Mental health clinical audit protocol

2014 release

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Acknowledgments

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Abbreviations

AIDS	acquired immunodeficiency syndrome
AMI	acute myocardial infarction
BMI	body mass index
BP	blood pressure
CARPA	Central Australian Rural Practitioners Association
CHD	coronary heart disease
COAD	chronic obstructive airways disease
CVA	cerebrovascular accident
ECG	electrocardiograph
FBC	full blood count
GP	general practitioner
HIV	human immunodeficiency virus
IHD	ischaemic heart disease
IM	intramuscular
LFT	liver function test
MBS	Medicare Benefits Schedule
PHC	primary health care
TFT	thyroid function test

Version control

Version	Release date	Description
2.0	22/09/2010	First release after pilot phase
3.0	31/08/2012	Format adjustments and content changes
2013 release		Minor content (terminology) changes
2014 release	8/9/2014	Protocol update only

Summary of changes

Summary of changes to the mental health audit protocol, release 2014

Section/question	Description of change
Introduction	Additional paragraphs 'why audit mental health care?'
All sections	References updated
	Changes agreed by working group and users have been considered, however, due to technical limitations and other reasons, they will be incorporated into future reviews of the mental health tool.

Introduction

This protocol should be used in conjunction with *Improving the quality of primary health care: A training* manual for the One21seventy CQI cycle.

Eligibility of clients

To be eligible for inclusion in the mental health audit, a client must:

- have a diagnosed mental illness or a mental health disorder which is likely to recur and which includes: symptoms of depression, or marked anxiety and agitation, or emotional distress, or psychotic symptoms such as hearing voices or seeing things or associated behavioural disturbance or difficulty. Many will have associated substance misuse problems or social problems such as domestic violence
- have experienced symptoms for more than six months in the past or at least one relapse/recurrence of symptoms suggesting a need for ongoing care
- be currently unwell or have been identified as unwell in the past twelve months
- be 16 years or older
- Have lived in the community for six months or more during the past 12 months.

Note: clients with a history of mental illness but who have been formally discharged from ongoing care should not be included.

Clients do not need to have been seen by a regional mental health team to be included in audit.

Sample size and confidence interval

Refer to *Improving the quality of primary health care: a training manual for the One21seventy cycle*, Section 5, for more information on determining the sample size with regard to the population size for this audit, and the confidence interval required for the reported indicators.

The 'eligible population' referred to in this protocol is the number of clients with a documented mental health disorder who are deemed eligible by the criteria as listed above.

Recommendations for sample size

- For services with up to 100 clients in the eligible population, we recommend a sample size of *at least 30 client records* per audit. This sample should provide an adequate estimate (for quality improvement purposes) of the proportion of clients receiving specific services.
- Health services with large eligible populations may wish to increase the sample size to reduce the confidence intervals around the sample estimates. Health services with smaller eligible populations (30 or fewer) should audit all client records and be cautious when using and comparing reported data.
- Be aware of the confidence interval for your results — this is important when interpreting the data in your reports.

Why audit mental health care?

In a recent national health survey, although the majority of Aboriginal and Torres Strait Islander adults reported feelings of positive wellbeing, nearly one-third felt high or very high levels of psychological distress — more than twice the rate for non-Indigenous Australians. Furthermore, three-quarters (77%) of Aboriginal and Torres Strait Islander adults reported that they or their close friends or family had experienced at least one life stressor in the previous 12 months (Australian Institute of Health and Welfare 2010). Despite these high rates of distress, in 2008–09 only 1.0% of general practitioner consultations for mental health-related disorders were for Aboriginal and Torres Strait Islander Australians (Australian Institute of Health and Welfare 2010). Nationally, just over one-quarter (26%) of Aboriginal and Torres Strait Islander people aged 15 years and over reported problems accessing one or more health services.

The recurring nature of mental health disorders is as disabling as any chronic disease and its relapsing nature accounts for one of the highest levels of disease burden of any condition (Nagel 2006).

As all vulnerable groups are most likely to be seen in the primary care setting, there is a need to explore the response of these services to their needs and to establish guidelines for best practice.

The terms ‘medical record’, ‘client record’, ‘primary health care record’, ‘patient information system’ and ‘client information system’ are used throughout this audit and protocol, however, it refers to the or whatever is used to document client care. This is an audit of the care documented. To ensure continuation of care, it is important that all care is documented and available to health practitioners who will have ongoing responsibility of a person with a mental health disorder.

Using the mental health clinical audit tool and protocol

This protocol provides:

- the rationale behind the questions in the audit tool and how they relate to best practice or current guidelines
- the questions to audit and a description of what to look for in client records, including timeframes around when certain services are scheduled
- explanation of the options available for selection in the website data entry page.

The protocol is valuable for meaningful interpretation of the reports.

Review

Changes to this tool and protocol are carefully monitored to ensure that trending over CQI cycles is possible. If you notice discrepancies between what is documented in the protocol and what is recommended best practice in your jurisdiction, or have any questions or suggestions, please contact One21seventy by email: one21seventy@menzies.edu.au or phone 1800 082 474. Your feedback is appreciated.

Section 1 General information

1.1 Client ID

For each participating health service, the auditor will prepare a master list of participants that contains the participant name, date of birth, and participant number (client ID). This list will be marked 'confidential' and stored securely to prevent inappropriate identification of client records.

Assign a unique three-digit identification (ID) number for each client audited. At data input, this three-digit number will be automatically prefixed with the tool and health centre IDs.

1.2 Medicare number

Is the client's current Medicare number recorded in his or her medical record?

Indicate **1-Yes** or **0-No**.

1.3 Date of birth

Record the client's date of birth. Record as **dd/mm/yyyy**.

1.4 Gender

Record the gender (sex) of the client.

Indicate **1-Male** or **2-Female**.

1.5 Indigenous status

Record the client's Indigenous status as stated in their medical record. Indicate **one** of the following:

1-Aboriginal

2-Torres Strait Islander

3-Both (client is both Aboriginal and Torres Strait Islander)

4-Neither (client is neither Aboriginal nor Torres Strait Islander)

5-Not stated (there is no clear record of client's Indigenous status).

1.6 Auditor

Record the name of the person doing the audit (initial and surname).

1.7 Audit date

Record as **dd/mm/yyyy**.

Note that the audit date will be the same for all client records being audited in this year. Even if all auditing cannot be completed in a single day, continue to use the same audit date for all client records and audit the medical records retrospectively from this date.

Section 2 Attendance at the health centre

Access to health care

AIHW (2010) report the barriers to accessing appropriate health care, such as cultural competency, remain a problem for Aboriginal and Torres Strait Islander people.

Barriers to service access and engagement for Aboriginal and Torres Strait Islander peoples include communication, world view differences, stigma and discrimination (Eley et al. 2006, Kowanko et al. 2004, Vicary & Westerman 2004). In addition, despite high rates of co-morbidity, early detection in other health settings is limited (Dowden et al. 2011, Rumbold et al. 2011).

