Queensland Centre for Mental Health Learning

Comprehensive Care Webinar Transcript
Physical Health Screen – Number 7

Good morning, everyone and welcome to this Comprehensive Care Webinar number seven. My name is Emma Martin, and I'm a clinical educator for the Queensland Centre for Mental Health Learning. And we're joined also with James Hoey, Clinical Educator for Insight, and in collaboration with the Mental Health Alcohol and Other Drugs Branch. Today's session is focused on the physical health screening in comprehensive care.

We're going to be led by a team of specialists in the area through a series of videos that help us to understand the process and the story in our use with physical health screening. Consultant Psychiatrist Dr. Nicky Korman is leading the way. She'll tell us more about the topics that we'll cover in a moment.

But to get us started, let us pay respects to the traditional owners of the lands and the seas from the places on which you're joining and the elders of the past, the present, and those emerging. We also acknowledge the lived experience of those with mental illness, those impacted by suicide or substance use, and the contributions that their friends, their families, their carers, and staff make to their recovery.

So, as we said, Nicky and the team have developed a number of videos, and also some resource links, which we'll watch in turn. After we view these together, there'll be a quick question and answer session, a live session. And so, what we'd really appreciate you doing throughout the viewing of these is to consider the kinds of questions that you might like to ask of our panel at the close.

We're also very fortunate and thankful today that we've got Dr. John Reilly, our Chief Mental Health Alcohol and Other Drugs Officer who will be joining us, and he will lead the panel at the end of the session. So, to get us started, let's head to our first snippet of content video, which Dr. Nicky Korman has put together in collaboration with one of our consumers, Tom, who has experienced a recovery through his physical as well as his mental well-being.

[VIDEO PLAYBACK]

Hi, my name is Dr. Nicky Korman. I'm a psychiatrist working in Metro South Addiction and Mental Health Services. Today we want to talk about the use of the physical health screen form, which is part of the new Comprehensive Care Package that Mental Health Branch has released on CIMHA. In this webinar, we will specifically be looking at the physical health screening form, and we will cover the importance of physical health screening, speak to a consumer whose experienced physical health problems themselves, look at some of the functionality of the physical health screen form, and finally provide you with some resources that may help with physical health screening.

People with severe mental illness can present with significant physical health challenges and chronic conditions, which can be distressing and also cause premature mortality of up to 10 to 15 years compared to the general population. Lifestyle risk factors such as inactivity, poor

nutrition, and smoking, together with the metabolic side effects of medications we prescribe for their mental health, can contribute to higher rates of preventable diseases, such as cardiovascular disease and diabetes.

We know that consumers of our mental health service are concerned about their physical health, and they want us to help them improve both their physical and mental health together. Therefore, it's vital that we screen our consumers' physical health and provide an initial management plan for any abnormalities detected. It's also really important that we communicate these results with the individual and with their general practitioner and any other health practitioners involved.

It's recommended that this form be used on admission to the mental health service, at relevant intervals throughout their care, and at least once per year.

OK, so now we're going to talk to a consumer from the mental health service about his feelings about his own physical health and the importance of physical health screening.

Hi, my name's Tom Jost. I'm 54 years old. I was first diagnosed with acute paranoid schizophrenia 13 years ago. The symptoms that I've been struggling with started decades before that, which I can only now really appreciate. I had poor concentration and difficulty coping with life situations. It's difficult for me to accept this now that I've actually had it for so long. But in some ways, it's sort of learning to accept my whole struggle apart from my life.

One of the ways I coped with my schizophrenia both before and after the acute phase was with competitive road cycling. I did most of the training alone, using long, hard rides to exhaust myself and obliterate whatever bad feelings I had at the time. My symptoms of paranoia and delusions are under control now thanks to the drug Abilify, but I struggled with the increased body weight the antipsychotic drugs are known for.

Part of that's caused by the reduced drive to engage in any physical activity, which led to me lying in bed all day when I was living with my parents. After doing nothing but lie in bed for about 16 months, I lost all my muscle tone. I was extremely depressed, and my weight ballooned from 78 to 98 kilograms.

While medication has allowed me-- given me the freedom to be free from worry of having any more delusions or ending up going to the court system, things like that, you can do without, and on the flip side is that it can make you feel a little bit lethargic at times, and particularly adds on, seems to add on extra weight, quite a bit, in some cases.

I'm really glad that mental health staff taken an interest in my physical health because it's not just my imagination that the drugs help you put on so much weight. You just think, well, what am I supposed to do about all this? And I'm glad that at least the attempts with diet and exercise to reduce those effects.

My cholesterol was getting alarmingly high at one point, it got up to 6, at least to the point where something had to be done. So, I started taking a statin at night, a statin pill. And also, I sort of consciously cut back on fatty, cholesterol-high foods. So, between the two of those things, it's come down to 2, which everyone seems quite happy about.

Moving to the CCU helped provide some structure and activities during the day, one of which was organised gym sessions. The sessions are designed and supervised individually by exercise physiologists. I understood that I had lost all my muscle tone and I needed to take it really easy when first starting back in the gym. I do feel encouraged in general when nurses and other mental health staff take an interest in my physical health. My own experience in life is that physical health and fitness plays an intrinsic role in my mental health.

[END PLAYBACK]

EMMA MARTIN: Next up, we introduce Senior Nutritionist Donni Johnston, who will lead us through the functionality of the physical health screening form in CIMHA. And then Dr. Nicky and Donni will provide a roleplay for us to demonstrate how it is we can use the physical health screening in practise. So, don't forget as you're watching these to keep the questions coming. James is watching the chat and formulating some questions for the panel after that.

Just bear with us. We're just-- here we go.

