Government of Western Australia
Department of Health

‘Triage to Discharge’

Mental Health Framework for Statewide Standardised Clinical Documentation

Version 11.0
Author: Mental Health Unit, HDWA
Commencement date: December, 2013
Review date: August 2021
Version Control

VERSION #	DATE (DD/MM/YY)	REVISED BY	COMMENTS
1-8	9/07/14	OMH	
9	19/01/16	OMH	
10	17/03/2021	MHU	Restructure of information and revisions based on SSCD Policy review consultation.
11	9/8/2021	MHU	Information added regarding: Additional modules section Revised Assessment module section

Acknowledgement

The Mental Health Unit, Department of Health Western Australia, acknowledges the contributions of staff from the North Metropolitan Health Service - Adult Mental Health Service in the development and compilation of these guidelines.

Contents

Introduction

Mental health care is especially dependent on good clinical documentation. Assessment and diagnosis requires detailed and subjective information, often obtained from many sources. Care may be provided by a team of multidisciplinary clinicians, often from different services, and frequently after hours or in emergency settings. The patient Treatment, Support and Discharge Plan needs to be accurately communicated over time.

The "*Review of admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*" (July 2012) by Professor Bryant Stokes (the Stokes Review) made recommendations to strengthen the safety and quality of clinical documentation to ensure the patient and their carer is actively involved. The recommendations in the Stokes Review include:

1.1.3	Developing standard documentation for service provision, including model of care, patient risk assessment and risk management.
2.2	Every patient must have a care plan and be given a copy of it. Prior to discharge, the care plan must be discussed in a way that the patient understands and be signed off by the patient. With the discharge plan, the carer is also involved, as appropriate.
4.5	Compliance with the electronic information system is mandatory.
7.3	The care plan must accompany the patient between community and other treatment settings; and be communicated to new clinicians at the time of transition. This ensures the care passport maintains treatment continuity.
7.5	The assessment, care plan and decision to refer a patient from one public mental health service to another should be seamless. The patient should not experience further assessments as barriers to entry. There should be no requirement to repeat triage.

In September 2012, representatives from across Western Australia (WA) Health agreed to finalise set of standardised clinical documentation to be implemented across the State. In October 2013 this work was revitalised by the Office of Mental Health (OMH) as the Statewide Standardised Clinical Documentation Implementation Working Group. There are seven mandatory documents for adult mental health services and six mandatory documents for Child and Adolescent Mental Health Services (CAMHS), which will be incorporated onto the Psychiatric Services Online Information System (PSOLIS). These documents must be completed as part of the comprehensive mental health assessment process, from triage to discharge.

The mandatory clinical documents are known as the Statewide Standardised Clinical Documentation (SSCD). It is acknowledged that the documents are based on those developed by New South Wales, and that the former Mental Health Division of the WA Department of Health was granted permission to use the documents across public mental health services.

The SSCD were reviewed by the OMH against the National Mental Health Standards (2010) and the *Mental Health Act 2014* (MHA 2014) to ensure that all essential data fields were incorporated. The SSCD were reviewed by Legal and Legislative Services and approved by the Chief Psychiatrist.

Background

In 2008, the *Clinical Risk Assessment and Management (CRAM) in Western Australian Mental Health Services – policies and standards* document was produced to outline the implementation of clinical documentation in the WA Health Services. CRAM was designed to give staff a common, evidence-based understanding of the principles of clinical risk assessment, and the capacity to manage and communicate clinical risks. The standards of CRAM, which included identifying, evaluating, treating and monitoring consumer risk factors, continues to be the key principle in ensuring the safety and quality of care provided in mental health services across WA Health. With the rescinding of the CRAM policy, SSCD continues to strengthen the original intent of CRAM and current policies including Clinical Care of People Who May Be Suicidal, and Clinical Care of People With Mental Health Problems Who May Be At Risk of Becoming Violent or Aggressive, by improving the safety and quality of patient care through standardising clinical documentation across the state.

SSCD implementation was originally intended to take place electronically, via PSOLIS. However, in February 2013 it was recognised that the electronic process would be delayed. The Executive Directors of Mental Health Services in WA (North Metropolitan Health Service (NMHS), South Metropolitan Health Service (SMHS), WA Country Health Service (WACHS) and the Child and Adolescent Health Service (CAMHS)) agreed that the implementation of paper- based SSCD should occur ahead of the electronic implementation.

The Mental Health Unit is working with Health Support Services (HSS) to incorporate the SSCD into PSOLIS in order to comprehensively address the Stokes Review recommendations.

Three documents of the SSCD suite are currently required to be completed in PSOLIS:

- Triage (current version)
- Risk Assessment and Management Plan (Currently on PSOLIS as Brief Risk Assessment)
- Treatment, Support and Discharge Plan (Currently on PSOLIS as Management Plan).

The remaining documents: Assessment (CAMHS version titled - Initial Assessment), Physical Examination, Physical Appearance (Not applicable to CAMHS) and Care Transfer Summary are to be completed in paper-based format or the sanctioned writable PDF format until each document is on PSOLIS.

MHS can use other program-based documentation and contemporaneous progress notes to supplement information documented in the SSCD as appropriate. All SSCD are to be completed, printed and placed in the patients' medical record. Compliance with the three documents currently to be completed on PSOLIS will enable clinicians to review a patient's current Brief Risk Assessment (BRA) and Management Plan, which will be referred to as RAMP (future version's name) and Treatment, Support and Discharge Plan in this document from this point forward.

Introduction to documents and framework

The principles of formalised assessment are:

- Provision of consistent and standardised documentation for the assessment of clinical presentation as a common frame of reference between mental health services.
- Effective communication of clinical assessment between treatment providers across the care continuum.
- A regular review of the clinical assessment and Treatment, Support and Discharge Plan, with changes in the consumer's clinical state or risk level documented.
- The identification and evaluation of specific risks to be incorporated in the management plans as identified by the standardised risk assessment tool (RAMP).
- Escalation of concern regarding risk when the risks are unable to be contained by the risk management plan.

How to use this framework

The primary aim of these guidelines is to provide guidance for the use of the SSCD to document an episode of care from triage through to discharge. This document introduces and identifies the process for use of SSCD in mental health inpatient and community settings. The SSCD are the place to document clinical information; they are not a substitute for skills, training, supervision or clinical judgement.

Clinicians must continue to refer to relevant assessment policies and processes, as addressed through these guidelines, as well as local health service policies regarding medical record documentation.

The SSCD identified in this document are mandatory - the 'minimum data set' required for the comprehensive assessment of the patient. It is up to each clinician to identify where additional documents are required to thoroughly assess the physical health and mental health status of a consumer. It is important to recognise that there are also time frames for completion of certain documents. These are determined by requirements outlined under the MHA 2014.

Introduction to the clinical framework

All Mental Health Services will complete the SSCD as outlined in Table 1. The completion of the modules should be guided by the clinician's informed judgement regarding the consumer's clinical status and needs at the time. Progress notes can be used to supplement information documented in the modules as appropriate, by the treating clinician.

Table 1. Statewide Standardised Clinical Documentation

Essential Adult modules: *(To be used for all adult settings)*
1.1 Triage (mandatory suite – complete in PSOLIS) (SMHMR900) 1.2 Risk Assessment and Management Plan (mandatory suite - complete in PSOLIS) (SMHMR905) 1.3 Assessment (mandatory suite) (SMHMR902) 1.4 Physical Examination (mandatory suite) (SMHMR903) 1.5 Physical Appearance (mandatory suite) (TMHMR904) 1.6 Treatment, Support and Discharge Plan (mandatory suite - complete in PSOLIS) (SMHMR907) 1.7 Care Transfer Summary (mandatory suite) (SMHMR916)
Essential Child and Adolescent modules: *(To be used for all CAMHS settings)*
1.1 Triage (mandatory suite – complete in PSOLIS) (SMHMR900) 1.2 Risk Assessment and Management Plan (mandatory suite - complete in PSOLIS) (CAMHS002) 1.3 Initial Assessment (mandatory suite) (CAMHS001) 1.4 Physical Examination (mandatory suite) (CAMHS005) 1.6 Treatment, Support and Discharge Plan (mandatory suite - complete in PSOLIS) (SMHMR907) 1.7 Care Transfer Summary (mandatory suite) (CAMHS003) ** Note: Physical Appearance is not applicable for CAMHS.*

Clinicians should use the clinical documents as tools to record the information in a structured format, rather than as guides to assessment and clinical practice. Clinical judgement is paramount in guiding information gathering.

Principles of the SSCD

The following principles are intended to support documentation at all points of care, from triage to discharge, through clear expectations in recording and retrieval of information.

1. The aim of clinical documentation is to support safety and quality in clinical care.
2. Documentation is designed to support thorough clinician assessment and management considering behaviour, skills, knowledge and attitudes.
3. Documents alone do not lead to good team communication. Continuity of care is supported by effective business processes for comprehensive information exchange.
4. Documents are tools which support processes such as treatment support and discharge planning, clinical reviews and supervision.
5. Priority for mandatory items should be guided by evidence for clinical issues associated with poor outcomes:
    a. assessing and managing risk
    b. corroboration of information
    c. communication at points of transition.
6. Getting information out of records is as important as putting it in: records should be designed to make navigation and retrieval of key items as easy as possible.
7. Summarised RAMP information needs to be accompanied by supporting clinical narrative to reflect the principles of ‘structured clinical judgement’.
8. Documentation needs to be supported by an audit and accountability framework to monitor and report compliance with SSCD. This will foster a cycle of continuous quality improvement.