Strategies for improved access include developing Aboriginal and Torres Strait Islander friendly services, strengthening the role of Aboriginal and Torres Strait Islander mental health professionals (Brideson 2004), diminishing stigma through adapted and innovative mental health promotion strategies (Beyondblue 2011, Menzies School of Health Research 2011), and implementing routine screening and early detection through use of valid and appropriate screening tools (Nagel et al. 2011, Schlesinger et al. 2007)

2.1 Date of last attendance

Time since last attendance is a useful measure of the level of client engagement with the health centre. A record of attendance includes a record that the client was seen by a health worker (refer to question 2.5 for types of health workers). If the client made a visit to the health centre but left without an assessment by a health worker, this should *not* be recorded as having attended the health centre.
Record the date the client last attended the health centre for care. Record as **dd/mm/yyyy**.

Note: If the client is seen through an outreach service related to the health centre this should also be included as this is a record of service contact. It is acknowledged that some clients do not visit the health service itself as their first point of call.

2.2 Follow up attempt since last attendance

If the client has not been seen at the health service in last 12 months, is there any record of unsuccessful follow-up attempt since last attendance?

Indicate **1-Yes** or **0-No**

Indicate 9- N/A if the date last attended is within 12 months of audit date.

2.3 Reason for last attendance

The reason for last attendance can shed light on client engagement in ongoing management of their condition, as well as to identify opportunities for routine checks and tests that might arise in the context of other visits to the health centre.

Indicate the reason for last attendance

Table 2.1: Record the reason for the client's last attendance at the health centre

Reason	Examples
1-Mental health care	Routine review, follow-up, and/or treatment
2-Acute care	General acute care (not mental health related) e.g. infections, trauma
3-Other	Antenatal care, immunisation, health check, any other reason
4-Mental health crisis	Acute distress

2.4 If 'Other', state reason for previous attendance

If 'Other', reason for previous attendance in Question 2.3, provide a brief description of reason for last attendance.

Client engagement

Identifying which staff member was the first point of contact for the client at their most recent attendance is a measure of centre processes and of Aboriginal and Torres Strait islander health worker engagement with program delivery.

Some health centres have a clear policy on which type of health worker should be the first to see clients. The information from this audit item may show the health centre how well this policy is being implemented.

2.5 First Seen by

It is acknowledged that mental health clients will often see more than one health professional. This question is not about who (or how many people) the client saw during a visit, but which health professional the client saw first when they arrived at the health service. Indicate the health professional who first saw the client at the last attendance

1-Aboriginal and/or Torres Strait Islander Health Worker/Practitioner

2-Nurse

3-General Practitioner

4-Psychiatrist

5-Psychologist

6-Mental Health Worker

7-Counsellor

8-Other

9-Not stated

NOTE: '8-Other' can include traditional healer/Indigenous community worker or other culturally appropriate person

2.6 Date of last mental health presentation

Record the date the client most recently attended the health centre for mental health care as **dd/mm/yyyy**.

Date of last Mental Health presentation must be on or before date of last attendance

Section 3 Recording of key health information

Mental health disorders

In the most recent national health survey, although the majority of Aboriginal and Torres Strait Islander adults reported feelings of positive wellbeing, nearly one-third felt high or very high levels of psychological distress — more than twice the rate for non-Indigenous Australians. Furthermore, three-quarters (77%) of Aboriginal and Torres Strait Islander adults reported that they or their close friends or family had experienced at least one life stressor in the previous 12 months (Australian Institute of Health and Welfare 2011). Despite these high rates of distress, in 2008–09 only 1.0% of general practitioner consultations for mental health-related problems were for Aboriginal and Torres Strait Islander Australians (Australian Institute of Health and Welfare 2010). Nationally, just over one-quarter (26%) of Aboriginal and Torres Strait Islander people aged 15 years and over reported problems accessing one or more health services.

As all vulnerable groups are most likely to be seen in the primary care setting, there is a need to explore the response of these services to their needs and to establish guidelines for best practice.

3.1 Depressive disorder

Depressive disorders can include:

- bipolar affective disorder
- major depressive episode
- adjustment disorder with depressed mood (recovery in less than 6 months)
- depressive disorder secondary to substance use
- other depressive disorders.

Indicate if the client has a documented diagnosis of a depressive disorder.
If '**1-Yes'**, record the date of diagnosis. Record as **dd/mm/yyyy.**

3.2 Anxiety disorder

Anxiety disorders can include:

- obsessive–compulsive disorder
- phobic disorder
- adjustment disorder with anxiety
- generalised anxiety disorder
- post traumatic stress disorder
- panic disorder with or without agoraphobia
- anxiety secondary to medical cause
- anxiety secondary to substance use
- other anxiety disorder.

Indicate if the client has a documented diagnosis of an anxiety disorder.
If '**1-Yes'**, record the date of diagnosis. Record as **dd/mm/yyyy.**

3.3 Other mood disorder

Other mood disorders can include:

- dysthymia
- adjustment disorder with depressed mood, anxious mood or mixed affective disorders (these may last longer than six months and meet the eligibility criteria if the precipitants persist).

Indicate if the client has a documented diagnosis of an 'other mood disorder'.
If '**1-Yes'**, record the date of diagnosis. Record as **dd/mm/yyyy.**

3.4 Psychotic disorder

Psychotic disorders can include:

- schizophrenia
- schizophreniform disorder
- schizoaffective disorder
- delusional disorder
- other psychotic disorders.

Indicate if the client has a documented diagnosis of a psychotic disorder.
If '**1-Yes'**, record the date of diagnosis. Record as **dd/mm/yyyy.**

3.5 Substance use disorder

Substance use disorders can include:

- substance dependence or abuse
- substance-induced psychotic disorder
- substance-induced mood disorder
- substance-induced anxiety disorder
- other substance use disorders.

Indicate if the client has a documented diagnosis of a substance use disorder.
If '**1-Yes'**, record the date of diagnosis. Record as **dd/mm/yyyy.**

3.6 Eating disorder

Eating disorders can include:

- anorexia nervosa
- bulimia nervosa
- other eating disorders.

Indicate if the client has a documented diagnosis of an eating disorder.
If '**1-Yes'**, record the date of diagnosis. Record as **dd/mm/yyyy.**

Perinatal depression

Antenatal depressive episodes can be a reaction to the pregnancy itself, to associated health issues or to other major life stressors. Depressive symptoms in pregnancy can also be due to a continuation or relapse of a pre-pregnancy condition — especially among women who stop taking medication on confirmation of pregnancy (Henshaw 2004, Oates 2006).

Antenatal anxiety may occur in response to fears about aspects of the pregnancy (e.g. parenting role, miscarriage, congenital disorders), or as a continuation of a pre-pregnancy condition and/or comorbid with depression. Higher levels of self-reported anxiety or anxiety disorder in pregnancy increase the risk of depression postnatally (Austin et al. 2007b).

Non-psychotic disorders occurring in the postnatal period include depression, as well as a range of anxiety disorders including generalised anxiety, phobias, obsessive compulsive disorder and post-traumatic stress disorder (Rogal et al. 2007), adjustment disorder, panic disorder and agoraphobia (Matthey et al. 2003).