[VIDEO PLAYBACK]

Today we're going to walk through the physical health screen form. This is one of three forms introduced as part of the Comprehensive Care Package. This part of the webinar will cover where to find the form on CIMHA, the functionality of the form, as well as writing a management plan. Later in the webinar, we'll run through how this looks in practise in a roleplay with a consumer.

So, to access the physical health screening form on CIMHA, you start at your landing page, which you can see on the screen here. You head into Clinical Record, and then down to Clinical Documents, and choose Add a Note. Moving through the time and date that's appropriate for you, down under Category on the left-hand side there, we choose Assessment. And then you will find Physical Health Screen form in the template.

So, this is how the physical health screen form looks on your screen. You can see at the top there is the consumer's name and details. And the first part we'll head to is the metabolic screen part on the left. So here you have the opportunity to add in all of the screening measures from height, weight, BMI, waist circumference, blood pressure, and pulse. Now, it's important to remember that height is measured in metres and weight is done in kilograms.

Moving on to the general health and substance use questions, you can run through whether a consumer has seen their GP in the last year, side effects from medication, also falls rates, and then any screening involvement scores from your tobacco and alcohol substance screening forms.

It's important to note with the metabolic screening section that this is just a cross-sectional view of these measures. If you want to be able to track a consumer's changes over time, it's important to use the metabolic monitoring form to achieve this.

Now, moving down below, you'll see a series of food and nutrition questions, diabetes questions, physical activity, and also oral health questions. So, running through these questions with the consumer, if you do note that they answer a question and it requires

further inquiry, you can do this and make notes around this in the initial management plan, which we'll get to soon.

So further down after the oral health questions, you'll also notice that there are some handy links to further screening and information that can be quite helpful. Below that is the pathology section. Now, in this section, you can either transcribe the pathology results, or there is an option to attach a document and insert it in this section here.

Similar for the urine drug screen results, and then down we get to the management plan. This is the most important part of the physical health screen form, as we know it's important not just to screen consumers, but to actually intervene in areas that are identifies as a risk. So, you can see that my draft was successfully saved, which is excellent.

So, the initial management plan down here, when you click on it, you can type into that just free text. So, some examples of things that would be included in the initial management plan include referrals to the local healthy groups or programmes, referrals to a GP or other primary care professional, information that you intend to share with a GP or receive from a GP. And other actions that the clinician intends to take, such as performing some goal setting with the consumer, providing health education, or finding out about scheduled health checks can all be mentioned here.

The final part of completing the physical health screen form, we can integrate this form into other parts of the consumer's care by using the hyperlink function to link documents with other documents within CIMHA. And finally, once the form is completed, it's important to share it with other service providers that are involved in the consumer's care.

You can do this internally through the Share function at the top of the screen. And you can share that with staff that are within the mental health service and other parts of Queensland Health. Or if you need to share it externally, you can do this through local confidential methods. This would be to people such as your GP or other primary health care providers.

Note, the questions on the fiscal health screen form are structured in a way that they are able to be asked of a consumer by any staff, including Aboriginal and Torres Strait Islander health workers and peer workers. The only information which requires specific clinical knowledge is the blood pressure and pulse, which can be transcribed into this document based on the measurement performed by a nurse or a doctor.

[END PLAYBACK]

[VIDEO PLAYBACK]

Dr Nicky: Hi Donni, thanks for coming in to see me today. I understand that you first came to the service several weeks ago with a referral from your GP about increasing depression and wanting some help with treatment for that. And last week we met and discussed starting on some antidepressant medication, which you started last week, and getting some help from a psychologist for some therapy. How are you feeling today?

Donni: Yeah, I'm still feeling pretty low. But I feel like now things might change. I'm a bit more hopeful that things are moving again.

Dr Nicky: OK, well, I'm glad to hear that you're feeling more hopeful about getting some help. Today I wanted to talk a little bit about your physical health, for several reasons. First of all, people's physical health can adversely affect their mental health and vice versa. And we also know that if there are physical health problems, if we intervene early, we might be able to prevent more serious problems like diabetes or heart disease down the track. And finally, we also know that if we can help people with certain aspects of their physical health, like improving diet or physical activity, that that might actually help improve their mental health.

Is that OK if I ask you some questions, screening questions, about your physical health? The other plan would be to take some measurements, some baseline measurements, and note them down in our screening form. And finally, if there are any challenges you're having, we might be able to make a plan together and send them off to your GP. Is that OK?

Donnie: Yeah.

Dr Nicky: Yep? OK. So Donni, can you tell me, have you seen a GP in the last year?

Donnie: Yeah, not recently. I've seen one in the last year, but just not since I've been feeling so down.

Dr Nicky: OK. So, is there someone that we would be able to communicate results from?

Donnie: Yeah.

Dr Nicky: Today's discussion? OK, excellent. Have you been experiencing any side effects from the fluoxetine we started last week for your depression?

Donnie: No. No, but it's only been a week.

Dr Nicky: Yeah, OK. It would be good to keep an eye on that. And please let your case manager or myself know if you notice anything new. Yeah.

What about cigarettes? Do you smoke cigarettes?

Donnie: Yeah, I probably smoke maybe about 20 a day. But I just, I need that right, I don't even want to think about that right now. I just need that. It's the only thing that's helping me through.

Dr Nicky: OK. And what about alcohol? Do you drink alcohol regularly?

Donnie: Not recently. I used to when I was hanging out with my friends. We'd just have a couple just to be social, but nothing lately.

Dr Nicky: OK, nothing recently.

What about other substances?

Donnie: No, no.

Dr Nicky: OK.

All right, I wanted to ask you a little bit about your weight now. Do you weigh yourself?

Donnie: No, no, I haven't for a while.

Dr Nicky: OK. Have you had any concerns about your weight recently?

Donnie: No, I haven't really noticed any.

Dr Nicky: What about weight changes, putting on weight or losing weight recently?