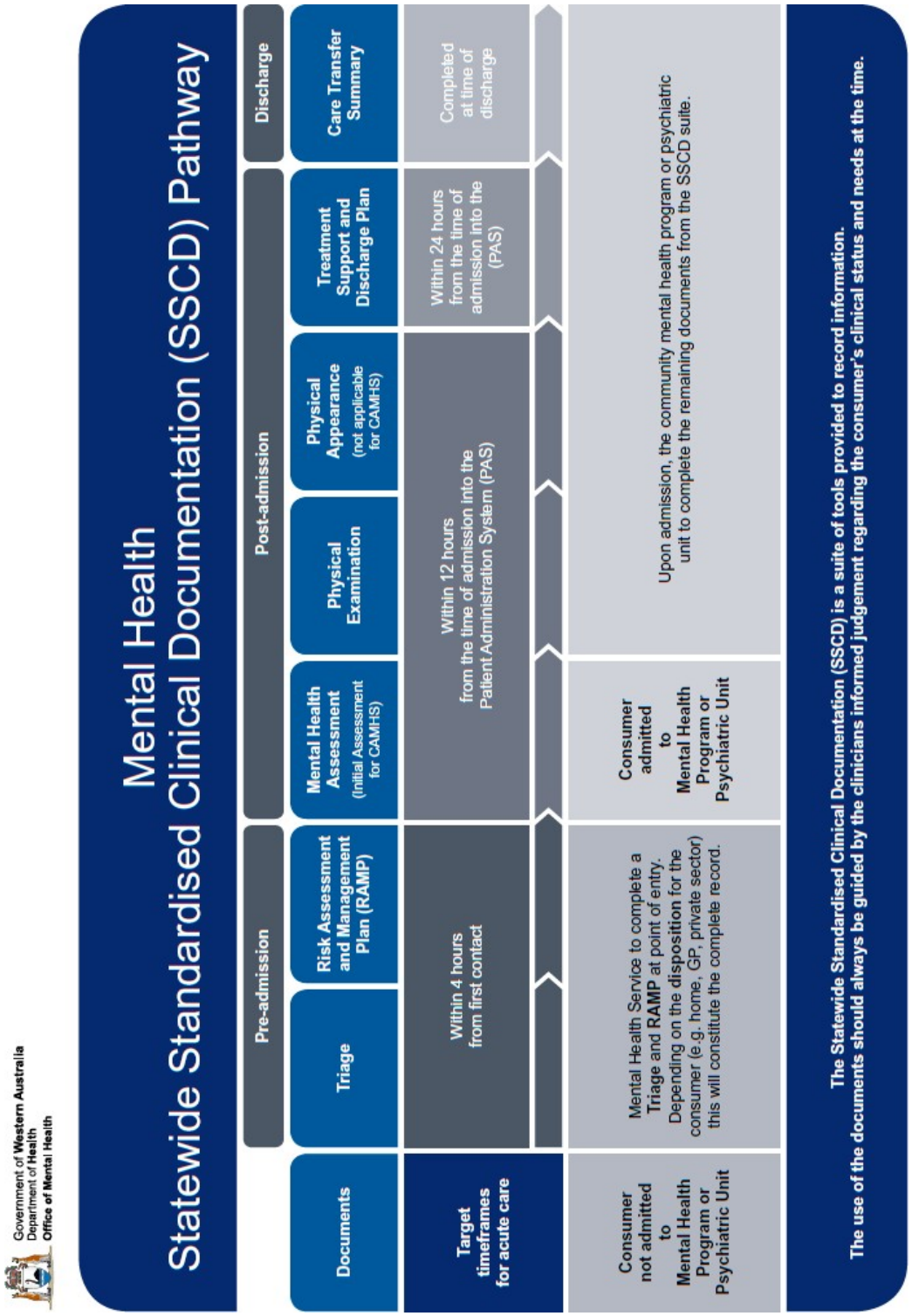
The SSCD will be evaluated and improved upon following the statewide implementation.

General requirements for all clinical documentation

- The use of the SSCD should always be guided by the clinician's informed judgement regarding the consumer's clinical status and needs at the time.
- Clinical documents have been designed to be completed by one mental health professional, at one point in time.
- Where the document is completed by more than one person, then each subsequent professional should identify the section they have completed by writing the heading 'Addendum' next to it and undertaking sign off below the information provided including the name, designation, date, time and signed (all printed legibly).
- Acronyms and initialisms familiar to WA Health employees may not always be known to the target audience. An acronym or initialism in a different context or for a different readership can mean something very different or nothing at all. All staff are reminded that any abbreviation should be used with caution and, if there is possibility of confusion, the word or symbol should be written in full.
- If a completed clinical document is photocopied for the purposes of information transfer, then the original and photocopied document should not be altered by the addition of information.
- A copy of any information that has been recorded during a patient's journey as part of the SSCD suite of forms should be provided to the admitting facility when the patient transfers to another hospital.
- The copy can be a second printout of the writable PDF form or a photocopy. It is recommended for any copied paperwork to be date/time stamped and signed by the receiving hospital.

SSCD Pathway Table

The SSCD Pathway is applicable for both acute and community settings, however target timeframes are for acute care only.



1.1 Triage

Overview

- Triage is the process of determining the urgency of response required for a consumer, based on a referral or presentation to mental health services.

Purpose:	Clinicians must triage all referrals. Triage documentation have been developed for use in both face-to-face and telephone triage but must include referrals from all sources. All referrals must be logged.
Target services:	All mental health services conducting telephone or face-to-face triage.
Completion requirements:	The triage modules can be completed by any appropriately qualified and experienced mental health professional.
Documentation title & format:	Triage (electronic – PSOLIS, essential) and Triage document (SMHMR900)

Process

- Triage can be conducted face-to-face or over the telephone.
- It is generally the 'point of entry' to the service and as such should be a welcoming experience, incorporating an assessment of need, risk complexity, acuity, advocacy and diversion to more appropriate service/s if indicated.
- The triage process should be respectful of the rights of carers and consumers, including Advanced Health Directives.
- Best practice customer service.
- Triage may be the first opportunity to identify cultural or linguistic requirements, or sexual, gender or bodily diversity of the consumer.

1.2 Risk assessment & management plan (RAMP)
(Currently on PSOLIS as Brief Risk Assessment)

Overview

- Mental Health Services continually work towards improving all aspects of service delivery by adopting strategies to ensure risks are managed safely and effectively.
- To assist clinicians in the assessment and management of risk, the RAMP has been updated and introduced into PSOLIS as a mandatory requirement.
- RAMP should include a structured and sensitive interview with the consumer, and where appropriate, with carers and other support persons. Efforts should be made to ascertain the consumer's own views about their trigger factors, early warning signs of disturbed or violent behaviour and other vulnerabilities, and the management strategies of these issues.
- Risks cannot be eliminated completely. Incidents can occur even with the best risk management practices. Evidence based guidelines and clinical risk assessment documentation can assist in the treatment and support of the consumer to mitigate the potentiality of harm and to optimise patient outcomes.

- It is imperative that clinicians document all levels of risk for each consumer in their assessment processes, to decide which (if any) clinical risks the patient may be subject to and what risk mitigation strategies are required to reduce the level of risk.
- The Chief Psychiatrist's Standards for Clinical Care (2015) state "The mental health service should conduct risk assessments of all patients throughout all stages of the care continuum, including patients who are being formally discharged from the service, exiting the service temporarily and/or are being transferred to another service."
- This will enable clinicians to complete a priority needs analysis of their caseload and ensure appropriate allocation of workload.
- The RAMP enables 'structured clinical judgement' of the patient's current risk profile. The document provides prompts regarding evidence-based risk factors, and the clinician can provide clinical comment on the risks they have identified. From this assessment, the clinician is able to provide their 'Overview/Impression' and to summarise their perceptions of the level of risk. This is an assessment of the likelihood of the risk situation occurring and the significance of the event if the adverse outcome (risk) identified came to pass. The final requirement of this process is for the clinician to outline specific risks and strategies/actions to mitigate these in the RAMP.
- The RAMP document must be placed in the medical record file and a notation made in the progress notes outlining that the document has been completed.

Purpose:	The aim of these documentation forms is to record information to help clinicians to make informed judgments about clinical assessment and risks, by providing a framework for good practice. This framework is informed by the policy and principles of CRAM.
Target services:	All mental health services conducting assessment
Completion requirements:	The module can be completed by any appropriately qualified and experienced mental health professional
Documentation title & format:	Risk Assessment and Management Plan (SMHMR905) & (CAMHS002)

Consideration of the LGBTI+ status of an individual:

- The National LGBTI Health Alliance (February 2020) state that compared to the general population for:

Suicide ideation

- Lesbian, gay and bisexual people aged 16 and over are over **six** times more likely
- Transgender people aged 18 and over are nearly eighteen times more likely
- People with an intersex variation aged 16 and over are nearly five times more likely
- LGBT young people who experience abuse and harassment are even more likely to have thoughts of suicide
- 22% of Same-Gender Attracted and Gender Diverse young people between 14 and 21 years have thoughts of suicide, which increases to 30% for those who have experienced verbal abuse and to 60% who have experienced physical abuse

Suicide Attempts

- LGBTI+ young people aged 16 to 27 are five times more likely
- Transgender people aged 18 and over are nearly eleven times more likely, with 48.1% of transgender and gender diverse people aged 14 to 25 have attempted suicide in their lifetime
- People with an intersex variation aged 16 and over are nearly six times more likely
- LGBT young people who experience abuse and harassment are more likely to attempt suicide

Self-Harm

- LGBT young people are nearly twice as likely to engage in self-injury
- Transgender people are six and a half times more likely
- People with an intersex variation are three times more likely
- LGBT young people who experience abuse and harassment are even more likely to have self-harmed

Mental Health Disorders

- Lesbian, gay and bisexual people are twice as likely to have symptoms that meet the criteria for a mental health disorder in the past 12 months, with 41.4% of homosexual/bisexual people aged 16 and over met the criteria for a mental disorder and had symptoms in the last 12 months
- LGBT people are twice as likely to be diagnosed and treated for mental health disorders
- Transgender people are nearly twice as likely to be diagnosed or treated with a mental disorder and anxiety than lesbian and gay people, and nearly three times than the general population

USE OF CRISIS SUPPORT SERVICES

- 71% of LGBTI+ people21 aged 16 to 27 indicated that they did not use a crisis support service during their most recent personal or mental health crisis
- 32.6% of LGBTI+ people aged 16 to 27 who had not used a crisis support service during their most recent personal or mental health crisis indicated that their decision was due to anticipated discrimination

Source: National LGBTI Health Alliance, (February 2020). SNAPSHOT OF MENTAL HEALTH AND SUICIDE PREVENTION STATISTICS FOR LGBTI PEOPLE, available at: **https://www.lgbtihealth.org.au/statistics**