For more information see

beyondblue: the national depression initiative — clinical practice guidelines for depression and related disorders — anxiety, bipolar disorder and puerperal psychosis — in the perinatal period

www.beyondblue.org.au/index.aspx?link_id=6.1246

3.7 Mental health disorder secondary to medical cause

Disorders secondary to medical cause can include:

- psychotic disorder secondary to medical cause
- depressive disorder secondary to medical cause
- anxiety disorder secondary to medical cause.

Indicate if the client has a documented diagnosis of a mental health disorder secondary to a medical cause.

If '**1-Yes'**, record the date of diagnosis. Record as **dd/mm/yyyy.**

3.8 Other disorder

Other disorders can include:

- other related mental health diagnoses that meet eligibility criteria
- personality disorder may be an appropriate inclusion criterion if linked with social and occupational dysfunction.

Indicate if the client has a documented diagnosis of any other disorder.

If '**1-Yes'**, record the date of diagnosis. Record as **dd/mm/yyyy.**

3.9 Sectioned under a Mental Health Act

Different states will have different versions of a mental health act. You will need to refer to your own state/territory for their Mental Health Act.

Is there documented evidence in the client's record that the client has been sectioned under a Mental Health Act in the last 12 months?

Indicate **1-Yes** or **0-No**

3.10 Date of order

Record the date of the order if present.

Record as **dd/mm/yyyy**

Shared care

Key recommendations regarding a shared care model encourage GPs to be closely involved in the care of people with mental illness despite the geographical challenges in Australia (McGorry, 2003).

Integrating specialised health services – such as mental health services – into Primary health care is one of WHO's most fundamental health care recommendations (WHO, 2007)

3.11 Shared care

It is important to ascertain whether the client is in a shared care arrangement, as the client record at the health service may have incomplete records of care. If some of the clients' care is being delivered by the state mental health team (or other providers), services delivered may not be fully documented in the client's record. Shared care may also include collaboration with other mental health care providers.

Is there documentation of shared care with another health provider for mental health assessment or care in the last 12 months?

Indicate **1-Yes** or **0-No**.

3.12 If no shared care, record of referral

If there is no documentation of a shared care arrangement, indicate if there is any documentation of referral to another mental health care provider for assessment or care in the last 12 months

Indicate the health provider the client was referred to

1-Mental health worker, **2-Psychiatrist**, **3-Psychologist**, **4-Counsellor**, **5-Traditional Healer/ Indigenous Community Worker**, **6-Other**, **7-No referral** or **9-N/A** if client is in a shared care arrangement

Care plans

GP Mental Health Treatment Medicare items provide a structured framework for GPs to undertake early intervention, assessment and management of patients with mental disorders, as well as providing referral pathways to psychologists, social workers and occupational therapists. The GP Mental Health Treatment items are for patients with a mental disorder who would benefit from a structured approach to the management of their care needs (Australian Government, 2011).

The care plan focus promotes coordination of care, continuity of care, communication across disciplines and engagement of the consumer. These principles are linked with a number of national recommendations, best practice guidelines and Indigenous health initiatives. The link with Medicare items is practical in terms of data collection, encouragement of best practice and funding acquisition (Hickie and McGorry 2007).

3.13 GP mental health care plan

To be current, a care plan must be dated within the last 12 months.

Is there is documentation in the medical record that the client has a current GP mental health care plan (MBS item 2700, 2701, 2715 or 2717)?

Indicate **1-Yes** or **0-No**

3.14 Alternative mental health care plan

To be current a care plan must be dated within the last 12 months.

Is there is documentation in the medical record that the client has a current alternative mental health care plan?

Indicate **1-Yes** or **0-No**

9-N/A if there is a GP mental health care plan identified

3.15 Clinical goals

Is there is documentation of the clinical goals in the mental health care plan (MBS item 2710 or alternative)?

Indicate **1-Yes** or **0-No**

9-N/A if there is no current care plan identified

3.16 Self-management or recovery goals

Is there is documentation of the client's self-management or recovery goals in the mental health care plan (MBS item 2710 or alternative)?

Indicate **1-Yes** or **0-No**

9-N/A if there is no current care plan identified

3.17 Goals reviewed

Is there evidence in the in the mental health care plan (MBS item 2710 or alternative) that either clinical or self-management (or both) goals have been reviewed in the last 3 months?

Indicate **1-Yes** or **0-No**

9-N/A if there is no current care plan identified

Section 4 Risk factors

Risk factors

Risk factors such as smoking, substance use and alcohol consumption are major contributors to disease, disability and death. Next to depression, drug misuse, anxiety, alcohol use and tobacco use were the most frequently reported mental health related problems managed by GPs for Indigenous Australians (AHMAC, 2012)

Documenting the presence or absence of these risk factors for the client means that opportunities arising during regular tests and checks can be used to talk with the client about the possible effect of these factors on their health.

Brief interventions

Brief interventions that address smoking, nutrition, alcohol intake, other substance use and physical activity are recommended for all chronic disease clients as part of routine care. Client education is an important aspect of management of chronic disease. These actions can be all documented in the client's record.

4.1 Smoking status

For the purposes of this audit, 'smoking' refers to the smoking of tobacco only and not to smoking of any other substance. Chewing tobacco is not included here.
Indicate the client's current smoking status, as documented in the client's medical record in the last 12 months.

1-Smoker if there is a record of the client smoking tobacco.

2-Non-smoker if there is a record that the client does not smoke tobacco.

3-Not stated if there is no record of the client's smoking status in the last 12 months.

4.2 Brief intervention for smoking

Brief interventions may be delivered in a variety of ways depending on the approach of the clinician and the circumstances of the client. Approaches to recording of brief interventions will also vary. For the purpose of the audit, the record of a brief intervention for smoking should at least indicate either that a brief intervention has been delivered, or that the client has been asked about their use of tobacco and their intentions or interest in quitting.

If the client is documented as smoker, is there documentation that the client has received a brief intervention for smoking in the last 12 months?

Indicate **1-Yes** or **0-No**

9-N/A if there is no record of tobacco use.

Tobacco addiction

The 2011 National Heart Foundation national tobacco campaign recommends referring clients to their Quitline. They suggest nicotine replacement therapy or oral therapy (bupropion or varenicline) for clients who smoke more than 10 cigarettes or units of tobacco per day and have no contraindications.

Alcohol use

It is acknowledged that discussion about recorded alcohol use is difficult to assess in some populations.

To define a client's level of risk for alcohol consumption, it is suggested that health personnel ask and record a description of the client's stated general alcohol consumption. This can then be measured against the NHMRC guidelines, if needed. For healthy men and women, drinking no more than two standard drinks on any day does not increase the lifetime risk of harm from alcohol related disease or injury (NHMRC 2009).

4.3 Alcohol use

What is the client's current use of alcohol, as recorded within the last 12 months?

Indicate

1-Higher risk if alcohol use is recorded as more than two standard drinks in any one day.

2-Low risk if recorded as two standard drinks or less in any one day.

3-Risk level not stated if alcohol use is recorded, but the amount is not stated.

4-No alcohol use if it is recorded that the client does not use alcohol.

5-Not stated if the client's alcohol use is not recorded.