Donnie: No. I know that I'm not eating properly. My diet is terrible, but I just haven't weighed myself.

Dr Nicky: OK, all right. Well, we might hop on the scales and have a look at that in a moment, if that's all right with you, yeah. Tell me a little bit more about your diet being terrible. What's been happening recently?

Donnie: I just can't be bothered cooking at the moment. I'm just not really making much food at all. It's pretty much just drinking lots of iced coffee during the day.

Dr Nicky: Mm-hmm, yep, yep. OK, how much iced coffee do you think you're drinking?

Donnie: I don't know. I get one of the big bottles of the iced coffee, and then probably maybe, like, 3 cups. Yeah.

Dr Nicky: OK. Yeah, and are you drinking any other drinks that have sugar in them?

Donnie: No.

Dr Nicky: Soft drink or energy drinks?

Donnie: Not really having much else at all.

Dr Nicky: OK, what about other food? What are you eating at the moment?

Donnie: Sometimes my partner will bring some food home when he comes home from work. Like, I had a half meat pie the other day that he brought home. I just really can't be stuffed making anything for myself.

Dr Nicky: OK, yep, so it's really hard for you to go and cook food for yourself.

Donnie: Yeah, yeah.

Dr Nicky: Are you eating any fruit and vegetables?

Donnie: No.

Dr Nicky: OK. All right, OK.

I want to ask you about physical activity levels now. So, can you tell me how long approximately you might be sitting or lying down during the daytime?

Donnie: Pretty much all day. I get up when my partner goes to work, and then I'll get up a bunch of times just to have a ciggy. But really, I'm just lying down watching TV, on my phone most of the day.

Dr Nicky: How long has that been going for now?

Donnie: Oh, just since I've been feeling low the last couple of months.

Dr Nicky: OK, yeah. So how many days per week might you be doing any sort of moderate physical activity, such as a brisk walk or a bike ride, where you're out of breath, but you can still talk while you're doing the activity?

Donnie: My mum tried to make me go for a walk last week. And I was going for about 10 minutes, and I felt really out of breath already, and I just felt rubbish. Like, I just, I really haven't been doing anything at all.

Dr Nicky: That sounds really tough, so not doing any regular kind of activity?

Donnie: No.

Dr Nicky: OK, all right.

So, do you have any physical health problems that might be getting in the way of you trying to function during the day at the moment?

Donnie: No, no. No, nothing's broken, no injuries.

Dr Nicky: Do you have any persistent pain?

Donnie: No. I do feel stiff when I get up and about, but it's probably just from laying around so much.

Dr Nicky: So, it sounds like you've been feeling so low recently that you don't really want to do any type of activity during the day.

Donnie: Yeah, no just not motivated at all.

Dr Nicky: I'm wondering if you'd be happy for me to communicate our discussion today with your GP, particularly around the fact that you're struggling with your diet and that you're not doing very much activity at all, and maybe see if the GP is willing to make a referral to a dietician and exercise physiologist.

Donnie: Yeah.

Dr Nicky: Yeah, have you ever seen a dietician or an exercise physiologist before?

Donnie: No, never.

Dr Nicky: One of the things we know is that having poor nutrition can really affect how you're feeling in yourself, and it can affect your physical health. And a dietician could potentially help you with that. And I was also wondering about whether an

exercise physiologist could do a baseline assessment of your fitness and maybe support you to increase your physical activity levels.

Donnie: Yeah, that sounds good.

OK, yeah.

Dr Nicky: All right, it'd be good to get some baseline measurements now, such as you weight, your waist, your blood pressure, pulse, that kind of thing. And then we'll note those down and then track them over time. Is that OK?

Donnie: Yeah. I can keep my clothes on, though, right?

Dr Nicky: Yeah, yeah, for sure, for sure. OK, we'll go over to the scales.

Donnie: OK.

Dr Nicky: Great.

OK, we're just going to do your weight now. If you're able to just pop your shoes off, up on the scales. OK, great.

So Donni, the other thing we talked about today is you smoking about 20 cigarettes a day, but you're not quite at a stage where you want to address that.

Donnie: Yeah.

Dr Nicky: Is that right?

Donnie: Just not ready to think about yet.

Dr Nicky: Is it OK if we maybe come back to that at a time down the track?

Donnie: Yeah.

Dr Nicky: Yeah, OK, great. The other thing I wanted to mention was that your GP could arrange some baseline tests that help us to understand your physical health a bit better, such as fasting blood sugar level and cholesterol. So, I was going to see if we could coordinate arranging that.

Donnie: Yeah.

Dr Nicky: OK.

So, I'm going to write down some of the things we talked about today in our physical health screen form, and then, with your permission, send this to the GP and also share with your new case manager, Irene, because I think they could also maybe help provide you with some support to make some changes around your diet and physical activity levels.

Donnie: Yeah, I'm OK with that.

Dr Nicky: OK. There might be some other things within the mental health service that could be of interest for you down the track, such as a walking group or attending cooking classes. So, we'll let you know about that.

Donnie: Yeah.

Dr Nicky: We'll put that in the initial management plan.

Donnie: Yeah, that sounds good.

Dr Nicky: OK. Your case manager might want to talk to you about your physical health as time progresses, and they might come back to you and repeat some of these measurements, if that's OK.

Donnie: Yeah, yep.

[END PLAYBACK]

EMMA MARTIN: OK. So that concludes the presentations about the physical health screen in Comprehensive Care. We can see that the messages are coming to the chats. The questions are coming into the chat. What we can do now is invite our panellists to join us, and we can consider some of those in a bit more detail. So, if our panellists would like to join, and, James, if you'd like to join as a moderator, that'd be great.