Intersections for LGBTI with Other Identities and Experiences

Population Group	What We Know
Aboriginal and Torres Strait Islander People	▪ 4% of people with an intersex variation [cxx]
	▪ 1.5% of LGBTI young people aged 16 to 27 [cxxi]
	▪ 3% of LGBT young people aged 14 to 21[cxxii]
	▪ 3.7% of transgender and gender diverse[27] people aged 14 to 25 [cxxiii]
	▪ 2.3% LGBT people aged 16 and over [cxxiv]
	▪ 2.3% of transgender and gender diverse people aged 18 and over [cxxv]
People with a Cultural and Linguistic Diversity	▪ 28.6% of LGBTI young people aged 16 to 27 identify with a racial or ethnic background other than Anglo-Celtic. 18% report having experienced a conflict between their cultural background and their sexuality or gender identity [cxxvi]
	▪ 18% of LGBT young people aged 14 to 21 identify as being culturally and linguistically diverse [cxxvii]
	▪ 16% of transgender and gender diverse young people aged 14 to 25 were born outside of Australia [cxxviii]
	▪ 18.2% LGBT aged 16 and over were born overseas [cxxix]
	▪ 20.2% of transgender and gender diverse people aged 18 and over were born overseas, and 5.5% are from a non-English speaking background [cxxx]

People with Disabilities	▪ 27% of people with an intersex variation aged 16 and over identify as having one or more disabilities [cxxxi]
	▪ 36% of transgender people aged 18 and over[28] identify as having a mental health issue that they described as being a disability or chronic health condition [cxxxii]
People from Rural, Regional and Remote Areas	▪ 5.9% of transgender and gender diverse people aged 18 and over (1.7% transgender men, 8.1% transgender women) live in regional or remote Australia [cxxxiii]
	▪ 18% of LGBT young people aged 14 to 21 live in rural areas, 2% in remote areas [cxxxiv]
	▪ 20% of LGBT people aged 16 and over live in inner and outer regional areas, and 0.7% in rural and remote areas [cxxxv]
People Experiencing Homelessness	▪ 6% of intersex people report they have precarious accommodation or homelessness, couch surfing or living on the street. [cxxxvi]
	▪ 22% of transgender and gender diverse[29] people aged 14 to 25 report experiencing accommodation issues and homelessness [cxxxvii]
	▪ 51% of LGB young people, and 71% of gender diverse young people aged 14 to 21 don't live at home with family [cxxxviii]

(National LGBTI Health Alliance, 2020)

1.3 Assessment

Overview

- Assessment allows mental health clinicians to ensure complete and accurate documentation of each episode of care, including an extensive history.
- The assessment process ensures current and ongoing needs of the consumer are identified.
- The assessment document is used to identify consent from the consumer and carer, as well as legal status and other issues of relevance.
- As per MHA 2014 and Charter of Mental Health Care Principles 7 and 14, mental health services providing treatment and care to people of Aboriginal or Torres Strait Islander descent must ensure collaboration, to the extent that it is practicable and appropriate to do so, with -
  - (a) Aboriginal or Torres Strait Islander mental health workers; and
  - (b) significant members of the patient's community, including elders and traditional healers.

Purpose:	The assessment clinical document provides a framework for documenting a mental health assessment on first contact, or at other times when a comprehensive mental health assessment is indicated.
Target services:	All mental health services conducting assessment
Completion requirements:	The module can be completed by any appropriately qualified and experienced mental health professional
Documentation title & format:	Mental Health Assessment (SMHMR902) & (CAMHS001)

Process

- The assessment document is to be completed post admission, once a consumer is admitted to a community mental health program or psychiatric unit.
- A clinician who is identified as competent to undertake consumer assessment within the multidisciplinary team can complete the initial assessment document.
- Based on the information gathered during the initial assessment and RAMP, clinicians must complete all of the relevant outcome measures and record the results in PSOLIS.
- The clinician must offer the consumer relevant evidence-based tools (Kessler 10 for adult services) to inform the assessment. These (Kessler 10, HoNOS) are also nationally mandated to be completed every 90 days and on activation of the patient. The completed outcome measures enhance and support dialogue and engagement with the consumer.
- Following completion of the initial assessment document, the referral should be presented to the team for discussion, management plan formulation and allocation.
- Initial assessment document must be placed in the medical record file and a notation made in the progress notes outlining that the document has been completed.
- Where clinically appropriate, clinicians should indicate in the Social History section, whether a Functional Assessment was used.

Consideration for Drug and Alcohol History section

- Where clinically appropriate, clinicians should indicate in the Drug and Alcohol History section, which drug, tobacco and alcohol assessment tools are used.
- The Alcohol, Smoking and Substance Involvement Screening Tool ((ASSIST) SMHMR966) is the preferred tool to record information where clinically appropriate.
- Clinicians should also record in the Drug and Alcohol History section of the MH Assessment document:
    - a short summary of any drug, tobacco and alcohol assessment tool(s) used and/or refer to relevant tool(s) (e.g. 'Please see attached [insert tool] for summary and/or details').
    - if the consumer smokes and the relevant information (e.g. time to first cigarette, how many cigarettes smoked per day and duration of use).
    - the provision of any drug, tobacco and alcohol advice to the consumer.

1.4 Physical examination

Overview

- All admissions to inpatient units should have a physical examination at the time of admission, or within 12 hours of admission.
    - This is a more comprehensive medical assessment than provided by the Emergency Department.
- All admissions to community mental health care should have the physical examination completed within one month of the initial assessment and can be undertaken by the consumer's general practitioner. Mental Health Services should liaise with the general practitioner to complete. If adequate physical examination documentation is available within the previous month, then a repeat examination is not required unless clinically indicated.

Purpose:	The physical examination clinical document provides a structured format for the completion of a physical examination undertaken by a medical officer.
Target services:	All mental health services. Where possible emergency departments and general practitioners.
Completion requirements:	The clinical document can be completed by a medical officer or general practitioner. The initial component of the first page can be completed by an appropriately qualified and experienced nurse.
Documentation title & format:	Physical Examination (SMHMR903) & (CAMHS005)

Process

The responsible Consultant Psychiatrist is to:

- Ensure the overall care and coordination of a patient's physical and oral health care during an inpatient stay complies with the policy through supervision and clinical governance processes.
- Actively supports the inclusion of the patient for the purposes of information sharing regarding investigations and physical health care strategies.
- Be guided by the patient's history of physical examination and investigations as well as the known common risks of psychotropic medications.
- Encourage and influence the development of ongoing relationship-building with the GPs, Specialists and other significant health professionals involved in the patient's physical and/or oral health care.

The Medical Officer/Registrar/Intern/Junior Doctor[1] has the responsibility to:

- Document in the patient's record if the patient refuses to consent or consent is unclear.
- Conduct a physical examination upon admission (or within 12 hours following admission)
- Document in the inpatient's medical record:
    - any clinical decisions for not conducting physical investigation/s or
    - reasons if not conducted within the above specified timeframe.
- Ensure the physical examination has been conducted.
- Ensure a physical health care review is conducted after admission and at regular timeframes thereafter, in accordance with policy, if the patient is in extended care.
- A copy of the completed Physical Examination should also accompany the care transfer summary at discharge from an inpatient setting. This is the minimum requirement for transfer of care.

[1] Note: Interns and Junior Doctors will be supervised by the Consultant

Community or non-acute inpatient mental health care:

- All consumers undergoing extended community or non-acute inpatient mental health care should have their weight and Body Mass Index (BMI) measured every six months or more frequently if the consumer is identified as overweight.
- All consumers undergoing extended community or non-acute inpatient mental health care should have physical examination no less frequently than every 12 months.
- For consumers 65 years or older, or who have a significant physical illness or disability, this should be no less frequently than every six months.
- The physical examination can be undertaken by the consumer's regular or nominated primary health care provider. Physical health care of mental health consumers relies on effective partnerships between mental health services and primary health care providers. In an effort to ensure ongoing physical health

assessments and monitoring, and to ensure the consumer's current and ongoing needs are identified and managed to promote optimal physical wellbeing, mental health services should request the consumer's regular or nominated primary health care provider to complete a physical examination (providing the SMHMR903 document template) or to obtain a copy of an appropriate physical examination and results for the mental health service's clinical records.

- For consumers without a regular primary health care provider, all reasonable attempts must be made to ensure access to primary health care. Consumers must be identified who are unable to access mainstream primary health care due to the severity of their illness and mechanisms identified to meet their physical health care needs such as an in-reach GP.
- If appropriate, physical health assessments may also be conducted by the community mental health service.
- Mental health services should document any correspondence with the consumer's regular or nominated primary health care provider to complete a physical examination or to obtain a copy of an appropriate physical examination and results.
- It is important to note that for LGBTI+ consumers, this process can be triggering of past traumas.

1.5 Physical appearance

Overview

- The Physical Appearance document is a structured approach to the documentation of appearance.
- The Chief Psychiatrist has approved this document as part of the mandatory SSCD for medication safety (in the absence of a wrist identification band) and for identification purposes.
- This document augments with existing protocols for identification verification, especially in community settings where patients are not expected to wear identifying information.
- Documentation of the appearance of consumers is important as there are limitations in the use of photography in mental health facilities to protect the consumers.

Purpose:	The physical appearance clinical document provides a structured way of documenting physical appearance
Target services:	All mental health services providing assessment.
Completion requirements:	The clinical document can be completed by any appropriately qualified and experienced mental health professional.
Documentation title & format:	Physical Appearance (SMHMR904).

Process

- The physical appearance document can be completed at the initial assessment or as soon as possible.
- Identifying characteristics should be recorded on the clinical document as indicated.

** Note: Physical Appearance is not applicable for CAMHS.*

** Note: It is important to remember that when recording physical appearance, this may be different to the sex assigned at birth.*

1.6 Treatment, Support and Discharge Plan

Overview

- The treatment support and discharge plan goals should be informed by:
    - the consumer,
    - evidence based outcome measures, determined during assessment,
    - clinical judgement of the case manager, and
    - Identified clinical issues which need to be addressed.