4.4 Brief intervention for higher risk alcohol use

Brief interventions may be delivered in a variety of ways depending on the approach of the clinician and the circumstances of the client. Approaches to recording of brief interventions will also vary. For the purpose of the audit, the record of a brief intervention for reducing alcohol related harm should at least indicate either that a brief intervention has been delivered, or that the client has been asked about their use of alcohol and their intentions or interest in reducing their alcohol consumption.

If there is a record of higher risk alcohol use, is there a record that the client has received a brief intervention for alcohol use within the last 12 months?

Indicate **1-Yes** or **0-No**

9-N/A if the client's alcohol use is not documented as higher risk.

Other Drugs

For the purposes of this audit question, 'drug misuse' includes marijuana/cannabis and refers to any legal, illegal, prescription or non-prescription drug or substance used inappropriately and may include one or more of the following: pharmaceutical drugs such as pain killers, analgesics, tranquilisers or sleeping pills; inhalants; steroids; barbiturates; amphetamines or methamphetamines (speed); heroin; methadone; other opiates (opioids); cocaine; LSD or other synthetic hallucinogens; natural hallucinogens; ecstasy; ketamine; GHB; any injected drugs; cannabis or marijuana; glue or petrol sniffing.

4.5 Drug misuse

What is the client's drug use, as recorded within the last 12 months?
Indicate

1-Current misuse if there is a record of current use/misuse of drugs

2-Past misuse if there is a record that the client has used/misused drugs in the past

3-Never misused if there is a record that the client has never used/misused drugs

4-Not stated if there is no documentation of the client's drug use/misuse in the last 12 months

4.6 Brief intervention for drug misuse

For the purpose of the audit, the record of a brief intervention for drug use should at least indicate either that a brief intervention has been delivered, or that the client has been asked about their use of drugs and their intentions or interest in reducing or ceasing use of drugs. This may include discussion of risks, education strategies for lifestyle change, readiness to change, and may a be session lasting less than 5 minutes, or longer counselling sessions.

If there is documentation of current drug misuse, is there documentation that the client has received a brief intervention for drug use within the last 12 months?

Indicate **1-Yes** or **0-No**

9-N/A if there is no record of drug use.

BMI

Body mass index (BMI) determines if a client has a healthy weight for their height. BMI is calculated by dividing the weight (in kilograms) by the square of the height (in metres). A BMI is based on a person's weight and height and is calculated to determine whether a person is in a healthy weight range. Note that a BMI does not distinguish between the weight of fat and the weight of muscle, so there can be some exceptions to this guideline. Note that some people have normal BMI but larger-than-normal waist circumference; these people are at risk and should be advised to lose weight and increase physical activity.

Body mass index interpretation with normal waist circumference from CARPA (2014)

Body mass index	Result	What to do
<18.5	Underweight	Medical consult Advise healthy eating
18.5–24.9	Healthy weight	Advise to keep active
25.0–29.9	Overweight	Advise to lose weight or not gain more weight
≥30.0	Obese	Medical consult Advise to lose weight

4.7 Body mass index (BMI)

Is the client's BMI recorded within the last 12 months?

Indicate **1-Yes** or **0-No**.

4.8 BMI Value

If '1-Yes' in question 4.7, record the BMI value (must be greater than 10 and less than 60)

If BMI is not recorded, enter '**0**' in the BMI value field.

4.9 Brief intervention for overweight/obesity

For the purpose of the audit, the record of brief interventions for reducing overweight or obesity should at least indicate either that a brief intervention has been delivered, or that the client has been asked about their weight and their intentions or interest in reducing their weight.

If BMI is ≥25, is there a record that the client has received a brief intervention for overweight/obesity within the last 12 months?

Indicate **1-Yes** or **0-No**

9-N/A if BMI <25

The cycle of mental and physical health conditions

Up to 12 per cent of ten-year life expectancy gap with non-Indigenous Australians has been attributed to mental health conditions; four per cent to suicide; and six per cent to alcohol and substance abuse. Stress in children is associated with chronic disease later in life.

Mental health conditions are associated with high rates of smoking, alcohol and substance abuse, and obesity that also contribute to chronic disease: the single biggest killer of Aboriginal and Torres Strait Islander peoples.

And to complete the cycle, in 2008, 39 per cent of Aboriginal and Torres Strait Islander peoples reported the experience of the death of a family member or close friend, and 31 per cent reported serious illness or disability, as stressors in the previous 12-months. These were the most common types of life stressors reported. (Holland, et al 2013)

4.10 Nutrition

Is there documentation that brief intervention/counselling for nutrition has been delivered in the last 12 months?
Indicate **1-Yes** or **0-No**.

4.11 Physical activity

Is there documentation that brief intervention/counselling for physical activity has been delivered in the last 12 months?

Indicate **1-Yes** or **0-No**.

Comorbidity

People with depression co-morbid with one or more chronic diseases have the worst health scores of all the disease states. This has been found to be the case for people from diverse backgrounds and sociodemographic conditions in many countries. These findings underscore the urgency of addressing depression as a public-health priority to reduce disease burden and disability (Moussavi et al. 2007).

The National Co-morbidity Project found that persons in the general Australian community who have co-morbid substance use and mental disorders have poorer outcomes than those who have a single disorder (Teesson 2000).

4.12 Organic complications of alcohol misuse

Diagnoses can include: cirrhosis, pancreatitis, dementia, cardiomyopathy, GORD (gastro-oesophageal reflux disease), and alcohol related trauma. For the purpose of this audit, these complications should be documented as being related to alcohol misuse.

Is there any documented evidence in the client's record that the client does or has suffered from organic complications of alcohol use?

Indicate **1-Yes** or **0-No**.

4.13 Asthma or chronic obstructive airways disease (COAD)

Is there any documented evidence in the client's record that the client has had a diagnosis of asthma or any other COAD?

Indicate **1-Yes** or **0-No**.

4.14 Hypertension

Is there any documented evidence in the client's record that the client has had a diagnosis of hypertension?

Indicate **1-Yes** or **0-No**.

4.15 Type 2 Diabetes

Is there any documented evidence in the client's record that the client has had a diagnosis of type 2 diabetes?

Indicate **1-Yes** or **0-No**.

4.16 Ischaemic heart disease (IHD) or acute myocardial infarction (AMI)

Is there any documented evidence in the client's record that the client has had a diagnosis of ischaemic heart disease or if the client has had a heart attack (acute myocardial infarction)?

Indicate **1-Yes** or **0-No**.

4.17 Hyperlipidaemia

Hyperlipidaemia (abnormally high levels of fat in the blood) is an important risk factor for cardiovascular disease. It is common in people with chronic diseases.

Is there any documented evidence in the client's record that the client has had a diagnosis of hyperlipidaemia?

Indicate **1-Yes** or **0-No**.

4.18 Kidney disease

Is there any documented evidence in the client's record that the client has had a diagnosis of kidney disease?

Indicate **1-Yes** or **0-No**.

4.19 Cerebrovascular accident (CVA)

CVA, or stroke, is a blockage or haemorrhage of a blood vessel leading to the brain, causing inadequate oxygen supply. Depending on the extent and location of the abnormality, stroke results in such symptoms as weakness, paralysis of parts of the body, speech difficulties and, if severe, loss of consciousness or death.