And we've got on the screen in front of us, when everyone joins, Dr. John Reilly, our Chief Psychiatrist and Chief Mental Health Alcohol and Other Drugs Officer. We've got Dr. Nicky Korman, our Consultant Psychiatrist, who you've seen demonstrate our processes, who works for Metro South Addiction and Mental Health Services.

We've also got Donni Johnson, our Senior Community Nutritionist working for Metro South Addiction and Mental Health Services, and Carla Ruffini with us thank you, Carla, for joining us, our team leader with Older Persons Mental Health Services. We've got Dr. Justin Chapman with us also, good morning, Justin who is a Principal Project Officer situated with Mental Health Alcohol and Other Drugs Branch. So, thank you all for joining us. James, I might hand over to you now. You're just on mute, mate.

JAMES HOEY: That's good. Thanks very much for that. And thanks, Emma. Thanks, everyone, for joining us. I'm just keeping an eye on the chat because I see that questions are coming in as we speak. So, excuse me if I'm sort of looking all over the screen, and I wasn't looking at the mute button then.

So look, I guess I'd throw out a couple of questions, and happy to allow the panel to identify who they feel would like to answer, a few questions around clarification in relation to the physical health screening process and, obviously, the form that's attached to that. In terms of the timing, so how early in a client/consumer's engagement in, say, community settings, whether that's, I guess, mental health or alcohol and drugs settings, would you suggest that this be completed?

JOHN REILLY: Look, I'm happy to jump in and just say, I think that's a clinical decision, James. So that's a decision that you can't, you have to individualise. I think, as Nicky said, the intention is that it's an expectation that it should happen because it's really important. But it then depends on the context, because if in the community you're seeing someone where it seems quite possible that their physical health might be one of the significant factors contributing to their current presentation, it might be really vital to approach that immediately.

In another context with a person whose physical health appears to be really very stable or not an immediate concern, then it might be quite appropriate to wait a little depending on engagement. So it's very difficult. But I think that the key issue there is recognising that it's important to come to at some point, and as soon as reasonably possible. But others might have some more specific views. And I think it's a team consideration, in my mind.

JAMES HOEY: Thanks very much, John. Just out to anyone else in the panel there who is working out there in the services, do you have a view?

NICKY KORMAN: I was going to say, I mean, people want some direction, and I agree with it being flexible. But probably in a community setting, you'd want to do it within at least the first four to six weeks if possible. That might not necessarily be a KPI, John.

But I think if we're just trying to give advice around, I think leaving it six months, and then in the meantime, you've started a new antipsychotic, and people have put on six months' worth of weight, that's too late to wait. But we've also got to take into account that there is the metabolic monitoring form, which is also available on CIMHA, which has the longitudinal capacity to track weight and metabolic measurements that's different to this cross-sectional form.

So I guess from my point of view, as long as people are getting a baseline metabolic measurement, and then if their weight is going up, they're actually tracking that and trying to intervene early, then that's really important. But in terms of filling out this physical screen form that's a bit more comprehensive than the metabolic measurements, I would have thought it would be good to do in the first four to six weeks if possible so that we've got a baseline there, if that's helpful to services to sort of aim for.

JOHN REILLY: Can I just comment, Nicky, because I agree completely. But I also think it's team-based because community teams, in my mind, are also acute care teams, as well as perhaps then a continuing care team across an AOD sector, where you might be thinking that it's quite possible the consumer you see is currently using substances intravenously. You're concerned about their apparent low weight and infections. It might be necessary to do it on the first appointment because you might actually be thinking you're not going to see someone again.

So that's why I kind of am a bit reluctant to say anything like four to six weeks, because it really does depend, I think, on the context. But I do agree with you. Therefore, each individual team needs to be considering their context. And certainly, for a team that's picked someone up into, say, case management in the community, then I think your guide of four to six weeks might be a very appropriate guide. So, it still has to have some degree of flexibility, I guess, is the reason for me not jumping in to say some time.

JAMES HOEY: OK. No, thank you both for that. And this may be, then, an extension of that conversation in a similar way. So, I know you mentioned in one of the videos earlier on that was presented around at least once per year regular intervals. Is there any requirement around that in terms of, or recommended guidance around the frequency?

JOHN REILLY: Justin and I haven't gone back to check what we've said in the actual form, so I'll have to go and do that. But I certainly would have thought that an annual. It's certainly set up to be done on an annual basis, so as Nicky suggested. It also can be episode-linked. So, I think that's one of our challenges that, I think, it's useful often to do these things in a new episode.

If someone's, say, admitted to an inpatient unit, then it's sometimes worth reconsidering. But if they've had three admissions in the past six months, then it may not be necessary to keep going over it. But certainly, for someone in the community that's continuing to receive treatment over time, if it's not necessary to do it each episode, then I think looking at an annual basis is, in my mind, a good idea.

Having said that, I know that within the Mental Health Clinical Collaborative that they have a preference, I think, for six-monthly and that there is some guidance around six-monthly metabolic monitoring as opposed to necessarily completing this form, although that guidance varies with guidelines, really, and the evidence, I don't think, is particularly strong if you go across the board, but maybe in certain groups. But Nicky, you might have a view on that, and others.

NICKY KORMAN: Yeah, I think the issue is that this form covers metabolic monitoring, but it also covers other things. And to give a KPI around this form if this is the only tool, we're using for metabolic monitoring is kind of tricky, because essentially what we're saying is we don't have strong evidence around how often this broader physical health screening should be done because it's only just being brought into mental health services. So, we haven't had a chance to really collect data on the impact of doing that and how frequently.

But in terms of the frequency of metabolic monitoring, I really agree with the Clinical Collaborative around metabolic monitoring should be done at least every six months. It should be done sooner than that for someone who's starting on an antipsychotic. Six months is too long to wait to be doing metabolic measurements for the first time, because in six months someone will have put on 20 kilos.