Purpose:	The treatment support and discharge plan provide a framework for summarizing the goals and clinical issues to be targeted in the episode of care, with the intent of aiding the monitoring of clinical status by the consumer, their carer or support persons, their GP and other service providers.
Target services:	All mental health services providing treatment and intervention.
Completion requirements:	The clinical document can be completed by any appropriately qualified and experienced mental health professional, for example, the care Coordinator/key worker etc. The Chief Psychiatrist's Standards for Clinical Care (2015) state "The care plan will be reviewed, as a minimum, every three months." As per Charter of Mental Health Care Principles 14, A mental health service must take a collaborative approach to decision making, including respecting and facilitating the right of people experiencing mental illness to involve their family members, carers and other personal support persons in planning, undertaking, evaluating and improving their treatment, care and support. As per MHA 2014 and Charter of Mental Health Care Principles 7 and 14, mental health services providing treatment and care to people of Aboriginal or Torres Strait Islander descent must ensure collaboration, to the extent that it is practicable and appropriate to do so, with a) Aboriginal or Torres Strait Islander mental health workers; and b) significant members of the patient's community, including elders and traditional healers.
Documentation title & format:	Treatment, Support and Discharge Plan (electronic – PSOLIS, essential).

Process

- The treatment support and discharge plan provides consumers and their carers and support persons with evidence of treatment efficacy and alternatives to enable proper choice of both entry to the service and agreement to treatment.
- The allocated Care Co-ordinator should identify the targets and the choice of interventions in collaboration with the consumer and/or carers, and with other mental health professionals and service providers as required.
- The Care Co-ordinator takes responsibility for coordinating appropriate interventions, including the monitoring and review of a patient's clinical status and recording this appropriately in the Treatment, Support and Discharge Plan.
- In settings where multiple professionals are involved in care planning and its implementation, it is practical for the documentation of this to be undertaken by the allocated Care Co-ordinator.
- Where services are being provided by community managed organisation (external service or other internal programs) within a health service, then the involved clinicians can make entries in the medical records including

documentation of their name and service, date and signature.

- If using standard outcome measures reports to review Treatment, Support and Discharge planning and rate progress, these should be attached to the relevant review module.
- The Care Co-ordinator must ensure that every consumer has a Treatment, Support and Discharge Plan documented which adequately covers the period of care.
- The document should outline specific strategies for the consumer, carer and/or support persons, the GP and others involved in their care. This is an opportunity to consider the relapse signature of the consumer and individual signs or symptoms which would alert the team to clinical deterioration of the consumer's mental state.
- The consumer and carers will sign the Treatment, Support and Discharge Plan and be given copies of the document.
- When a consumer identifies as part of the LGBTI+/sexual, gender or bodily diverse community, it is important to remember that this may impact on all aspects of their life.

1.7 Care transfer summary

Overview

- Ideally, discharge planning should be commenced at admission to an inpatient unit or entrance to a community mental health service.
- The Care Transfer Summary allows for documentation of issues requiring ongoing management, where care is being transferred to another mental health service or other service provider, such as a general practitioner.
- The document is intended for use in both inpatient and ambulatory care settings and should be completed on or before the day of discharge.

Purpose:	Written communication of the current episode of care and its outcomes, and issues that require ongoing monitoring, when care is being transferred to another mental health service or other service provider
Target services:	All mental health services providing treatment and intervention
Completion requirements:	In inpatient services, the medical officer and in community settings, the community medical officer or appropriately qualified and experienced mental health professional Please note: The Care Transfer Summary is not required when electronic discharge summaries (e.g. NaCS) are available. Consultation Liaison Psychiatry Services may collect information in an electronic discharge summary (e.g. NaCS).
Documentation title & format:	Care Transfer Summary (SMHMR916) & (CAMHS003)

Process

- Issues such as language or cultural barriers and any sensory impairment can be documented in 'Communication issues'. This includes if an interpreter is required, then the preferred language should be noted, for example: 'Arabic interpreter required'. Where cultural issues are present, a brief risk assessment should be noted.
- Documentation of 'current medications.' If these details are comprehensively outlined in other sources (e.g. inpatient pharmacy printout, referral letter), the clinician can attach this to the Care Transfer Summary and document this under 'Current Medications'. The brief documentation should indicate attachment details, for example 'see attached referral letter for details on current

medications'.

- The module makes provision for the documentation of 'contacts' to identify any corroboration undertaken as part of care transfer or discharge planning, as well as provide contact details to aid any subsequent communication. The prompts provided in the 'contacts' table regarding 'role/service' (e.g. Case Manager / Care Co-ordinator) are not meant to be definitive or exhaustive.
- Provision is made for clinicians to specify 'other' contacts, thereby making the module more flexible and responsive to differing presentations. In the case of 'Clinicians who provided care during the current episode' the intent of this information is to facilitate communication.
- In inpatient settings, the Care Transfer Summary should be signed by a medical officer.
- In community settings, the Care Transfer Summary should be signed by the community medical officer or the Case Manager / Care Co-ordinator.
- The Care Transfer Summary must be accompanied by a copy of the Treatment, Support and Management Plan, the RAMP and a copy of the completed Physical Examination. This is the minimum requirement for the transfer of care.
- *Note: It is vital to gain the LGBTI+ consumers' consent as to who clinicians communicate information to. For e.g. an individual may not be "out" to their NOK. It is important to record who can be told this type of information.

Additional Documentation and Support Material

The SSCD and guidelines represent the starting point in a comprehensive process to embed the mandatory SSCD across mental health services. As per the SSCD policy, the SSCD are minimum mandatory requirements. This does not prevent additional records being included in the patient's care record, consistent with variations in approach or care pathways for different client groups or clinical settings.

The Mental Health Unit, Department of Health, has made available additional documentation and support material in key areas that Health Service Providers can use in clinically appropriate situations. Where possible, clinicians should document the key findings in the Mandatory SSCD documents.

As previously acknowledged, the original documents are based on those developed by New South Wales Health who granted permission to the former Mental Health Division of the WA Department of Health to use the documents across public mental health services. Similar to the documents/support material, the guidelines below are largely based on the NSW's Mental Health Clinical Documentation Guidelines (2014) and reviewed and/or adapted to the WA context.

Overview of Mental Health Clinical Documentation table:

Overview of Mental Health Clinical Documentation		
Mandatory Core Modules:	**Additional Modules:**	**Support Material:**
Modules to be used in all settings and age groups	Modules to use in appropriate clinical situations	Educational and other resources to support module completion and/or use
TRIAGE	Family Focused Assessment COPMI Cognitive Assessment (RUDAS) Cognitive Assessment (3MS-MMS) Alcohol, Smoking and Substance Involvement Screening Tool (ASSIST) Functional Assessment Consumer Safety Plan Transcultural Assessment Cultural Gathering Tool Metabolic Monitoring Oral Health Check List Abnormal Involuntary Movement Scale (AIMS) Family and Domestic Violence modules	Family and Domestic Violence toolbox (external site) PSOLIS Support Page (external site)
RISK ASSESSMENT AND MANAGEMENT PLAN		
ASSESSMENT		
PHYSICAL EXAMINATION		
PHYSICAL APPEARANCE		
TREATMENT SUPPORT AND DISCHARGE PLAN		
CARE TRANSFER SUMMARY		

Family Focussed Assessment (COPMI)

Purpose	Where at assessment, parental/carer status has been determined and the child is aged 18 years or less, then the Family Focused Assessment (Children of Parents with a Mental Illness (COPMI)) module provides a structured format for documenting parent/carer and child functioning. The module addresses the impacts of the parent's/carer's mental illness or disorder on the child, with this inclusive of child protection concerns.
Target services	All adult mental health services. While intended principally for adult mental health services, the module can be used by other services where appropriate. For instance, if a client of CAMHS has been identified as having parental/carer responsibilities for a child aged 18 or less, then the module can be completed.
Completion requirements	The module can be completed by any appropriately qualified and experienced mental health professional.
Associated resources	Relationship to the Assessment module Where the Family Focused Assessment (COPMI) module has been completed as part of assessment, this should be noted in the Assessment module under 'Parental Status and/or Other Carer Responsibilities' on page 4.

Process

- The module's first page assists clinicians to summarise assessment information available on the parent/carer and child. Ideally, the available information should reflect that it was gathered from a face-to-face assessment, with corroborative information also obtained. The summarised information may reflect information gathered as a result of liaison between Child and Adolescent and Adult mental health services.
- Page 2 assists the collation and analysis of available information for the purpose of determining urgency of response, with this assisted by the identification of strengths/protective factors and vulnerabilities/risk factors. Clinicians are also prompted to provide an 'Overview' indicating whether the 'parent's/carer's symptoms and behaviour interfere with undertaking parental and/or essential household duties' and whether the 'parent's/carer's symptoms and behaviour are having a negative impact on the child'. The final requirement is for the clinician to outline 'specific issues to be addressed in (the) management/care plan' for the parent and child.
- The information domain headings used in the module reflect, where possible, the information domains of the Assessment module. For example, page 1 uses 'Mental State Examination' headings. This is intended to aid clinicians to collate information already documented in the Assessment module. Where the use of the Family Focused Assessment (COPMI) module alerts clinicians to gaps in their assessment information and the need to gather more information, similarities in the headings between the module and the Assessment may also aid this process.
- If the parent/carer has more than one child, then a separate COPMI module may need to be completed for each child.

Cognitive Assessment tools

Cognitive Assessment (RUDAS)

Purpose	The *Cognitive Assessment (RUDAS)* module provides a structured format for the documentation of cognitive functioning through the availability of the Rowland Universal Dementia Assessment Scale (RUDAS). This Scale was developed by Storey and colleagues (Storey, Rowland, Basic, Conforti & Dickson, 2002) to function as a 'multicultural minimental state examination'.
Target services	While intended for Older Adult services, Adult services can use the module.
Completion requirements	The RUDAS can be completed by an appropriately qualified and experienced mental health professional who has undertaken training on the use of the RUDAS and/or has experience with its use. This reflects the developers' instructions for use.
Associated resources	*RUDAS Administration and Scoring Guide. See* Dementia Australia's Rowland Universal Dementia Assessment Scale (RUDAS) resources webpage: https://www.dementia.org.au/resources/rowland-universal-dementia-assessment-scale-rudas *Relationship to Assessment module* Where the *Cognitive Assessment* (RUDAS) module has been completed at assessment, this should be noted in the *Assessment* module under the 'Mental State Examination' heading 'Cognitive and Intellectual Functioning'.

