumers when they attend, helping consumers to take their medication or remind them when its due, preparing special diets, assisting with therapies and treatments and dressing wounds.

The emotional support provided by carers and families can help consumers to stick to any required medication and encourage them to make healthy lifestyle changes, such as giving up smoking or getting some more physical exercise.

Need more information?

If you need more information about physical health care for mental health consumers, contact your local mental health service:

.....

Proforma: tracking occurrence of observations and investigations relevant to ongoing physical health issues

This is provided with the intention that mental health services adapt it for their local circumstances.

Investigation (see Guidelines for further information)	Since last review? Y/N	Results/ location	Comment	Since last review? Y/N	Results/ location	Comment
Physical examination						
Waist-hip ratio						
EUC						
LFT						
FBC						
ECG						
Blood glucose						
Lipid profile						
CXR						
Pap smear						
Faecal haemoccult						
Mammogram						
Drug levels						
Other investigations						
Health interventions						
Smoking cessation						
Weight control						
Exercise						
Other						

Guidance on measuring waist-hip ratio and involuntary movements

Waist Hip Ratio (WHR) is obtained by:

- Measuring the waist circumference around the narrowest point between ribs and hips when viewed from the front after exhaling.
- Measuring the hip circumference at the point where the buttocks extend the maximum, when viewed from the side.

(Adapted from *Waist-hip ratio is the dominant risk factor predicting cardiovascular death in Australia* Welborn, Dhaliwal and Bennett, 1993).

Involuntary movements can be measured by:

- Conducting an examination using the Abnormal Involuntary Movement Scale (AIMS) - see following page for pro-forma.

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

<p>Instructions: complete examination procedure before making ratings movement</p> <p>Ratings: rate highest severity observed, rate movements that occur upon activation one less than those observed spontaneously</p>	<p>CODE 0 = none 1 = minimal, may be extreme normal 2 = mild 3 = moderate 4 = severe</p>
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EXAMINATION PROCEDURE

Either before or after completing the examination procedure observe the patient unobtrusively at rest (eg in waiting room). The chair to be used in this examination should be a hard, firm one without arms.

<ol style="list-style-type: none"> 1. Ask patient whether there is anything in his/her mouth (ie. Chewing gum etc.) 2. Ask patient about the current condition of his/her teeth. Ask patient if he/she wears dentures. Do teeth/dentures bother patient now? 3. Ask patient whether he/she notices any movements in mouth, face, hands, or feet. If yes, ask to describe and to what extent they currently bother patient or interfere with his/her activities. 4. Have patient sit in chair with hands on knees, legs slightly apart and feet flat on floor. Look at entire body for movements while in this position. 5. Ask patient to sit with hands hanging unsupported. If male, between legs, if female and wearing a dress, hanging over knees. Observe hands and other body areas. 	<ol style="list-style-type: none"> 6. Ask patient to open mouth. Observe tongue at rest within mouth. Do this twice. 7. Ask patient to protrude tongue. Observe abnormalities of tongue movement. Do this twice. 8. Ask patient to tap thumb, with each finger, as rapidly as possible for 10-15 seconds, separately with right hand, then with left hand. Observe facial and leg movements. 9. Flex and extend patients left and right arms, one at a time. Note any rigidity and rate. 10. Ask patient to stand up. Observe in profile. Observe all body areas again, hips included. **11. Ask patients to extend both arms outstretched in front with palms down. Observe trunk, legs and mouth. **12. Have patient walk a few paces, turn, and walk back to chair. Observe hands and gait. Do this twice. <p><small>** Activated movements</small></p>
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Facial and oral movements	1. Muscles of facial expression eg movements of forehead, eyebrows, periobital area, cheeks, include frowning, blinking, smiling, grimacing	0	1	2	3	4
	2. Lips and perioral area eg puckering, pouting, smacking	0	1	2	3	4
	3. Jaw eg biting, clenching, chewing, mouth opening, lateral movement	0	1	2	3	4
	4. Tongue rate only increase in movement both in and out of mouth. Not inability to sustain movement	0	1	2	3	4
Extremity movements	5. Upper - arms, wrists, hands, fingers. Include choreic movements (ie rapid, objectively purposeless, irregular spontaneous). Athetoid movements (ie slow, irregular, complex, serpentine). Do not include tremor (ie repetitive, regular, rhythmic)	0	1	2	3	4
	6. Lower - legs, knees, ankles, toes. eg, lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	0	1	2	3	4
Trunk movements	7. Neck, shoulders, hips eg rocking, twsiting, squirming pelvic gyrations	0	1	2	3	4
Global judgements	8. Severity of abnormal action	0	1	2	3	4
	9. Incapacitation due to abnormal movements	0	1	2	3	4
	10. Patient's awareness of abnormal movements	0	1	2	3	4
Dental status	11. Current problems	0	1	2	3	4
Dentures	12. Does patient normally wear dentures?	0	1	2	3	4

Clinician's Signature		Date of examination	
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References regarding specific clinical scenarios

The following are references to material that may be useful in obtaining more specific information regarding the physical health issues related to mental health conditions and management. NSW Health does not endorse any of the references provided.