So, there's better recommendations around metabolic monitoring that Jackie Curtis's group have put out that people can have a look at that I think is in our resources for this webinar as well. But I think ideally if a service is able to do this form more than annually, if a service is able to do this form six-monthly, then that would be really good. I know, John, you've been a bit anxious about setting that as a KPI.

And I know in the, I think in the instructions you've got for the use of this form, it says on admission and once a year, which is why we included that in the webinar. But my personal feeling is it would be better if we could do it at least every six months. But yeah, I understand that it's tricky because the form covers more than metabolic monitoring. And it depends on which service is using this form versus, say, the metabolic monitoring form as their way of tracking the weight and the change in blood pressure and cholesterol, et cetera.

JAMES HOEY: OK, no, thank you very much. And I think, I'm just responding to some questions here. That's great. So just moving on through some of the other questions that have been raised, and a lot of them, I guess, are also about forms and how they fit together.

And just to confirm, the blood pressure and HR measures can be completed by an appropriate qualified, trained allied health clinician where are in alignment with local protocols and scope of practise. So, I guess that refers back to the guidance given around those types of obs being picked up by nurses and doctors. And I think the question here is referring to the fact that there are some allied health or some trained groups out there or some local procedures that might vary from that. Just any views on that?

JUSTIN CHAPMAN: I'll just jump in because no one else is. But, Cassidy, I think is definitely referring to exercise physiology and exercise physiologists getting more and more traction in mental health services, which is great to see. And I believe the consensus is, absolutely, if it's within your scope of practise and part of your local team or protocols, anyone who's qualified can do those measures, can help out the team and the consumers and do those.

JAMES HOEY: Great. Thank you very much.

JUSTIN CHAPMAN: And I think it was just part of because I think the current fact sheet just says doctors and nurses, and that's why it was read verbatim by Donni. But yeah, to be adapted.

JAMES HOEY: Oh, good. Good point, thanks.

NICKY KORMAN: I would agree with Justin there on that one, absolutely. Is it possible to change the wording on the fact sheet, John, to include these other allied health professionals? Because I think that would be really good.

IRENE FRANCISCO: Can I just jump in here? The fact sheet does actually say that, "And other health professions who are in alignment with local protocols and scope of practise." So it is covered. I'll put the link in the chat for that document as well.

JUSTIN CHAPMAN: Yeah, and that information might actually be in a different place as well. Like, maybe in the screening form itself it says doctor or nurse, but there's a couple of different sources of that info. We'll have a look to update them so it's consistent if we can. yeah.

JAMES HOEY: Great. Great, great. Good collateral coming from everybody there. Thank you for jumping in as well. So just coming back, I guess, a little bit to the timing of things, there's just been a comment raised here around if a client has a pre-existing disease process such as diabetes, should the process, the physical health screening, be completed as soon as possible?

JOHN REILLY: Yeah, look, absolutely. And that's why I was saying that I think it needs to be individualised, because clearly if you've got someone that you know and they know has diabetes, and if you take the roleplay from Nicky, if that patient also had diabetes, she would have obviously been going in more detail into some of those questions. And clearly that should be leading onto rapid action. So I think it does vary with the presentation, and so I think that's clear.

JAMES HOEY: That's great. Thank you very much. And thank you, Jen. Jen from Cairns has just popped a link in the chat there to respond to the earlier question around, will the recordings be available? They will be available from that site, as well as also they'll be available from the QCMHL website, and also the Insight website, for different groups that are familiar with those. Just give us probably about a week or so to have that posted.

So they will be available. Or you can email Emma or myself. We're happy to follow up if you're having any difficulty with locating those.

Just a few other questions that were raised around questions such as falls rates, would those questions be required to be asked of all clients, say, if you were working with young people or people that potentially may not necessarily present with those types of risks?

JOHN REILLY: Look, I'm happy to jump in, I think. But again, one of the issues with this form is that there wasn't individual single questions that we were able to find that we could access. So it's very clear this is a form that we've simply created. It was created from a base of the surgical form that was developed. But that didn't seem to address a number of the issues that we would have with consumers of Mental Health Alcohol Other Drug services that we might be seeing over more extended periods of times.

So therefore, we did essentially make some questions up to try to address particular issues. One of those was falls. Clearly there are evidence-based tools that are used within Queensland Health with regard to falls risk assessment that we would obviously encourage. But what we needed was to have a single question that we could put onto this that addressed the issue of falls.

Look, I think you could obviously say, look, it's not an issue in certain patient groups. But I guess the challenge is that we are often putting people, as Nicky highlighted with regard to weight, onto medications, which can sometimes have an impact on hypotension and be an issue with regard to falls. It's just a generic question. And clearly if you ask it once, and the patient is dismissive and has not had a fall, that's that.

But there are sometimes unusual turn-ups from that and people that, in fact, are having, young people can obviously have falls as well. And that might be worth, therefore, asking the question at least once. But look, again, people might well at times have issues with some of the questions. As Nicky highlighted, it's early days with regard to a form of this kind. And it's actually going to be about trialling the experience and then seeing what the data actually is, I think.

JAMES HOEY: Good. Thank you very much, John. Does any of the other panel members

NICKY KORMAN: I was just going to say I guess I actually had the same sort of question when I was doing the roleplay with Donni, who I was trying to give as an example of a young person with depression. And we ended up taking the falls question out because it just didn't really seem to fit organically with the standard type of physical health conversation that I would have with people.

But obviously, it's there as a prompt. And I guess the way I would see these new forms, particularly this screening form, is we've had to try and cover a lot of different populations in one form. There's the old age to consider with the falls. There's people with metabolic risks,

which is a lot of people on antipsychotics. And then there's sort of drug and alcohol questions to consider and pathology results to add in. And so one form is trying to do a lot of different things.