Is there any documented evidence in the client's record that the client has suffered from a CVA or stroke?

Indicate **1-Yes** or **0-No**.

4.20 Hepatitis C positive

Is there any documented evidence in the client's record that the client has had hepatitis C positive serology?

Indicate **1-Yes** or **0-No**.

Section 5 Audit of current treatment

Treatment

Antipsychotic medication is the ideal treatment for some mental illnesses, especially schizophrenia. Cognitive or psychological therapy may also be appropriate, depending on individual situations.

Specific key recommendations in the treatment for a first episode of mental illness proposes making comprehensive and sustained intervention and treatment a priority to minimise the psychosocial impact illness may have on long-term outcomes. This includes a combination of psychiatric medications and an increased research effort to develop more effective and better tolerated drug therapies. Other recommendations include appropriately managing depression, substance misuse, interpersonal and family stress (McGorry et al 2003).

There are also few psychological, psychiatric or family therapies or treatments with any proven efficacy for Aboriginal or Torres Strait Islander clients and families. Hence it may be necessary to explore local solutions, consider traditional healing methods and modify existing treatments to be culturally sensitive (RANZP, 2009).

5.1 Oral antipsychotic medication

Antipsychotic medications are medication used to treat the symptoms psychosis. Common antipsychotic medications are listed in Appendix 1.

Is there documentation of a current prescription for oral antipsychotic medication?

Indicate **1-Yes** or **0-No**.

5.2 Oral antidepressant medication

Common antidepressant medications are listed in Appendix 1.

Is there documentation of a current prescription for oral antidepressant medication?

Indicate **1-Yes** or **0-No**.

5.3 Oral mood stabiliser medication

Common mood stabiliser medications are listed in Appendix 1.

Is there documentation of a current prescription for oral mood stabilizer medication?

Indicate **1-Yes** or **0-No**

5.4 Intramuscular (IM) antipsychotic medication

Common IM antipsychotic medications are listed in Appendix 1.
Indicate if the client has a current prescription for IM antipsychotic medication.
Indicate **1-Yes** or **0-No**

5.5 Anti-anxiety and hypnotic medication

Common anti-anxiety and hypnotic medications are listed in Appendix 1.

Is there documentation of a current prescription for anti-anxiety and/or hypnotic medication?

Indicate **1-Yes** or **0-No**.

5.6 Other psychiatric medication

Is there documentation of a current prescription for other psychiatric medication? See some examples of other medication in Appendix 1.

Indicate **1-Yes** or **0-No**.

5.7 Alternative treatment

Determine if the client is taking any other forms of non-prescription medication related to the current treatment (e.g. St John's wort, vitamins or minerals).

Indicate **1-Yes** or **0-No**.

5.8 Use of dosette or Webster pack

Is there documented evidence that client's medication is repackaged in a Webster pack, blister pack or dosette?

Indicate **1-Yes** or **0-No**

9-N/A if there is no record of oral medication

Section 6 Hospitalisations and discharge

Hospitalisation

Between 2004–05 and 2008–09, hospitalisation rates for mental and behavioural disorders were around 1.7 times higher for Aboriginal and Torres Strait Islander persons than for non-Indigenous persons across all years (SCRGSP 2011). Importantly, mental and behavioural disorders due to psychoactive substance use was the most common mental health-related condition for which Aboriginal and Torres Strait Islander people were hospitalised (AIHW 2011b). Of even more concern, hospitalisation for mental and behavioural disorders was the most significant variable that increased the likelihood of being discharged against medical advice. Aboriginal and Torres Strait Islander people were vastly over-represented in this category (AIHW 2011a).

Follow up

People leaving hospital after an admission for an episode of mental illness have heightened levels of vulnerability and, without adequate follow up, may relapse or be readmitted. The post discharge period is also a period of great stress and uncertainty for families and carers. One of the measures of 'post discharge community care' is 'continuity of care' including prompt community follow up in the vulnerable period following discharge from hospital (DoHA, 2013).

6.1 Mental health related hospital admissions

Documentation of hospitalisation may be an entry in the progress notes that client has returned from hospital admission; discharge summary; letter from specialist referring to hospital admission, or another type of communication.

Record the **number** (including '0' if appropriate) of hospital admissions in the last 12 months that were related to mental health

6.2 Other hospital admissions

Documentation of hospitalisation may be an entry in the progress notes that client has returned from hospital admission; discharge summary; letter from specialist referring to hospital admission, or another type of communication.

Record the **number** (including '0' if appropriate) of hospital admissions in the last 12 months that were NOT related to mental health

6.3 Resolution of mental health disorder on discharge

If there is documentation of mental health related hospital admissions, indicate if there is documented evidence in the client's notes of resolution (this would infer that no follow up is necessary) of their mental health disorder upon discharge from hospital; check in the discharge notes for admissions related to mental illness. Is there any documented evidence in the notes of a resolution in the client's mental health on discharge?

Indicate **1-Yes** or **0-No**

9-N/A if the client has not had any mental health related hospital admissions in the last 12 months.

6.4 Discharge letter or follow up plan

Is there a clear record of a discharge letter or follow up plan or instructions in the client's medical record?
Indicate **1-Yes** or **0-No**
9-N/A if the client has not had any mental health related hospital admissions in the last 12 months.

Section 7 Scheduled services

Accessing appropriate care

Once consumers have accessed services they still feel barriers to quality care, confidence in assessment is low and there continues to be high risk of misdiagnosis, under-detection of illness, and lack of cultural safety (Nagel et al. 2008, Wand et al. 2009).

Strategies for comprehensive assessment include: engagement of families and carers (Nagel 2010), holistic assessment incorporating culture, acknowledgement and understanding of difference in body language and interpretation of mental state assessments, adherence to cultural protocols, training in two way approaches to assessment, and strategies for collaborative goal setting (Haswell-Elkins et al. 2009, Laliberte 2010; Nagel et al. 2009).

Health professionals need to blend traditional and modern ways of understanding and treating illness in order to develop services that understand the dynamic relationship between mind, body and spirit in Indigenous cultures (Kirmayer 2003, McLennan and Khavarpour 2004, Murray et al. 2002, Roxbee and Wallace 2003, Trudgen 2000).

The following questions distinguish between a **general health team** and **mental health team**. The general health care team may consist of the local primary health care professionals. The mental health team may be mental health professionals who are internal, external, or visitors to the primary health care service. This is to help distinguish the services delivered by health professionals who may not have mental health as their specialty area (general health team), and services delivered by health professionals who specialise in mental health (mental health team). Further information about suggested service providers, and pathways of care is available in the Queensland Health mental health protocols (see references).

Comprehensive assessment

7.1 Mental health assessment

Mental health assessment (MSE, mental state examination) includes a review of strengths, symptoms and stressors, social functioning and physical health, a brief description of appearance and/or behaviour, mood, perception and thought. The plan includes biological, psychological and social elements.

Indicate if there is documentation which meets the criteria of three or more of the above items in a given service contact within the previous 6 months in the client's medical record.

