UCLPartners

# The Mental Health Review

The UCLPartners-Primrose guide to performing a mental health review for a person with a Severe Mental Illness in the context of their physical health

# Welcome to the UCLPartners-Primrose Mental Health Review guide

## What is UCLPartners-Primrose?

The UCLPartners-Primrose (UCLP-Prirmose) framework has been developed to help people with Severe Mental Illness receive the best care for their physical health as well as their mental health. The framework is designed so that those patients with the greatest clinical risk from physical risk factors are prioritised. Working with the framework ensures that patients receive the treatment they need at the right time. Lowering blood pressure and cholesterol for example will lead to rapid reduction in risk of a heart attack or stroke.

All patients with a diagnosis of a Severe Mental Illness should receive an annual Physical Health Check. When patients do not respond to invitations to the physical health check or do not attend appointments it can sometimes indicate that they need more specialist mental health support to do so. In this instance, the mental health nurse supporting the surgery or PCN should review and make contact with the patient. This guide sheet will provide an overview of the steps involved in this part of the process.

## What role will you play?

There are many reasons why a patient may not be responding to the invitation for their physical health check. Some people may not have or use their phone very often, whilst others may feel anxious about contact from health providers. Your role will be to: (i) work out the best way to identify and address any of these needs so that (ii) the person is able to attend to their physical health. Your primary objective is to ensure that everyone who needs physical health support receives it. Regardless of how you do this, it's important that all UCLP-Primrose colleagues work together, communicating to each other patient priorities and outcomes continuously throughout the process.

## What will you do?

Ultimately you can decide the best way to identify why a patient may not be attending, and how best to support them to engage. However, to follow are some suggestions for what you could do:



## Step 1:
## The Desktop Review

**When a patient is highlighted as not having responded to their invitation, it's useful to perform a desktop review of the patient's notes to assess the person's mental health/social complexity and the need for support to engage with care.**

**You might consider:**

Does the person have any history of non-attendance at appointments?

Have they recently had any interaction with a healthcare worker or service?

Does the person have a recent risk assessment?

Does the person have any needs, like a physical disability or learning disability, that you might need to consider?

Is there any reason the patient may not be available - for example they are in acute or long-term inpatient care, in prison, living in another area?

## Step 2:
## The Action Plan

**You can then use this information to formulate an action plan of how to best contact the person.**

**You might want to consider:**

Contacting the patient yourself (or a member of your team, or peer support worker etc.); are you able to reach them if you explain your role and reason for contacting them?

Reaching out to the patient's family, or any mental health services that they use. Try to gather collateral information to assess the person's current mental health. Staff should of course be sensitive about any issues of confidentiality, for example where a patient has previously expressed a wish for relatives not to be contacted. Nonetheless it is usually possible to reach out to a patient's network without divulging confidential information about their health, and generally in their best interests to do so

Use information gathered to review and respond to the person's mental health needs in the way that is most appropriate for them.

## Step 3:
# Ongoing support

**After you have made contact with the patient and have established with them the purpose of the contact, please consider with them the kind of ongoing support they will need to attend to their physical health.**

**You may need to:**

Oversee and support their journey where required.

Provide additional communication and prompts to remind them of their appointments; they may want to hear from you specifically when their next appointment is.

Allocate a staff member to accompany them to appointments where needed.

Provide joint physical health consultations with clinicians or HCAs as needed. Seeing a familiar face might be key to their continued engagement.

Support behaviour change with brief and intensive interventions.

If it's available, ask the person if they would like peer support. Best evidence shows that peer support helps with relapse prevention and to improve physical health outcomes.

Ask about/ listen for evidence of wider social issues, e.g. around money, housing, or loneliness. If appropriate, consider supporting the patient to engage with a social prescriber, care coordinator or care navigator.