And I guess maybe if we use the idea of the physical health screening form as a prompt for conversation around physical health with people, and not all the questions will necessarily be relevant. And they might not necessarily be asked exactly on the form in the way that you're going to conduct your interview, which is kind of what I was trying to roleplay, that we weren't specifically asking questions off that form, but using the form as a bit of a springboard for generating those conversations and remembering to ask about sedentary behaviour and about diet quality and about physical activity levels.

And then ideally what you come up with in that interview that you then come up with some sort of management plan. So I don't know that I would necessarily see the form questions as being the only things that you should ask or you must ask those questions exactly. It's more to generate a discussion around important physical health domain areas. That's kind of how I've seen it.

JAMES HOEY: Terrific.

DONNI JOHNSTON: And if, sorry. And if you're unsure at all about the best way to ask those questions, I know that Emma's going to post a resource one-pager that has a bunch of links for some great online training as well as some brief intervention tools that will help you guide those questions.

JAMES HOEY: Terrific. Thanks very much, all, and thank you, Donni. And yes, that's just been posted into the chat by Irene. That's also available by the QCMHL and the Insight Comprehensive Care toolkit page. So you're welcome to go back and revisit those. And Irene's also kindly popped into the chat there the link to the, via Qheps the fact sheet surrounding the physical health screen form as part of the suite of documents that were released with Comprehensive Care.

OK, folks, a couple of other things that have just come in here around the sorry, I just need to go back here for a moment is the and I know this was mentioned, but probably also good to have the opportunity to discuss and clarify. Should we still be using the metabolic monitoring document? There does appear to be a variance in information. I'm assuming that's between the two forms.

JOHN REILLY: Well, I'm not sure about the variance in information necessarily. Obviously, they are different forms, so there's certainly different information collected in them. Look, I think the I was certainly involved in not continuing with the metabolic monitoring form when we introduced this metabolic screen.

And so I guess the issue with that is the main issue that people were concerned about with regard to the metabolic monitoring form within mental health services that had been using it was the loss, as Nicky has highlighted, of the repeated measure of metabolic screens and being able to monitor that repeated measure. So clearly that was a loss, and that's the reason that the form has been reinstated.

I think that in an ideal world, though, and the reason that we did that was that we were looking towards perhaps being able to pull that data and look at the repeated measures in a different way. But certainly, I acknowledge that then the problem with that is that if it's linked to the form and to questions that people might then be reluctant to ask. So I think that what, in my mind, services need to recognise is that the physical health screen is actually encouraging what Nicky said and encouraging it in a much more specific way than perhaps previously.

That is, to actually have a discussion with the consumer in regard to their physical health, and to consider with the consumer their physical health from a preventive perspective as well as from a current action-oriented perspective. The problem with the metabolic monitoring form was that, although it did have some measures which could be looked at on a continuing basis, it didn't actually necessarily require any discussion.

So I guess from that point of view, I was seeing that this is an improvement in the way in which we need to be moving, and that we need to actually be encouraging conversations, as Nicky was highlighting, and that the form, per se, didn't necessarily do that. So I think that's one of the reasons. I'm happy to expand further, but I'm sure members of the panel and others might have views around that too.

JAMES HOEY: Anybody else like to jump in on that? Oh, Carla, lovely to see you.

CARLA RUFFINI: Yeah, I'm happy to I work in a community team with older persons. So what we have found with the introduction of the screening that we actually use that on our initial assessments, and then we use a metabolic monitoring form for clinic appointments when patients come in so that we can check their obs and things like that. And then the clinicians on the three-monthly review will review the physical health screen. And then if there's anything needs to be done, they'll update it.

They don't always do it, like was said. Every if they've reviewed it and it's not changed, then it will continue. And then it's just that each we have a prompt that, probably every three months, have a look at it if something's changed, particularly with older consumers, as something might happen in those three months that's been significant for whether it be their physical health or their mental health.

And yeah, so that's how we use it, which I think it's a lot more effective than getting someone to do the screen every time and just have that. And the metabolic monitoring form, as you said, it didn't have any there was no progression from that. So it's been good to introduce the screen as well, anyway.

JAMES HOEY: Oh, great. No, thanks.

CARLA RUFFINI: If that makes sense.

JAMES HOEY: No, it definitely does, Carla. And I think it refers back to some of those earlier points that our panellists have made around team decisions based on, obviously, assessment of the risks with the clients that you're working with or the cohorts that you're working with and the needs that you would be expecting. So that's terrific, thank you.

JOHN REILLY: James, could I just throw in the comment, sorry, but just in regard to that, what Carla said. So obviously, there was also the focused physical assessment form, which was actually intended to fill the function that Carla's described using the metabolic monitoring form for. So that was certainly intended to capture the metabolic screening information at repetition. Obviously, people were concerned that it didn't pull together a continuous measure, which the metabolic monitoring form does to some degree.

JAMES HOEY: Right, no, thanks for that addition there, John. And just a question here, does the panel in general and I guess this can include everybody who's kindly sharing their wisdom and their thoughts. Does the panel have any recommendations for supporting teams to use the physical health screen constructively and as a process to actively support consumers into preventative interventions?

NICKY KORMAN: I was just going to mention there on that that I know some Metro South staff, so Donni's been involved in this, and Justin and Andrea Parker and Cassie Dodd have developed a brief intervention tool. And it might be worth having a chat about that because I know that has been, it's a really excellent tool to help support asking good questions and making a plan around different domains of physical health. Can I kind of hand that over to someone? And I hopefully I think Cassie and Andrea are in the audience. So feel free to speak up as well.

JAMES HOEY: We'll probably just have to find out if they're there, Nicky, because they wouldn't be able to unmute at the moment. So is there anything that you're able to add to that?

DONNI JOHNSTON: I can fill the gap if you like.

JAMES HOEY: Thanks, Donni.