Indicate **1-Yes** or **0-No**

9-N/A if the client has not attended in the last 6 months

Indicate if the most recent instance of service was delivered by the **general health team OR the mental health team**

Note: There are two examples of different GP mental health care plans where the Mental State Examination (MSE) sections may be found in Appendix 1.

7.2 Adult health check

Indicate if there is a record of the client having an adult health check (MBS item 715), within the previous 12 months.

Indicate **1-Yes** or **0-No**

Indicate if the most recent instance of service was delivered by the **general health team OR the mental health team**

7.3 Alternative adult health check (within previous 12 months)

Is there an alternative adult health check similar to MBS item 715 (previously MBS item 710, 704 or 706)?

Indicate **1-Yes** or **0-No**

Indicate if the most recent instance of service was delivered by the **general health team OR the mental health team**

7.4 Blood pressure (BP)

If the client is prescribed antipsychotic medication, their blood pressure should be checked regularly.

Indicate if there is a record of the client having their BP checked within the previous 6 months.

Indicate **1-Yes** or **0-No**

9-N/A if the client has not attended in the last 6 months

Indicate if the most recent instance of service was delivered by the **general health team OR the mental health team**

7.5 Review of medication by psychiatrist or registrar (within previous 12 months)

Indicate if there is a record of the client's medication being reviewed by a psychiatrist or registrar within the last 12 months. Review can be in person or by phone or video conference. This review may include: joint discussion about medication and effects, experienced medication side effects and/or medication compliance.

Indicate **1-Yes** or **0-No**

Indicate if the most recent instance of service was delivered by the **general health team OR the mental health team**

Treatment and care in the last 3 months

7.6 Family and/or individual counselling

Indicate if there is a record of counselling or discussion about mental health, mental illness and/or treatment with the client and/or their family within the previous 3 months.

Indicate **1-Yes** or **0-No**

9-N/A if the client has not attended in the last 3 months

Indicate if the most recent instance of service was delivered by the **general health team OR the mental health team**

7.7 Social issues counselling

Indicate if there is a record of counselling or discussion about social issues which may include social or family support services, housing conditions, food security, financial situation, domestic violence, substance misuse within the previous 3 months.

Indicate **1-Yes** or **0-No 9-N/A** if the client has not attended in the last 3 months

Indicate if the most recent instance of service was delivered by the **general health team OR the mental health team**

NOTE: 'Carer' is defined as a person who has a caring role with the client and whose life is affected by the client's welfare (Victorian Government Mental Health Services). 'Allied' refers to an 'ally' of the client, not an allied health person/professional. This is someone chosen by the client to help be responsible for the client when they are not able to make their own decisions (Mental Health Act Qld, 2000).

7.8 Engagement with family and/or carer(s) and/or ally

Indicate if there is a record of the health team engaging with the family and/or carer(s) and/or ally of the client within the previous 3 months.

Indicate **1-Yes** or **0-No**

9-N/A if the client has not attended in the last 3 months

Indicate if the most recent instance of service was delivered by the **general health team OR the mental health team**

7.9 Mental (Psycho) health education of client

Education can be delivered through written materials, flipcharts, DVDs, or other appropriate materials.

Indicate if there is a record of the client receiving education regarding mental illness within the previous 3 months.

Indicate **1-Yes** or **0-No**

9-N/A if the client has not attended in the last 3 months

Indicate if the most recent instance of service was delivered by the **general health team OR the mental health team**

7.10 Mental (Psycho) health education of family and/or carer(s) and/or ally

Indicate if there is a record of the client's family and/or carer(s) receiving education regarding mental illness, within the previous 3 months. The education can be delivered through written materials, flipcharts, DVDs or other appropriate materials.

Indicate **1-Yes** or **0-No**

9-N/A if the client has not attended in the last 3 months

Indicate if the most recent instance of service was delivered by the **general health team OR the mental health team**

Cultural engagement

Culturally competent services embody: cultural awareness, cultural respect, and cultural responsiveness. Culturally safe service environments are ones that are welcoming for Aboriginal and Torres Strait Islander peoples, with no assault, challenge or denial of their identity. The mere presence of Aboriginal and Torres Strait Islander staff has been demonstrated to increase the accessibility of services by contributing to a sense of cultural safety (Holland, 2013).

Practitioners need to be aware of sensitive and highly emotional issues and use alternative means of gathering information or consult with Aboriginal or Torres Strait Islander mental health workers (RANZP, 2009).

Cultural engagement in the last 3 months

7.11 Culturally appropriate service delivery or intervention

Indicate if there is evidence in the client's record that cultural influences and cultural treatments have been considered through discussion with family and local Indigenous practitioners, within the previous 3 months.

Indicate **1-Yes** or **0-No**

9-N/A if the client has not attended in the last 3 months

Indicate if the most recent instance of service was delivered by the **general health team OR the mental health team**

7.12 Engagement with an Indigenous health worker or Indigenous community worker

This question is about the most recent engagement (health related) with the client in the last 3 months. To ensure culturally appropriate service, engagement may be with any one of a variety of appropriate staff. Indicate if there is a record of the client engaging with an Indigenous health worker or Indigenous community worker or traditional healer within the previous 3 months.

Indicate **1-Yes** or **0-No**

9-N/A if the client has not attended in the last 3 months

Indicate if the most recent instance of service was delivered by the **general health team OR the mental health team**

Section 8 Investigations

Maintaining health

A specific key recommendation for people with mental illness on regular psychotropic medication is to maintain good physical health and promote prevention and early treatment of medical illness. The general medical care for people with mental illness should become an active focus (McGorry 2003).

8.1 Liver function tests (LFTs)

If the client is prescribed regular psychotropic medication, annual liver function tests are recommended. There are several laboratory tests which can be used to assess liver function; including AST, ALT, ALP, albumin, GGT, bilirubin, cholesterol and prothrombin.

Is there a record of a liver function test within the previous 12 months?

Indicate **1-Yes** or **0-No**

9-N/A if the client is not prescribed regular psychotropic medication

Record the date of the most recent test; record as **dd/mm/yyyy**

8.2 Serum urea

If the client is prescribed regular psychotropic medication, an annual serum urea is recommended. Is there a record of a serum urea test within the previous 12 months?

Indicate **1-Yes** or **0-No**

9-N/A if the client is not prescribed regular psychotropic medication

Record the date of the most recent test; record as **dd/mm/yyyy**

8.3 Serum creatinine

If the client is prescribed regular psychotropic medication an annual serum creatinine test is recommended. Is there a record of a serum creatinine test within the previous 12 months?

Indicate **1-Yes** or **0-No**

9-N/A if the client is not prescribed regular psychotropic medication

Record the date of the most recent test; record as **dd/mm/yyyy**

8.4 Thyroid function test (TFTs)

If the client is prescribed regular psychotropic medication, an annual thyroid function test is recommended.

Is there is a record of a thyroid function test within the previous 12 months?

Indicate **1-Yes** or **0-No**

9-N/A if the client is not prescribed regular psychotropic medication

Record the date of the most recent test; record as **dd/mm/yyyy**

8.5 Full blood count (FBC)

If the client is prescribed regular psychotropic medication an annual full blood count is recommended. Is there a record of a full blood count within the previous 12 months?