Process

- A score below 23 out of 30 indicates likely cognitive impairment.
- Please note that any score derived from the RUDAS requires clinical interpretation.
- While the RUDAS and 3MS/MMS are available to clinicians, it is not expected that both would be completed. Clinicians can choose the one which best meets their needs.
- While the RUDAS has been made available in response to the needs of Aged Care services, clinicians from other settings may elect to use it as a cognitive impairment screening tool.
- In addition to the RUDAS, the module makes provision for the documentation of any other cognitive tests undertaken. As a final prompt, it requires clinicians to provide a 'Clinical Overview/Issues to be Addressed in (the) Management/Care Plan'.
- Dementia Australia's RUDAS resources webpage has a range of further information and support material including links to an online video, administration and scoring guide and scoring sheets (Link)

Cognitive Assessment (3MS-MMS)

Purpose	The *Cognitive Assessment (3MS/MMS)* module provides a structured format for the documentation of cognitive functioning through the availability of the Modified Mini Mental State (3MS) (Teng & Chui, 1987). The module reflects the 3MS, with the shaded areas reflecting the minimental state (MMS)

	approximation contained with the 3MS.
Target services	While intended for Older Adult services, Adult services can use the module.
Completion requirements	The 3MS/MMS can be completed by an appropriately qualified and experienced mental health professional who has undertaken training on its use and/or has experience with its use. This reflects the developers' instructions for use.
Associated resources	*Relationship to Assessment module* Where the *Cognitive Assessment (3MS/MMS)* module has been completed at assessment, this should be noted in the *Assessment* module under the 'Mental State Examination' heading 'Cognitive and intellectual functioning'.

Process

- With the MMS approximation the total score is 30, the following ratings have been recommended:
  - 'Normal' is greater than or equal to 27
  - 'Cognitive impairment: 'Mild' = 20-26; 'Moderate' = 10-19; 'Severe' <10.
- With the 3MS the total score is 100 and a score under 76 indicates likely cognitive impairment.
- Please note that any score derived from the 3MS/MMS requires clinical interpretation.
- While the RUDAS and 3MS/MMS are available to clinicians, it is not expected that both would be completed. Clinicians can choose the one that best meets their needs.
- While the 3MS/MMS has been made available in response to the needs of Aged Care services, clinicians from other settings may elect to use it as a cognitive impairment screening tool.
- In addition to the 3MS/MMS, the module makes provision for the documentation of any other cognitive tests undertaken. As a final prompt, it requires clinicians to provide a 'Clinical Overview/Issues to be Addressed in Management/Care Plan'.

Drug and Alcohol Assessment tools

Alcohol, Smoking and Substance Involvement Screening Tool (ASSIST)

Purpose	The Alcohol, Smoking and Substance Involvement Screening Tool (ASSIST) module provides a structured format for the documentation of alcohol and other drug use on first contact or at other times when a comprehensive assessment is indicated.
Target services	The module applies to both inpatient and community settings.
Completion requirements	The module can be completed by any appropriately qualified and experienced mental health professional.

Associated resources	*Relationship to Assessment module* The *Assessment* module makes provision for the documentation of 'Drug and Alcohol History', with clinicians prompted to document past and current substance use, amounts and frequency, features of dependence and abuse, and prior treatments and their outcomes. Where the ASSIST module has been completed, this should be noted in the Assessment module under 'Drug and Alcohol History'.

Process

The module makes provision for structured documentation of substance use assessment, in addition to the provision made for 'Drug and Alcohol History' in the *Assessment* module. In terms of presentations where the ASSIST module should be completed, the following has been proposed:

- A consumer who has had more than 6 standard drinks on any one occasion within the last three months. If the consumer is an adolescent, then the module should be completed if s/he has consumed any alcohol in the last three months.
- A consumer who has used any of the following in the last three months: alcohol, tobacco, benzodiazepines, cannabis, amphetamine, cocaine, MDMA (Ecstasy), heroin, prescription analgesics, methadone, buprenorphine, solvents, hallucinogens.
- A consumer who is currently intoxicated or in withdrawal.
- Clinicians should use their clinical judgement regarding the completion of the module and should not exclude its completion for consumers outside this proposed range.
- Further information can be found on the Mental Health Unit's Alcohol and Other Drugs webpage (Link) and Clinical Guidelines for the Physical Care of Mental Health Consumers (UWA) (Link).

Functional Assessment tools

Functional Assessment

Purpose	The Functional Assessment module provides a structured format for the documentation of current functioning for consumers presenting to mental health services.
Target services	While intended for older adult mental health services, the module can be used by other services addressing rehabilitation issues, for instance, non-acute adult mental health rehabilitation services.
Completion requirements	The module can be completed by any appropriately qualified and experienced mental health professional.
Associated resources	*Relationship to the Assessment module* Where the Functional Assessment module has been completed at assessment, this should be documented in the Assessment module under 'Social History section'.

Process

- The information domains in the *Functional Assessment* facilitate the completion of the Resource Utilisation Groups – Activities of Daily Living (RUG-ADL), the Life Skills Profile (LSP) and relevant items on the HoNOS65+.
- Further information can be found on Australian Mental Health Outcomes and Classification Network's Training Manual: Older Persons Inpatient (Link)

Consumer Safety Plans

Consumer Safety Plan

Purpose	The Consumer Safety Plan module provides a structured format for the documentation of a Safety Plan.
Target services	All mental health services providing treatment and intervention.
Completion requirements	The Clinical Care of People Who May Be Suicidal Policy (Link) requires Health Service Providers and Contracted Health Entities to develop a local policy regarding the clinical care of people who may be suicidal that aligns to the Principles and Best Practice for the Clinical Care of People Who May Be Suicidal (Link) which includes developing a Safety Plan for each consumer who has a suicide risk. Whilst a specific document is not prescribed by The Clinical Care of People Who May Be Suicidal Policy, Health Service Providers are recommended to use the Statewide version (SMHMR932) where clinically appropriate. Note: Safety plans are also described within the Clinical Care of People with Mental Health Problems who may be at Risk of Becoming Violent and Aggressive Policy. The module can be completed collaboratively between clinicians, the consumer, their family and their personal support person.
Associated resources	Relationship to the Risk Assessment and Management Plan (RAMP and CAMHS RAMP The RAMP has section to help identify background and current factors for suicide and violence/aggression. There are specific policy requirements if a consumer is at risk of becoming violent/aggressive or has a suicide risk (please see below for relevant parts referenced in the policies);however, risk management planning and safety planning is a key part of the of the RAMP and CAMHS RAMP. Relationship to the Treatment, Support and Discharge Plan The Principles and Best Practice for the Clinical Care of People Who May Be Suicidal guidelines state "The Safety Plan can be incorporated as part of the treatment, support and discharge plan outlined in the *Mental Health Act 2014*. The Safety Plan must be revised and updated at points of significant transitions in care, as these represent times of potential increased in risk."

Process:

- The Consumer Safety Plan module (SMHMR932) is one tool in the process of responding to a consumer who may be suicidal by helping the consumer, their family and personal support person identify coping and calming strategies, triggers, early warning signs and additional information in the event an emergency situation occurs.
- The Clinical Care of People Who May Be Suicidal Policy (Link), Principles and Best Practice for the Clinical Care of People Who May Be Suicidal (Link) and local Health Service Provider policy should guide clinician's processes in responding to people who may be suicidal.
- The Clinical Care of People with Mental Health Problems who may be at Risk of

Becoming Violent and Aggressive Policy states “A Safety Plan must be included in the clinical file of all consumers who have a risk of becoming violent or aggressive.” (3.2). Please refer to the policy for further details.

- The Clinical Care of People Who May Be Suicidal Policy requires “Development of a Safety Plan for each consumer who has a suicide risk”. Please refer to the policy for further details.

Cross-cultural Mental Health Assessment tools

Transcultural Assessment

Purpose	The Transcultural Assessment module provides a structured format for the documentation of cultural information, where a consumer has been identified as being from a culturally and linguistically diverse background.
Target services	All mental health services providing treatment and intervention.
Completion requirements	The module can be completed by any appropriately qualified and experienced mental health professional.
Associated resources	*Relationship to the Triage document* The Triage document identifies any communication issues that can be replicated in Transcultural Assessment Module ‘Communication Issues’ section. The Triage document’s ‘Action taken’ section identifies whether an Interpreter is booked. *Relationship to the Assessment document* The Assessment document has the communication issues free text field replicated from the Triage document and Transcultural Assessment Modules. Country of birth, year arrived in Australia and primary language can also be captured in the Assessment document. A check box as to whether an interpreter is required and interpreter notes (e.g. if gender specified etc.) can also be captured in the Assessment module.

Process:

- “Physical care and assessment for consumers from Culturally and Linguistically Diverse Backgrounds (CALD) require a culturally sensitive approach. Health professionals should be aware of their own values and beliefs” (NSW Health, 2017).
- The NSW Health’s Physical Health Care of Mental Health Consumers Guidelines (Link) provides some information/guidance regarding the process and factors to consider when undertaking a Transcultural Assessment such as:
  a) Lack of proficiency in English.
  b) Impeded access to health services due to language difficulties and cultural expectations.
  c) Lack of awareness of available community services.
  d) Stressors experienced during the process of adapting to mainstream Australian Culture.
- The Transcultural Mental Health Centre (Link) has a range of resources on its ‘Cross-Cultural Mental Health Assessment’ webpage (Link) including the Cultural Awareness Tool (CAT) to assist health care providers to understand the influence of cultural diversity in mental health.
- Services are encouraged to use interpreters to complete the ‘Transcultural Assessment’ (as required).