DONNI JOHNSTON: The brief intervention tool was developed for Metro South Addiction and Mental Health Service, so it does have some specialised information on there. But that's no reason why it can't be adapted to other services. It's based around the 5 As framework of brief intervention.

And it's just a simple, big A3 page guide on how to work through asking some of those questions around diet and physical activity, because we know on the physical health screening form it opens some cans of worms around physical activity and diet but doesn't sort of give us enough direction on where to go from there. So by using the brief intervention tool as complementary to the screening form, it helps really guide those discussions towards real active intervention, rather than just that screening. But I can see that we've got Cass on now, so you can jump in if you like.

CASSANDRA DODD: Thanks, Donni. This form, as Donni said, could be adapted for other local HHS settings, though we're still in the process of rolling that out and the training package and doing all of the evaluation around that tool internally first. So once that process has been completed, we can absolutely share that tool and meet with the relevant people in the other HHSs is to roll that out statewide if people are interested.

JAMES HOEY: That's great. Thanks for offering that. I'll just jump in here for a moment and then come back to the panellists on this. There's also a resource link and a handout. In that,

you'll find links to some of the materials that's been developed on the Insight website, the Healthy Lifestyles toolkit, which runs you through a series of different brief intervention strategies, as well as then also options for intervention and planning around topics such as alcohol and drugs, smoking, physical health, pregnancy, those types of things.

JOHN REILLY: And could I just comment, James? So the other thing, of course, which was mentioned by Nicky and Donni, was the additional screening information. And so we did include My health for life there. But we recognise that those things might vary, so we're certainly trying to encourage what services are doing, which is looking at intervention and action. And so I think that certainly is a key issue that needs to be focused on.

The other comment that I would make is that ultimately it comes down to improvement of the way in which services are provided. So we've got the clinical interaction, and then we've got how much we as service providers improve both our individual practise and ensure that we're doing this more routinely, and how do we within our teams or services improve as well. So I think one of the issues there is motivation and trying to ensure that, obviously, consumers are motivated to actually take some steps.

And that then kind of comes back to us as service providers, how we're motivated perhaps to start picking up on this practise. And I think what Nicky was doing was really encouraging that. We're trying to encourage people to recognise the importance of this for consumers. And so I think any strategies that we can come up with from this group going out into other services around possible options for improvement in regard to this area is what we need.

And I guess with the physical health screen then, as I said, it's about asking questions, and so thinking about ways in which we might use those questions, both for action at the consumer level, but also thinking about where we are missing things, and when we look at the results that we get out of this, how well are we asking questions. And although I acknowledge that, of course, that motivational bit you're highlighting, Nicky, as well, we just want people to try using it, and they need to fit it to themselves.

But we also want to try and say, well, what are the questions that are actually more useful, and then be thinking about, well, can we find better questions? Should we be changing this? But the only way we're going to do that in the first instance is by having people actually use it, getting some data out of it, and then using that as the basis for improvement.

So I do encourage services to trial it. And in some of my discussions going around talking to services, I did have one senior nurse in a service tell me that he was fairly anti-the form, but that he tried to practise what he should. So he started to use it. And he was amazed that, over the first half a dozen patients that he used that, there were actually a lot of things that came out from actually just following the form that he hadn't anticipated and certainly wouldn't have expected to find out.

So I think that there are stories of that sort. And it's not a perfect form at this point. But I think it's well worth people actually putting into practise, trying to use as consistently as it is there, and then that we use that for feedback to actually improve both the form and, hopefully, our process of using it.

NICKY KORMAN: So John, can I just ask on that, would you suggest a kind of trial period for the state, followed by the capacity for formal feedback, and then a review of the questions? Is that something that we could hope to see arising out of this webinar?

JOHN REILLY: I wouldn't say necessarily arising out of this webinar, Nicky, but certainly arising out of the overarching process.

NICKY KORMAN: I see, yeah.

JOHN REILLY: And this is certainly an important part of that, no question, because I think with regard to a trial, remember, it's now been going for a year and 12 days, I think. So we have had a trial. What we know at the moment, though, is that the use rates aren't very high, not surprising. I mean, the fact that we're doing this webinar now obviously highlights that we haven't yet put an enormous amount of focus on this particular screen. And that's been taken up. Quite a lot of people had a lot of concern about the loss of the metabolic monitoring form.

So perhaps people have been more focused in a number of places on what they've lost, rather than perhaps what the opportunities are with this one. And it took us a while to create return to the metabolic monitoring form. So I think, yes, now is an opportunity just to kind of stop, hopefully to start to use this, and then to think about, down the track, what would be the ways to improve our process for both screening for physical health, measuring people's current physical health state, and then also measuring our actions along the lines that you were describing with your brief intervention form.

And for me, that comes back to kind of data bundles, really, as well, and care bundles. So at the moment, we can do some of that with regard to looking at physical interventions. But I guess we're not able to really very tightly link that. So I think that there are a number of different directions that we could be going in to be looking at further improvements to physical health care.

And Mental Health Clinical Collaborative, our clinical networks process, which now regard to brief breakthrough collaboratives, I would hope that over the next year or two that we've got opportunities to improve on our physical health care, perhaps using some of the data from the physical health screens, as well as our metabolic monitoring, to say, OK, now we'll focus on this aspect. But it may have to just be an aspect. May not be the whole thing at this point, though. That sounds great to me, but perhaps just a touch a little bit grandiose to be able to do it everything because we are struggling to do that. And then the form, as we've highlighted, does cover a number of different domains at this stage.

JAMES HOEY: Thank you there. Just a few another opportunity, I guess. This may be our last question in this Q&A section. But for any of the other panel members, just a reminder that the question is looking around any recommendations that you have to help teams out their support consumers with preventative interventions. I guess it's the idea that if we're going to screen, it's also about intervene as well. So just interested to know from your experience or any suggestions you might have.