Indicate **1-Yes** or **0-No**

9-N/A if the client is not prescribed regular psychotropic medication

Record the date of the most recent test; record as **dd/mm/yyyy**

8.6 Lipid profile

A lipid profile includes measurement of total cholesterol, high-density lipoprotein (HDL), low-density lipoprotein (LDL) and triglycerides.

If the client is prescribed regular psychotropic medication an annual lipid profile is recommended. Is there a record of a lipid profile within the previous 12 months?

Indicate **1-Yes** or **0-No**

9-N/A if the client is not prescribed regular psychotropic medication

Record the date of the most recent test; record as **dd/mm/yyyy**

8.7 Mood stabiliser (blood level)

If the client is prescribed mood stabiliser medication (see Appendix 1, Table 8) an annual mood stabiliser blood level check is recommended. Is there a record of a mood stabiliser blood level check within the previous 12 months?

Indicate **1-Yes** or **0-No**

9-N/A if the client is not prescribed regular mood stabiliser medication

Record the date of the most recent test; record as **dd/mm/yyyy**

Section 9 Follow-up of abnormal clinical findings

While the risk factors for mental illness such as substance misuse, trauma, and physical illness are rising, many people with mental illness do not receive treatment and there are high levels of unmet need. National initiatives highlight the importance of early intervention and treatment for vulnerable populations (ABS 2005).

Is there evidence of exacerbation or deterioration of any of the following symptoms and/or behaviours within the previous 12 months?

9.1 Sleep patterns

Indicate if there is evidence in the client's medical record of any change to sleep patterns within the previous 12 months.

Indicate **1-Yes** or **0-No**.

9.2 Hallucinations

Indicate if there is documentation in the client's medical record of exacerbation of hallucinations (may be auditory or visual) in the last 12 months.

Indicate **1-Yes** or **0-No**.

9.3 Mood

Indicate if there is evidence in the client's medical record of any change to mood within the previous 12 months.

Indicate **1-Yes** or **0-No**.

9.4 Psychotic symptoms

Indicate if there is evidence in the client's medical record of any psychotic symptoms within the previous 12 months.

Psychotic symptoms may include one or more of the following:

- hallucinations (commonly auditory but may be visual or olfactory)
- delusional thoughts
- thought disorder
- flattened affect.

Indicate **1-Yes** or **0-No**.

9.5 Medication side effects

Indicate if there is evidence in the client's medical record of any medication side effects within the previous 12 months.

Indicate **1-Yes** or **0-No**.

9.6 Aggressive behaviour

Indicate if there is evidence in the client's medical record of any aggressive behaviour within the previous 12 months.

Indicate **1-Yes** or **0-No**.

9.7 Social withdrawal

Indicate if there is evidence in the client's medical record of any social withdrawal within the previous 12 months.

Indicate **1-Yes** or **0-No**.

9.8 Self-care

Indicate if there is evidence in the client's medical record of any deterioration to self-care within the previous 12 months.

Indicate **1-Yes** or **0-No**.

If there is evidence of exacerbation or deterioration of any of the symptoms and/or behaviours as described above, indicate if there a record of:

9.9 Referral to another health professional

Indicate if the client has been referred to another health professional for follow-up care.

Indicate **1-Yes** or **0-No**

9-N/A if there is no documented evidence of exacerbation or deterioration of symptoms or behaviours in Q 9.1-9.8.

9.10 Medication adjustment

Indicate if there is documentation in the client's record of their medication being adjusted.

Indicate **1-Yes** or **0-No**

9-N/A if there is no documented evidence of exacerbation or deterioration of symptoms or behaviours in Q 9.1-9.8.

9.11 Medication reviewed, but not adjusted

Indicate if there is documentation in the client's record of their medication being reviewed but not adjusted.

Indicate **1-Yes** or **0-No**

9-N/A if there is no documented evidence of exacerbation or deterioration of symptoms or behaviours in Q 9.1-9.8.

9.12 Psychosocial and/or culturally appropriate intervention

Indicate if the client has received a psychosocial and/or culturally appropriate intervention.

Indicate **1-Yes** or **0-No**

9-N/A if there is no documented evidence of exacerbation or deterioration of symptoms or behaviours in Q 9.1-9.8.

Appendix 1

Table 1: Common medications and dosages to assist in identifying medications used in mental health — antidepressants

Medication	Trade name	Used for	Common side effects	Usual dosage mg/day *
Antidepressants				
Sertraline	Zoloft	Depression/anxiety	Gastrointestinal, insomnia, sexual, agitation	50–200
Fluoxetine	Prozac	Depression/anxiety	Agitation, headache, withdrawal, weight loss	20–80
Mirtazepine	Avanza	Depression/anxiety	Weight gain, sedation, dreams, dizziness	15–60
Escitalopram	Lexapro	Depression/anxiety	Insomnia, sedation, gastrointestinal, dizziness	10–20
Nefazodone	Serzone	Depression/anxiety	Gastrointestinal, hypotension, sedation, dizziness	200–600
Paroxetine	Aropax	Depression/anxiety	Withdrawal, sedation, sexual	20–60
Fluvoxamine	Luvox	Depression/anxiety	CNS, cardiac, gastrointestinal, sweating, headache	100 –300
Amitryptaline	Tryptanol	Depression/anxiety	Anticholinergic, sedation	75–150
Tranylcyproamine	Parnate	Depression/anxiety	Hypertensive crisis, insomnia, headache, palpitations, dizziness	10–30
Venlafaxine	Effexor	Depression/anxiety	Withdrawal effects, sexual, gastrointestinal, hypertension, insomnia	75–375 Effexor XR 150–225
Mianserin	Tolvon	Depression/anxiety	Sedation, hypomania, anticholinergic	30–120
Moclobemide	Aurorix	Depression/anxiety	Insomnia, dizziness, nausea, headache	300–600
Phenelzine sulfate	Nardil	Depression/anxiety	Hypotension, hypomania, agitation	15–60
Reboxetine	Edronax	Depression/anxiety	Headache, insomnia, tachycardia, nausea, sedation, weight gain	4–10

*Lower doses in elderly, physically unwell and at commencement
Note: Only common side effects recorded above, check dosage regime before prescribing. Only one trade name is included for each medication

Table 2: Common medications and dosages to assist in identifying medications used in mental health — antipsychotics