Cultural Information Gathering tool

Purpose	WA Country Health Service's Mental Health Cultural Information Gathering Tool is the nominated state-wide tool for staff to gather relevant cultural information for Aboriginal or Torres Strait Islander consumers to inform culturally appropriate assessment and management planning.
Target services	All mental health services providing treatment and intervention.
Completion requirements	The module can be completed by any appropriately qualified and experienced mental health professional.
Associated resources	*Relationship to the Triage document* The Triage document identifies Indigenous status and communication issues. The 'Action taken' section identifies whether an Interpreter is booked. *Relationship to the Assessment document* The Assessment document has the Indigenous status and communication issues areas similar to the Triage document as well as specific questions regarding whether the individual was offered the involvement of a significant member of the person's community, whether the offer was accepted and a check box as to whether an interpreter is required. *Relationship to the Treatment, Support and Discharge Plan* The Cultural Gathering tool can be used to inform culturally appropriate assessment and management planning.

Process:

- As per MHA 2014 and Charter of Mental Health Care Principles 7 and 14, mental health services providing treatment and care to people of Aboriginal or Torres Strait Islander descent must ensure collaboration, to the extent that it is practicable and appropriate to do so, with a) Aboriginal or Torres Strait Islander mental health workers; and b) significant members of the patient's community, including elders and traditional healers.
- Wungen Kartup Mental Health Service (SAMHS) supports both Aboriginal consumers and carers in accessing mainstream mental health services, and in better meeting the needs of Aboriginal people statewide (see brochure link).
- Clinicians are encouraged to familiarise themselves with the 'National guide to preventive health assessment for Aboriginal and Torres Strait Islander people 3rd edition' (Link).
- The NSW Health's Physical Health Care of Mental Health Consumers guidelines (Link) provides some information regarding key principles for working with Aboriginal communities in relation to physical assessment, care, and treatment of physical health needs including:
  a) Services working in partnership
  b) Holistic approach to mental health
  c) Flexibility
  d) Accessibility of services
  e) Ability to follow people across areas
  f) Respect and sensitivity for Aboriginal people
  g) Involvement of family and others in care
  h) Treating an individual as part of a family and the community
  i) Provision of education and training
  j) Illness prevention.
- Further contacts for Perth Aboriginal services – mental health services (Link).

Physical Health Care Tools

Metabolic Monitoring

The Clinical Guidelines for Physical Care of Mental Health Consumers (2010) describes Metabolic Syndrome as a recognised cluster of features predictive of both cardiovascular disease and type 2 diabetes including obesity, glucose intolerance/insulin resistance, hypertension and dyslipidemia. Metabolic syndrome is related to several factors including, but not limited to, medication use, lifestyle factors, psychosocial factors and comorbid physical illness.

Waterreus and Laugharne (2009, p.186) state that consumers "receiving antipsychotic medication are at a higher risk of developing metabolic syndrome than people in the general population, with prevalence estimates of metabolic syndrome in patients with a psychiatric diagnosis ranging from 24% to 53%." Consumers who have a mental illness are 2.5 times more likely to die from preventable physical illness than people in the general population (Stanley and Laugharne, 2010; Lawrence, Holman and Jablensky, 2001).

Purpose	The *Metabolic Monitoring* module provides a structured format to support the monitoring of consumers identified as having, or as being at risk of, metabolic syndrome.
Target services	All mental health services providing treatment and intervention.
Completion requirements	The module can be completed by any appropriately qualified and experienced mental health professional. ▪ Health Service Providers are responsible for adhering to the mandatory Chief Psychiatrist's Standards for Clinical Care (Link). ▪ The Chief Psychiatrist's Standard for Physical Health Care of Mental Health Consumers, Criteria 1.5, states: "There will be a standardized approach to regular physical screening and in particular metabolic screening. 1.5.1 Measurement of Body Mass Index (BMI). 1.5.2 Measurement of waist circumference. 1.5.3 Regular age appropriate screening relative to the medications prescribed." ▪ The mandated SSCD documents allow mental health services to adhere to the mandatory Chief Psychiatrist's Standards for Physical Health Care of Mental Health Consumers, Criteria 1.5. ▪ Whilst the *Metabolic Monitoring Module* is not mandatory as part of the 'State-wide Standardised Clinical documentation (SSCD) for Mental Health Services' policy, the Metabolic Monitoring document allows for a more detailed assessment and monitoring of metabolic syndrome as clinically appropriate. ▪ Health Service Providers may elect to mandate metabolic monitoring for admitted consumers to mental health services. ▪ The Medication Chart Policy (MP 0078/18) requires mental health services to use the WA Adult Clozapine Initiation and Titration Chart for adult mental health patients where required. Further information can be found on the Mental Health Charts and Clozapine Resources webpage (Link).
Associated resources	*Relationship to the Assessment and Physical Examination modules* ▪ The *Assessment* and *Physical Examination* modules

	contain questions to aid the identification of consumers at risk of metabolic syndrome. ▪ The *Assessment* module has space for the recording of information on the following metabolic syndrome risk factors, for example: – Under 'Family Medical/Mental Health History' (p.3), screening questions can address familial physical risk factors (e.g. family history of diabetes, obesity, cardiovascular disease). – Under 'Medical History' (p.2), personal physical risk factors can be addressed (e.g. history of diabetes, obesity, cardiovascular disease); and – Under 'Current Treatments' (p.3), 'Current medications' can be documented. A 'yes' to any of the above may indicate that a more detailed assessment of metabolic syndrome is required. ▪ The Physical Examination module contains documentation space for a range of metabolic syndrome risk factors in the general Appearances and Observations section. ▪ Metabolic risk factors can also be recorded under the Investigations section of the Assessment Module (p.6). ▪ Where blood results are available in hard copy, these can be attached to the module rather than transcribed. In the event of positive findings, blood results should be recorded in the Metabolic Monitoring module to minimise duplication and facilitate monitoring. *Relationship to the Treatment, Support and Discharge Plan* ▪ The module is to be used in conjunction with the Treatment, Support and Discharge Plan to aid the management and monitoring of any identified metabolic syndrome risk factors. Reviews are to be undertaken three monthly and more frequently when abnormalities are identified, or medication or dose is changed.

Process:

- The module targets consumers identified as having, or as being at risk of, metabolic
  syndrome, including those:
  - on antipsychotic medication
  - with familial physical risk factors (e.g. diabetes, obesity, cardiovascular disease)
  - with personal physical risk factors (e.g. diabetes, obesity, cardiovascular disease).
- The identification of these consumers is supported by the inclusion of screening questions within the Assessment and Physical Examination modules.
- The module includes diagnostic criteria and guidelines for intervention to assist the provision of appropriate care. In the case of waist circumference, there is a separate at-risk range identified for European men (≥94cm) compared to South Asian, Japanese, South & Central American men (≥90cm). Where a male consumer belongs to a non-European group that is not specified above (e.g. African, Aboriginal), clinicians are advised to be conservative and use the latter criteria.
- While the module targets key metabolic syndrome information domains, it makes provision for the inclusion of other health issues via the use of 'Other (specify)'. This approach aims to facilitate the use of the one document by all services, versus the development of multiple versions.
- To assist care planning and monitoring, the module is intended to be used at baseline (drug naïve if possible), at three monthly reviews and more frequently when abnormalities are identified, or medication or medication dose is changed. As a result, it is expected that the module will be used in conjunction with the

Treatment Support and Discharge Plan.

- Where possible, the module should be completed in collaboration with the consumer's General Practitioner. Where a consumer does not have a nominated General Practitioner, the mental health service should make reasonable efforts to link the consumer with an appropriate health care provider.
- Further information can be found in The Clinical Guidelines for Physical Care of Mental Consumers (Link) which also contains a clinical algorithm wall chart for monitoring metabolic syndrome (Link).

Oral Health Check List

Purpose	The Clinical Guidelines for Physical Care of Mental Consumers (2010) shows oral health is generally poor in people with mental illness as consumers are less likely to report visits to the dentist or to a dental hygienist, despite great need for dental services with problems such as bad odour, ulcerated, bleeding and/or inflamed mucous membranes, lips or gums, decayed and/or fractured teeth, calculus on teeth, and an absence of saliva. The TMHMR992 helps a clinician determine whether the consumer requires a referral to a dental practitioner.
Target services	All mental health services providing treatment and intervention.
Completion requirements	The module can be completed by any appropriately qualified and experienced mental health professional.
Associated resources	*Relationship to the Physical Examination document* The Physical Examination Document has an Oral Health section with a prompt to consider whether an oral health check is required for further investigation. *Relationship to the Treatment, Support and Discharge Plan* The module is to be used in conjunction with the Treatment, Support and Discharge Plan to aid the management and monitoring of any identified physical health issues.

Process:

- Mental health services are required to complete a Physical Examination document within 12 hours of admission; however, they may elect to undertake further investigations such as an oral health check at a later stage.
- As a result of routine assessment, clinicians should document:
  - Any referral actions resulting from the oral health check under the Assessment module's 'Initial Management Plan' to facilitate continuity of related information.
  - Any 'Physical and Dental Health Needs' on page 1 and 'Physical Health Care' Treatment/Support on page 3 of the Treatment, Support and Discharge Plan.

Abnormal Involuntary Movement Scale (AIMS)

Purpose	The Abnormal Involuntary Movement Scale (AIMS) module provides a structured format to examine, document and measure involuntary movements.
Target services	All mental health services providing treatment and intervention.
Completion requirements	The module can be completed by any appropriately qualified and experienced mental health professional.
Associated resources	*Relationship to the Physical Examination document* The Physical Examination Document's Neurological/Musculoskeletal section has a question about whether

	the Abnormal Involuntary Movement Scale (AIMS) test is required.

Process:

- Complete examination procedure before making ratings movement.
- For ratings: rate highest severity observed, and rate movements that occur upon activation, one less than those observed spontaneously.
- Examination procedures are listed on the Abnormal Involuntary Movement Scale (AIMS TMHMR991) document.
- Either before or after completing the examination procedure, observe the patient unobtrusively at rest (e.g. in waiting room). The chair to be used in this examination should be a hard, firm one without arms.
- Further information can be found on NSW Health's Physical Health Care of Mental Health Consumers Guidelines (Link).
- "The Abnormal Involuntary Movement Scale (AIMS) examination has been widely recommended for periodic screening for tardive dyskinesia" (Munetz and Benjamin 2006). NMHS bulletin provides further information specifically on tardive dyskinesia (Link).