NICKY KORMAN: So James, was the question supporting not just screening but intervention? So just to clarify there.

JAMES HOEY: Yeah. Yeah, yeah, just supporting consumers into preventive intervention, preventative interventions.

JUSTIN CHAPMAN: That question came from me. I just sent it to James too, because recently I've done some consultations statewide about how to address physical health under the new emerging services plan and into the future. And people were really saying, we need support to actually do something about it. Why are we going to use this screening form if all this stuff comes up and we can't actually do anything?

So I know, Carla, you've done a lot of work out at Darling Downs, is it, in supporting your team to be able to address physical health, and, of course, locally with Metro South with Donni and Nicky. So I was just after some feedback from the panel. Put you on the spot.

NICKY KORMAN: Well, I know in Metro South it's not just been one thing. There's lots of people working in different areas, whether it's sort of smoking or diet. I know we've got Andrea Parker and Cassie Dodd, who are our dietician exercise physiologist. Donni is our nutritionist.

And we've been working on different models depending on the service about providing different interventions. But the most important thing is that we've got those allied health clinicians in those roles that. So I guess to start with advocating for having dieticians and exercise physiologists if you're able to within your service as being incredibly helpful.

But I think the second thing that I found really helpful before we had those allied health professionals was actually having a physical health champion in your team, so someone who's got an interest in the assessment and providing linkages or being interested to upskill to provide the interventions themselves in physical health across diet, exercise, smoking, sleep, drug and alcohol, et cetera. So that's sort of having physical health champions.

Then there's the assessment itself. Like, you have to have the assessment before you can have the intervention. So actually within your team kind of saying, how often should we be assessing? As John was saying, he wants it to be flexible, but how often can we reasonably expect our clinicians or our PSPs to be doing assessments? And then looking at there's a lot of training out there now. Metro South has done some great work with providing different training for mental health clinicians, but that's not the only place.

There's also psychiatrists can get online training around upskilling in physical health. I know that the psychologists have the same thing. I think QCMHL has got some other resources that you can do some online training. And so actually having team leaders support mental health staff going and accessing this training, either in their work time or giving them if people are able to take professional development to do that. So really, then it's around the culture of supporting teams to be thinking about physical health.

And I guess just looping back to the whole beginning of this webinar with Tom in the webinar is that the consumers want us to pay attention. And so from the point of view of staff culture, we have to want to try and pay attention to it as well and really think that it's important when someone puts on a heap of weight or when they've got a terrible diet and they want to change that. So that's something that as mental health staff we could and should do

something about, both at the assessment phase and the intervention phase. So that's just some thoughts I've had.

JAMES HOEY: Thanks, Nicky. And just in the interest of time, Carla, is there anything that you wanted to add to that at all? No, that was a shake of the head. That was a no. OK, great. Just a couple of quick.

DONNI JOHNSTON: James, could I quickly add? So just building on from what Nicky said, it is really important to intervene when we do see those changes in eating behaviours and physical activity. But it's also really important to provide some level of intervention to all consumers because we know that all consumers of mental health services are at a far higher risk of poor health outcomes. And so having intervention as sort of like that first port of call around physical and lifestyle behaviours is really important for everyone.

JAMES HOEY: Good. And I'll just add also, clients of alcohol and drug services as well. So just a couple of quick questions here for those who are probably far more familiar with CIMHA than I am, is there a way by which future CIMHA functionality can create a pop-up at the proposed intervention intervals? I don't yeah, I guess that's the thing around there's not any sort of hard intervals that are being said. It's more about team decision, but as a reminder to check the assessments, that the assessments were considered.

I'll just leave that out there as a comment, particularly to our branch folk to take on board. And then our last one here I'm not that familiar with the form. However, is there a way to, I'm assuming this is talking about is there a way to monitor or look at trends of results other than just looking at it manually? Yep, John, thank you for your comment there. You're talking about using those 90-day review processes to

NICKY KORMAN: I think just quickly, I think, James, this is really tapping into the confusion around the presence of the physical screen form and then metabolic monitoring form. So if you want to watch the metabolic measurements trend over time, which I really strongly recommend, you need to use the metabolic monitoring form, which is in CIMHA.

But this physical screen form is broader, covers more domains, and allows you to put in a management plan, which the metabolic monitoring form doesn't have, so that, in a way, they probably should be used side by side if your service has a capacity to do so. And you've got to decide how to do that at this stage. And I think the other thing is just tapping into that other question around how often. So currently a lot of services are using the 91-day case review to prompt them to check in on physical screening and/or metabolic monitoring.

JAMES HOEY: Great. Thanks, Nicky. And Stacey's just put a lovely comment there around also using the planned pause function could also help meet with for that purpose as well. So thank you all very much for the panellists for sharing and for those who popped in questions. I'm just going to hand back to Emma now, who will take us to the end.

EMMA MARTIN: Thank you, everyone. Thank you so much to those who've made their contributions in creating this webinar. Thank you to all of you who have worked so that we've got the resource links that we have. You can see that there are the links a number of times in your chat.

Please download those links. There are toolkits, and there are conversations within that to help us in our practise. Thank you all for your motivation and for your considerations in how you want to develop your practise so that it can be the best for people across their whole of health journey. We much appreciate your participation today.

Please go and visit the resource hubs of both Insight and Queensland Centre for Mental Health Learning. In that place, you'll find the whole of the package of Comprehensive Care in one easy tab and all of the tools and resources that have been collected over the last year and a half or so. The very last thing that we will leave you with is a quick evaluation for you. That's going to be in your chat now. If you could, please, just let us know what your thoughts are about the webinar as you leave the room. We much appreciate it. And wishing you all the best. Thank you very much, and we look forward to more discussion on this soon. Thank you.