General

- *The Physical Health Mental Health Handbook*
May be accessed at <http://www.health.nsw.gov.au>

ECT

- *The Practice of ECT, A Task Force Report of the American Psychiatric Association*, second edition, APA Press, 2001, Washington DC.
- *The ECT Handbook Second Edition: The Third Report of the Royal College of Psychiatrists' Special Committee on ECT*, The Royal College of Psychiatrists, 2004, London.
May be accessed at: <http://www.rcpsych.ac.uk/files/pdfversion/cr128.pdf>
- *Therapeutic guidelines: Psychotropic Version 5*. Psychotropic Medications Psychotropic Writing Group. Melbourne: Therapeutic Guidelines Limited; 2003.
- *Australian Medicines Handbook*: Australian Medicines Handbook Pty Ltd 2007.

These last two references are available via NSW Health Intranet Clinical Information Access Program
<http://internal.health.nsw.gov.au:2001/>

Physical health related rehabilitation activities

- *Choosing Health: Supporting the physical needs of people with severe mental illness – Commissioning Framework*. Department Of Health, UK (2006) England
May be accessed at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4138212
- *Healthy Body Healthy Mind*. National Institute For Mental Health In England (NIMHE) (2004) England
May be accessed at <http://www.staffordshirementalhealth.info/ftp/document/pdf/shift-healthybody-workers.pdf>
- *Running on Empty – Building Momentum to Improve Well-Being in Severe Mental Illness*. Various Contributors, (2005)
May be accessed at http://www.hafal.org/pdf/runningonempty/RoE_English.pdf
- *Integrating physical activity into mental health services for persons with serious mental illness*. Richardson, C et al. (2005) Psychiatric Services. Vol no 56, pp. 324-331.

Relevant National Standards for Mental Health Services

The *National Standards for Mental Health Services* were endorsed by the Australian Health Ministers' Advisory Council's National Mental Health Working Group in December 1996 and are an essential mechanism in supporting mental health services to achieve high standard health care.

The standards can be used in a range of ways, including:

- To support the development of new services or service enhancement and continuous quality improvement;
- To inform consumers and carers about what to expect from a mental health service and as a check list for service quality;
- To assist consumers and carers to participate in a service's planning, development and evaluation processes.

The following standards have particular relevance to the responsibility of mental health services to ensure consumers have access to appropriate physical health care.

- 8.2.1** The MHS is part of the general health care system and promotes comprehensive health care for consumers, including access to specialist medical resources.
- 8.2.2** Mental health staff know about the range of other health resources available to the consumer and can provide information on how to access other relevant services.
- 8.2.3** The MHS supports the staff, consumers and carers in their involvement with other health service providers.
- 11.3.5** The assessment process is comprehensive and, with the consumer's informed consent, includes the consumer's carers (including children), other service providers and other people nominated by the consumer.
- Notes and Examples: Multidisciplinary assessment which includes physical, social and psychological strengths, risks, family*

& functional components, relevant history (including previous treatments such as medication), diagnosis and short-term individual care plan and is recorded in a standardised format for the MHS.

Information is gathered from a number of sources including, with the consumer's informed consent, the General Practitioner, private psychiatrist, school counsellors, family and other people nominated by the consumer.

- 11.3.6** The assessment is conducted using accepted methods and tools.
- Notes and Examples: May include diagnostic classification systems, functional assessments, psychometric testing, collaborative interview, family interview, suicide and other risk assessment, problem oriented assessment, formal clinical interview, mental status examination, standardized documentation format and includes physical assessment.*
- 11.4.6** The MHS ensures access to a comprehensive range of treatment and support services which address physical, social, cultural, emotional, spiritual, gender and lifestyle aspects of the consumer.
- 11.4.C.6** The MHS ensures that a system exists which monitors to prevent - and promptly provides the consumer with appropriate treatment for any adverse effects of medication.

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