Family and Domestic Violence toolbox

Family and Domestic Violence modules (FDV950, FDV951 and FDV952)

Women's Health Strategy and Programs (WHSP) within Women and Newborn Health Service, provides guidance, resources and training to WA Health staff in the areas of Family and Domestic Violence (FDV) and Gender-based Violence/Honour-based Violence. WHSP produced the Guideline Responding to Family and Domestic Violence, which provides best practice guidance on identifying and responding to FDV in a health service.

WHSP also provides FDV education and training for WA Health staff. The education and training program is for staff to assist with early identification, responding to and referrals for people experiencing FDV.

Purpose	The FDV950 module provides routine screening of clients to identify if they are experiencing Family and Domestic Violence. The FDV951 module is used during a risk assessment of a client who has disclosed they are being abused to assess their safety. The FDV952 module is a template for referring clients to an external Family and Domestic Violence support service. See Family and Domestic Violence Tool box for further information (Link).
Target services	While intended for adult health services, the module can be used by other services as required.
Completion requirements	It is recommended that mental health professionals undertake WNHS 'Introduction to Family and Domestic Violence' e-learning and 'Screening and Responding to Family and Domestic Violence' e-learning packages prior to commencing screening (See 'Education and Training' section on Family and Domestic Violence Tool box webpage). However, the modules can be completed by any appropriately qualified and experienced mental health professional.
Associated resources	*Relationship to the Risk Assessment and Management Plan*: ▪ The Risk Assessment and Management Plan document has a section on Family and Domestic Violence with screening questions directly from step 2 of the FDV950 module to help

	identify instances of Family and Domestic Violence.

Process:

- If Family and Domestic Violence has already been identified at assessment, for example, on presentation or in a referral, the clinician can still elect to complete the Screening for Family and Domestic Violence (FDV950) module.
- If Family and Domestic Violence is determined by the FDV950, or as a result of routine assessment, clinicians should assess risk using the FDV951.
- If Family and Domestic Violence is determined by the FDV950, or as a result of routine assessment, clinicians should also document this in 'Alerts/Risks' on page 1 of the Assessment module. Any actions resulting from the Screening should also be documented under the Assessment module's 'Initial Management Plan' to facilitate continuity of related information.

Electronic & physical storage of documentation

PSOLIS

The Psychiatric Services On-Line System (PSOLIS) is a mental health clinical information database that has been developed for use in all government mental health facilities throughout Western Australia. The system was developed by the Health Support Services (HSS) following extensive consultation with mental health clinicians. The system documents significant clinical information about a consumer's mental illness and episodes of care.

PSOLIS Triage

The triage function allows the triage officer to capture the clinical details of any referral to the service and the actions taken by the triage officer. Depending on the outcome of the triage event the system will/will not create a new referral. Care should be taken to outcome every triage event entered into PSOLIS to ensure that an open referral is not generated unnecessarily.

PSOLIS Risk Assessment and Management Plan

This functionality in PSOLIS is divided into 3 components:

- Incidents
- Risk assessment (RAMP)
- Alerts

An entry and review of the above should be guided by Alerts Standards Documentation, Incident Standards Documentation, RAMP & PSOLIS Business Rules.

PSOLIS Treatment, Support and Discharge Plan

All management plans in PSOLIS are multidisciplinary, thus any member of the team can make entries. A 'Treatment, Support and Discharge Plan' relates to the care of the consumer for a particular episode of care.

Care is planned with the consumer and carer ensuring that clinical risk is managed in order to achieve the best possible outcome. To achieve this, it is essential that NOCC (outcome measure tool) and the risk assessment tools work in collaboration to document the 'Treatment, Support and Discharge Plan'.

These tools assist in:

- Decision making at admission, clinical review and discharge
- Monitor the progress of the consumer
- To help better understand the needs of the consumer
- Evaluates the effectiveness of interventions
- Assist in maintaining continuity of care

Any changes in the consumer's risk level during their treatment needs to be reflected in the 'Treatment, Support and Discharge Plan' in a chronological order. The Treatment, Support and Discharge Plan is to include a summary of all risks identified, formulations of the situations in which risk may occur, and actions to be taken to reduce risk.

Medical record arrangement

Each health service has a separate medical records process. In many sites this includes an acknowledged "Order of Filing". As there is no statewide medical record process, it is important that senior mental health service staff have an agreed process for the filing of the Statewide Standardised Clinical Documents which are identified with the SMHMR90X nomenclature.

References:

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Appendix 1: Crisis Triage Rating Scale

The Crisis Triage Rating Scale (CTRS) is a brief rating scale developed to screen emergency psychiatric consumers rapidly. It differentiates between consumers who require hospitalisation from those who are suitable for outpatient crisis intervention treatment (Bengelsdorf et al., 1984).

The scale evaluates the consumer according to three factors: (1) whether they are a danger to themselves or others, (2) their support system, and (3) their ability to cooperate.

Rating A: Dangerousness

1) Expresses or hallucinates suicidal / homicidal ideas or has made a serious attempt in present episode of illness. Unpredictable, impulsive and violent.

2) Expresses or hallucinates suicidal / homicidal ideas without conviction. History of violent or impulsive behaviour but no current signs of this.

3) Expresses suicidal / homicidal ideas with ambivalence or made only ineffectual gestures. Questionable impulse control.

4) Some suicidal / homicidal ideation or behaviour or history of same, but clearly wishes to control behaviour.

5) No suicidal / homicidal ideation / behaviour. No history of violence or impulsive behaviour.

Rating B: Support System

1) No family, friends or others. Agencies cannot provide immediate support needed.

2) Some support can be mobilised but its effectiveness will be limited.

3) Support systems potentially available but significant difficulties exist in mobilising it.

4) Interested family / friends, or others but some question exists of ability or willingness to provide support needed.

5) Interested family, friends, or others able and willing to provide support needed.

Rating C: Ability to Cooperate

1) Unable to cooperate or actively refuses.

2) Shows little interest in or comprehension of efforts made on their behalf.

3) Passively accepts intervention strategies.

4) Wants help but is ambivalent or motivation is not strong.

5) Actively seeks treatment, willing to cooperate.

Responding to Urgency of Response

The mental health triage should clearly indicate which service is required to act on the Urgency of Response (UoR), e.g. the receiving mental health team.

Crisis triage rating scale

A. Dangerousness = _____

B. Support System = _____

C. Ability to Cope = _____

Triage Rating (A+B+C) = _____

Scores are:

Category A = 3 – 9

Category B = 10

Category C = 11

Category D = 12 – 13

Category E = 14 – 15

Category F = NA

Category G = NA

The clinician may make the rating following a brief assessment over the telephone. It is recommended that if the score is equal to or less than 9, the response to a client is of extreme urgency and should be followed with appropriate indication on the urgency of response scale and appropriate action. Note that if in residential aged care, Rating B can still be in range 2 to 5.

The CTRS is a brief rating scale developed to screen emergency psychiatric consumers rapidly.

It differentiates between consumers who require hospitalisation from those who are suitable for outpatient crisis intervention treatment (Bengelsdorf et al., 1984) subsequently determining required level of response.

The following minimum action / interventions have been compiled to assist the triage clinician respond to consumer / referrer needs:

Category A: Extreme Urgency: Immediate response requiring Police / Ambulance or Other Service (e.g. overdose, siege, imminent violence).

Category B: High Urgency: See within 2 hours / present to Psychiatric Emergency Service or Emergency Department in General Hospital (e.g. acute suicidality, threatening violence, acute severe non-recurrent stress).

Category C: Medium Urgency: See within 12 hours (e.g. distressed, suicidal ideation of moderate to severe nature, disturbed behaviour).

Category D: Low Urgency: See within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous).

Category E: Non Urgent: See within 2 weeks.

Category F: Requires further triage contact / follow up.

Category G: No further action required.

The receiving mental health team at the time of referral, will be responsible for follow up of non- presenting consumers, e.g. consumer fails to present to Emergency Department or is not present on home visit.

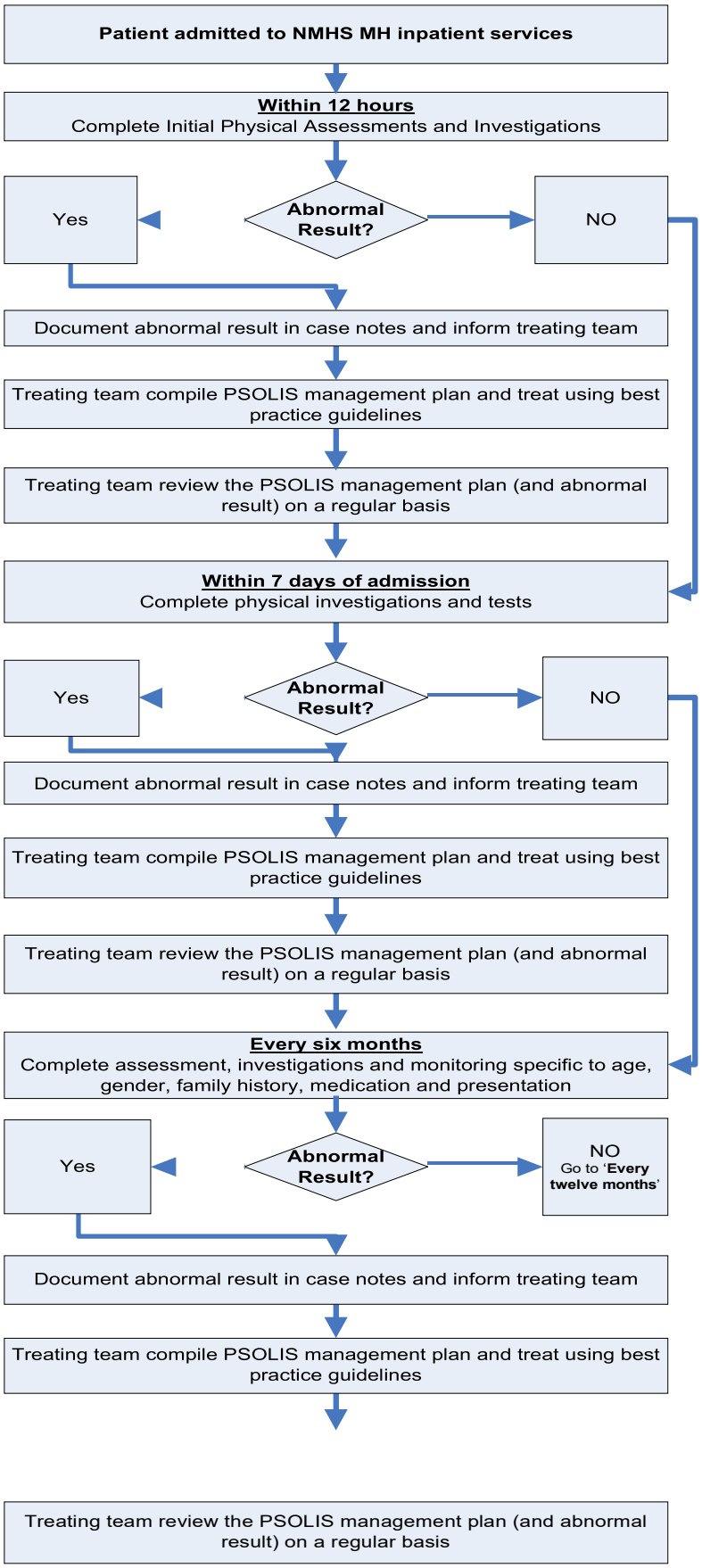
There may be occasions when the receiving mental health team is unable to respond within the assessed UoR timeframe. In these instances, it is the responsibility of the Mental Health Service to ensure that local processes are in place to manage and support the consumer until such time as the local mental health team is able to assume responsibility and make face-to-face contact with the consumer.