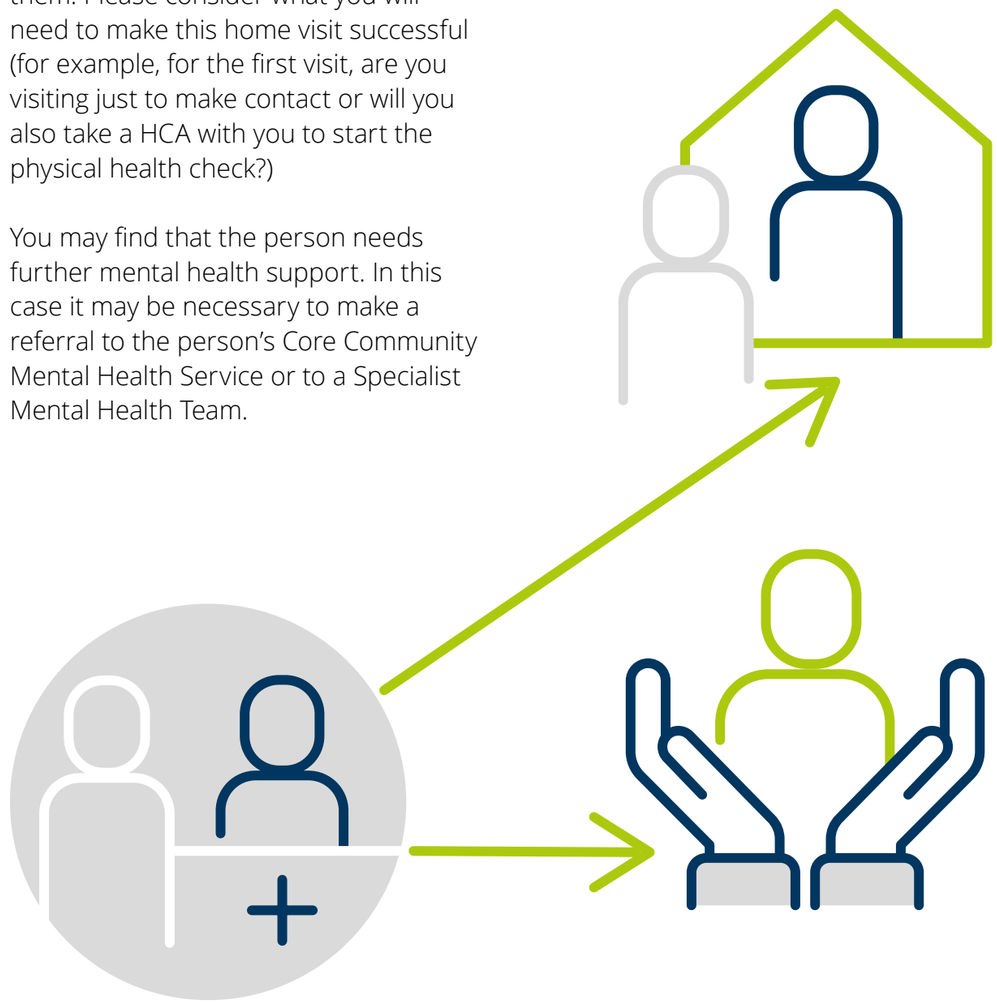
Involve supportive friends or family.



## Outreach and Additional Support

During the mental health review as outlined above, if the person still does not respond and you're unable to make contact with them, it may be necessary to visit them at home. As such, outreach via home visits will ensure that everybody who needs a health check and intervention will receive them. Please consider what you will need to make this home visit successful (for example, for the first visit, are you visiting just to make contact or will you also take a HCA with you to start the physical health check?)

You may find that the person needs further mental health support. In this case it may be necessary to make a referral to the person's Core Community Mental Health Service or to a Specialist Mental Health Team.



**Priority 1**
CVD risk factors poorly controlled
Obesity on antipsychotic medication

**Priority 2**
No BP in 18 months (proxy for health check and possible indicator of non-engagement)

**Priority 3**
All others with CVD risk factors

**Priority 4**
All others

## Invited for SMI Annual Health Check

**Patient engages**

**Patient does not engage**

### The Physical Health Check: HCA* *(default pathway)*

- Physical health check e.g. BP, weight, bloods, screening
- Identify physical health red flags
- Structured support for education and self management
- Identify social concerns & mental health red flags
- Explore patient's priorities
- Assess carer/friend/formal support needed to address physical health
- Brief interventions and signposting (e.g. smoking)

*This may be a HCA or another member of the wider workforce eg wellbeing coach, social prescriber.

### Clinical Review: Nurse/pharmacist/GP

- Review clinical conditions
- Optimise medication
- Manage clinical risk factors & co-morbidities
- Agree health priority and behaviour change goals

### Intensive Support for Behaviour Change: Trained staff member

- Working intensively on patient-led cardiovascular goals e.g. smoking cessation, weight management, adherence
- If available, Peer Coaches to provide less structured appointments to support the CVD goal or separate recovery focused goal

### Mental Health Review: MH nurse

- Undertake desktop review of patient to assess their mental health/complexity, to determine reasons they may not be engaging, and to assess their need for support
- Contact patient/ family/MH services to assess current mental health
- Review and respond to mental health needs
- Oversee and support patient journey where required
- Allocate staff member to accompany to appointments where needed
- Joint consultations with clinician or HCA type role as needed for physical health interventions
- Support behaviour change with brief and intensive interventions
- Refer for peer support if available and desired.

### Outreach

- Home visits
- Accompany to appointments

### Specialist Support

- Core Community Mental Health Service or Specialist Mental Health Team

### Wider Social Support: Social provider

- Maximise use of existing structures (social prescribing, MIND, care navigators) to address wider wellbeing concerns e.g. isolation/ accommodation/financial concerns. All clinicians to support patients to engage with wider social support at each stage in the Pathway, if needed.

# UCLPartners –Primrose: The Pathway

UCLPartners

170 Tottenham Court Road
London
W1T 7HA
uclpartners.com
contact@uclpartners.com