Medication	Trade name	Used for	Common side effects	Usual dosage mg/day *
Antipsychotics				
Aripiprazole	Abilify	Psychosis	Tardive dyskinesia, neuroleptic malignant syndrome, headache, hypotension, gastrointestinal, hyperglycaemia	15–30
Chlorpromazine	Largactil	Psychosis	Sedation, tardive dyskinesia, hypotension, photosensitivity	25–300
Clozapine	Clopine	Psychosis	Sedation, weight gain, constipation, agranulocytosis	200–900
Droperidol	Droleptan	Psychosis	Hypotension, sedation, extrapyramidal symptoms, arrhythmias	5–25 IMI
Flupenthixol	Fluanxol depot	Psychosis	Extrapyramidal symptoms, tardive dyskinesia, anticholinergic	20 2–4 wkly
Haloperidol	Serenace	Psychosis	Extrapyramidal symptoms, neuroleptic malignant syndrome, endocrine, QT prolongation	1–15
Olanzapine/ wafers	Zyprexa/ Wafers	Psychosis/ mood stabiliser	Weight gain, sedation, hypotension	5 - 20
Quetiapine	Seroquel	Psychosis	Hypotension, sedation, hyperglycaemia, neuroleptic malignant syndrome, tardive dyskinesia, weight gain	200–400
Risperidone (depot)	Risperdal Consta	Psychosis	Tardive dyskinesia, neuroleptic malignant syndrome, hypotension, agitation, weight gain, increased prolactin, hyperglycaemia	25–50 IM 2 wkly
Risperidone (oral)	Risperdal	Psychosis	(As above;.Drug is also available as disintegrating tabs)	2–6
Trifluoperazine	Stelazine	Psychosis	Sedation, extrapyramidal symptoms, tardive dyskinesia, neuroleptic malignant syndrome, hypotension, anticholinergic effects	1–6
Zuclopenthixol	Clopixol	Psychosis	Sedation, extrapyramidal symptoms, anticholinergic, neuroleptic malignant syndrome	10–50
Zuclopenthixol	Clopixol acuphase	Psychosis	Sedation, extrapyramidal symptoms, anticholinergic, neuroleptic malignant syndrome	50–150 IMI
Zuclopenthixol	Clopixol depot	Psychosis	Sedation, extrapyramidal symptoms, anticholinergic, neuroleptic malignant syndrome	200–400 IMI 2–4 wkly

*Lower doses in elderly, physically unwell and at commencement
(Depot) — many depot preparations are also available as oral preparations
Note: Only common side effects recorded above, check dosage regime before prescribing. Only one trade name is included for each medication

Table 3: Common medications and dosages to assist in identifying medications used in mental health — mood stabilisers (oral)

Medication	Trade name	Used for	Common side effects	Usual dosage mg/day *
Mood stabilisers (oral)				
Lithium carbonate	Lithicarb	Mood stabiliser	Renal effects, polyuria, goitre, thirst, weight gain	500 –1000
Sodium valproate	Valpro	Mood stabiliser	Haematological, neurological, hepatic dysfunction, gi, hair loss, weight gain	600–2000
Carbamazepine	Tegretol	Mood stabiliser	Sedation, gi, hepatic, endocrine, haematological	600–1000
Lamotrigine	Seaze	Mood stabiliser	Rash, central nervous system disturbance, arthralgia	50–400
Olanzapine/ wafers	Zyprexa/ Wafers	Psychosis/mood stabiliser	Weight gain, sedation, hypotension	5–20

*Lower doses in elderly, physically unwell and at commencement
Note: Only common side effects recorded above, check dosage regime before prescribing. Only one trade name is included for each medication

Table 4: Common medications and dosages to assist in identifying medications used in mental health — anti-anxiety/other

Medication	Trade name	Used for	Common side effects	Usual dosage mg/day *
Other				
Benztropine	Cogentin	Parkinsonism	Anticholinergic, tachycardia, confusion	2–6
Zolpidem	Stilnox	Insomnia	Tolerance, dependence, withdrawal	5–10
Clonazepam	Rivotril	Anxiety, agitation, mania	Dependence, sedation	1–8
Diazepam	Valium	Anxiety agitation	Tolerance, dependence, sedation	5–60
Oxazepam	Serepax	Anxiety agitation	Tolerance, dependence, sedation	15–45

*Lower doses in elderly, physically unwell and at commencement
Note: Only common side effects recorded above, check dosage regime before prescribing. Only one trade name is included for each medication

Appendix 2

Table 5: Australian integrated mental health initiative (AIMhi) example of GP care plan with Mental State Exam

MENTAL HEALTH ASSESSMENT FORM

PRINCIPAL NAME (AKA)	OTHER NAMES	DOB…/…/….
Things that help to keep this person well, happy, and strong: (spiritual, physical, family and social, mental and emotional)		
Current issue:		
Family and cultural background and personal history (Check for family history of mental illness)		
Some of the worries for this person are: (Tick or circle)		
☐	Family trouble, humbug or worry	
☐	Not doing much, like hunting, fishing, or other things	
☐	Work worry	
☐	Not sleeping well	
☐	Not eating good tucker	
☐	Too many cigarettes	
☐	Too much grog, ganja or other drugs, or gambling	
☐	Physical illness	
☐	Don't want medicine or treatment	
☐	Side effects of medicine – feel sleepy or tight muscles	
☐	Don't know about mental illness or treatment	
☐	Trouble cooking and shopping and caring for myself	
☐	Problem remembering things or finding my way around	
☐	Doing things which worry my family	
☐	Culture worry	
☐	Sitting down alone – not mixing much with others	
☐	Violent, strange, silly or bad behaviour	
☐	Hearing voices or seeing things	
☐	Feeling sad inside, no interest in doing things	
☐	Problem with being too happy or too much energy	
☐	Mixed up thoughts, paranoid, silly thinking	
☐	Self-harm behaviour or thoughts of suicide	
☐	Feeling anxious or nervous or jumpy	
☐	Other worries	
Past medical history (including head injury)		
Past psychiatric history and forensic history (trouble with police or court)		

Risk assessment Circle below 1= no apparent risk 2 = low risk 3 = significant risk 4 = serious risk 5 = extreme and imminent risk		
Self-harm/suicide	Harm to others	Vulnerability
1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Mental State Examination	
Appearance (look OK?) Behaviour (doing strange things?) Conversation (saying strange things?)	Affect (sad or worried or scared or?) Perception (hearing things or seeing things?) Cognition (confused/ mixed up?)
The main problem today is:	
The mental health diagnosis is:	
The plan today is:	

Type of treatment		What will happen, who will do it
☐	Medication	
☐	Compliance strategies	
☐	Life style changes (substance use, diet, exercise, smoking)	
☐	Social changes (go out bush, job training)	
☐	Cultural or spiritual activity or treatment	
☐	Other services / other treatments e.g. for physical illness	
☐	Review care plan goals or complete a care plan	
☐	Other	

Medication Refer to prescription for detail of all medications	Dose, frequency and route	Dr. signature and date

Table 6: Medicare Australia example of GP care plan with Mental State Examination

GP MENTAL HEALTH CARE PLAN (MBS ITEM 715 Number) PATIENT assessment			
Patient's Name		Date of Birth	
Address		Phone	
Carer details and/or emergency contact(s)		Other care plan YES ☐ E.g. GPMP / TCA NO ☐	
GP Name / practice			
AHP or nurse currently involved in patient care		Medical Records No.	
PRESENTING ISSUE(S) What are the patient's current mental health issues			
PATIENT HISTORY Record relevant biological psychological and social history including any family history of mental disorders and any relevant substance abuse or physical health problems			
MEDICATIONS (attach information if required)			
ALLERGIES			
ANY OTHER RELEVANT INFORMATION			
RESULTS OF MENTAL STATE EXAMINATION Record after patient has been examined			
RISKS AND COMORBIDITIES Note any associated risks and co-morbidities including risks of self-harm &/or harm to others			
OUTCOME TOOL USED	RESULTS		
DIAGNOSIS			

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