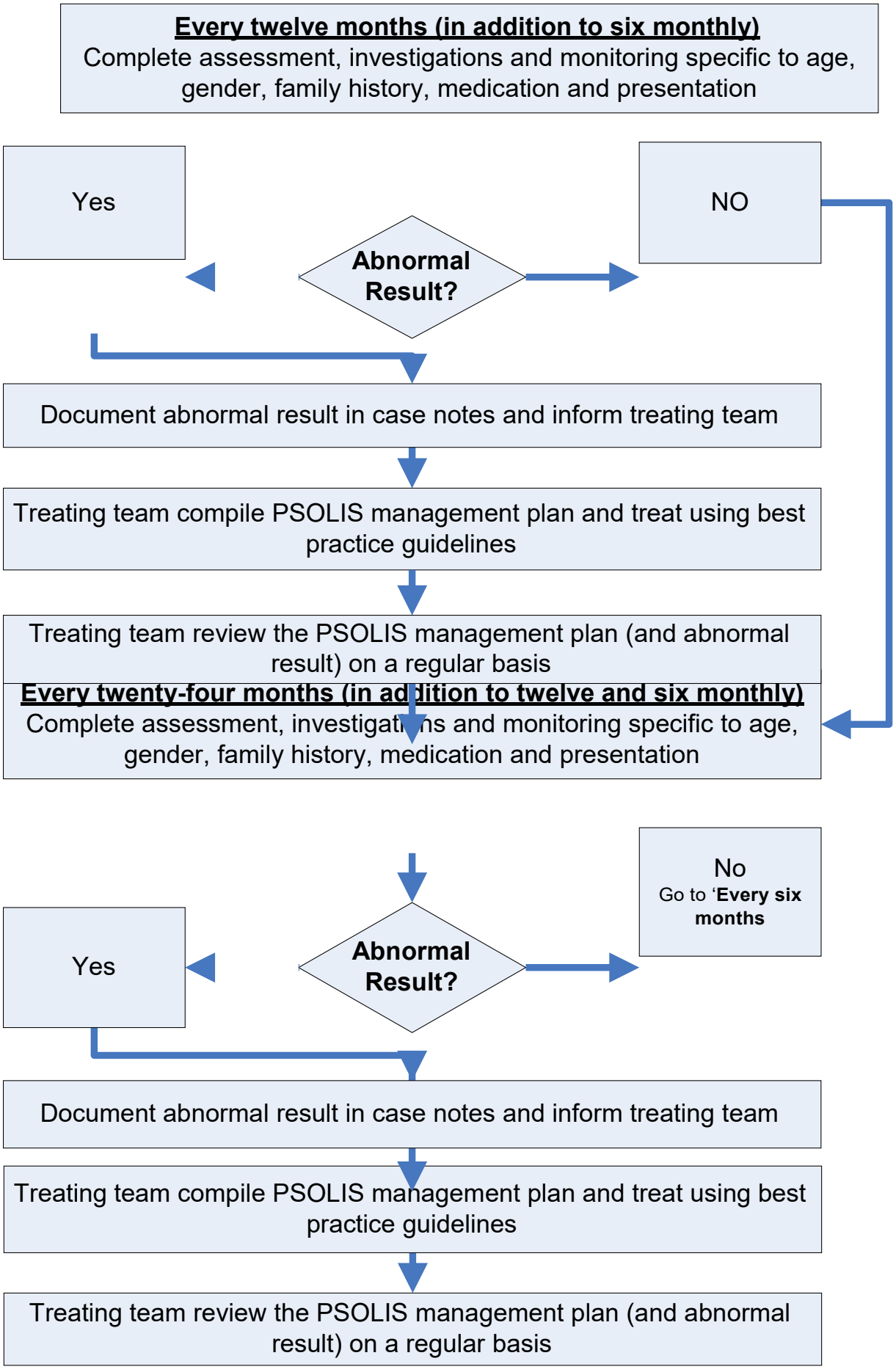
The key principle is to ensure, as much as is practicable, that the consumer is safe until face-to- face contact is made by the local mental health team clinician.

Crisis Triage Rating Scale / Urgency of Response Review

Confidence of assessment may indicate the need to review the CTRS either increasing or decreasing the urgency of response. Any changes to the CTRS / UoR must be comprehensively and clearly documented as to the reason for the change.

Appendix 2: Physical Health Care Standards Algorithm (NMHS example)




Every twelve months (in addition to six monthly)
Complete assessment, investigations and monitoring specific to age, gender, family history, medication and presentation
Yes
Abnormal Result?
NO
Document abnormal result in case notes and inform treating team
Treating team compile PSOLIS management plan and treat using best practice guidelines
Treating team review the PSOLIS management plan (and abnormal result) on a regular basis
Every twenty-four months (in addition to twelve and six monthly)
Complete assessment, investigations and monitoring specific to age, gender, family history, medication and presentation
Yes
Abnormal Result?
No
Go to 'Every six months
Document abnormal result in case notes and inform treating team
Treating team compile PSOLIS management plan and treat using best practice guidelines
Treating team review the PSOLIS management plan (and abnormal result) on a regular basis

Appendix 3: Medical Record Arrangement – Inpatient (example)

Divider/section	PMR	Non PRM paperwork	Description/notes
Risk Divider	PMR 01		• Clinical Alert Form
	PMR 4C		• Brief Risk Assessment
	PMR 10		• Patient Safety Plan
	PMR 100		• Falls Risk Management Tool
Current Admission Divider	PMR 02		• Continuum Check List
	PMR 2		• Personal Contact
	SMHMR 916		• Care Transfer Summary
	SMHMR 902		• Mental Health Assessment
	PMR 5		• AUDIT & DAST
	PMR 60D		• Psychotropic Medication Chart
	PMR 60A		• Long Stay Medication Chart
	PMR 5A		• Physical Examination Chart
	PMR 6		• NRT Assessment
	PMR 56		• NRT PRN Chart
		Management Plan	
		Nursing Assessment	
Discharge Summary Divider		HONOS	• Paperbased HONOS
	PMR 12		• Discharge Plan
Legal Forms Divider	PMR 4		• Voluntary Agreement
Clinical Divider	PMR 7		• Integrated Progress Notes
Physical Health	SMHMR 903		• Mental Health Physical Examination
	TMHMR 904		• Mental Health Appearance
	TBD		• Ongoing Physical Health Care Examination
	TBD		• Metabolic Monitoring
	PMR 38		• Adult Observation and Response Chart
NOCC / PSOLIS Divider			
Allied Health Divider			
Investigations and Lab Reports Divider	PMR 25A		Biochemistry
	PMR 25B		Haematology
	PMR 25C		Microbiology
	PMR 25D		Miscellaneous
Charts Divider			
Correspondence Divider			

Appendix 4: Medical Record Arrangement – Community (example)

Divider/section	PMR	Non PRM paperwork	Description/notes
Front of file		Patient Stickers Demographics	• Patient information sheet to be filled in by new patients and existing patients on an annual basis • Includes change of address forms
		Activation/De-activation forms	• Yellow form
		Referral	• All client referral information, current and historical
Risk Divider		BRA	• Completed BRA (from PSOLIS) and a printed copy for the file
	PMR01		• Note: the clinical alert form is/are always to be at the front of the current file behind the risk divider
Careplan/ drug & alcohol assessment		Plans	
		Drug and Alcohol Assessment forms	
NOCC/PSOLIS		NOCC	
		Client service events	
		Client triage details	
		Client reviews	
Scripts		Scripts	
Correspondence		All correspondence	• GP letters • Appointment letters • Authorisation for release of information
Discharge summary Divider			• Copies of previous discharge summaries
	SMHMR916		• Care Transfer Summary
Physical health care	SMHMR903		• Mental Health Physical Examination
	SMHMR904		• Mental Health Appearance
ED/OPD	SMHMR902		• Mental Health Assessment
Legal forms	PMR 8		• Outpatient notes
		Legal forms (forms that reflect actions under *MHA 1996*)	• These forms can be numbered form 1 to form 11. File in order date sequence • Community Treatment Orders
Charts	PMR 3		• Depot charts
Investigation and lab reports		Pathology/ investigation reports	

Instructions:

- Removed handwritten data collection forms
- Removed all duplicated paperwork
- Removed all staples
- Removed all sticky notes
- Placed all documentation in date order with the most recent on top – except out patients notes which is to be filed with the most recent at the back
- Placed patient labels on all relevant paperwork (exception is correspondence in the form of letters).

This document can be made available in alternative formats on request for a person with a disability.