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| **GP MENTAL HEALTH Treatment PLAN** – Version for children | | | | | | | | | | | | | | | | | | | | | | | |
| ***Notes:*** *This form is designed for use with the following MBS items. Users should be familiar with the most recent item definitions and requirements.*  **MBS ITEM Number:**  2700  2701  2715  2717  *Major headings are* ***bold;*** *prompts to consider lower case. Response fields can be expanded as required.* ***Underlined items of either type are mandatory for compliance with Medicare requirements.***  ***This document is not a referral letter. A referral letter must be sent to any additional providers involved in this mental health treatment plan.*** | | | | | | | | | | | | | | | | | | | | | | | |
| **CONTACT AND DEMOGRAPHIC DETAILS** | | | | | | | | | | | | | | | | | | | | | | | |
| **GP name** | | |  | | | | | | | | | | | | **GP phone** | | | | |  | | | |
| **GP practice name** | | |  | | | | | | | | | | | | **GP fax** | | | | |  | | | |
| **GP address** | | |  | | | | | | | | | | | | **Provider number** | | | | |  | | | |
| **Relationship** | | | **This person has been my patient since** | | | | | | | | | | | | | | | | |  | | | |
| *and/or* | | | | | | | | | | | | | | | | | | | | |
| **This person has been a patient at this practice since** | | | | | | | | | | | | | | | | |  | | | |
| **Was patient involved in discussion with GP about treatment plan?** | | | | | | | | | | | | | | | | | | | | Yes | | No | |
| **Was parent/guardian involved in discussion with GP about patient’s treatment plan?** | | | | | | | | | | | | | | | | | | | | Yes | | No | |
| **Was the parent considered for a mental health treatment plan?** | | | | | | | | | | | | | | | | | | | | Yes | | No | |
| **Patient surname** | |  | | | | | | | | | | | | **Date of**  **birth** (dd/mm/yy) | | | | | |  | | | |
| **Patient first name(s)** | |  | | | | | | | | | | | | **Preferred name** | | | | | |  | | | |
| **Gender** | | Female  Male  Self-identified gender: | | | | | | | | | | | | | | | | | | | | | |
| **Patient address** | |  | | | | | | | | | | | | | | | | | | | | | |
| **Patient phone** | | Preferred number:  Can leave message?  Yes  No | | | | | | | | | | | Alternative number:  Can leave message?  Yes  No | | | | | | | | | | |
| **Medicare No.** | |  | | | | | | | | | | | **Healthcare Card No.** | | | | |  | | | | | |
| **Parent/guardian details** | | | | | | | | | | | | | | | | | **Has patient consented for this Treatment Plan to be released to parents/guardians?** | | | | | | |
| First parent/guardian: | | | | | Relationship: | | | | | Phone number 1:  Phone number 2: | | | | | | | Yes  With the following restrictions: | | | | | | No |
| Second parent/guardian: | | | | | Relationship: | | | | | Phone number 1:  Phone number 2: | | | | | | | Yes  With the following restrictions: | | | | | | No |
| **Emergency contact person details** | | | | | | | | | | | | | | | | | **Patient/parent/ guardian consent for healthcare team to contact emergency contacts?** | | | | | | |
| First contact: | | | | | | Relationship: | | | | | Phone number 1:  Phone number 2: | | | | | | Yes | | | | No | | |
| Second contact: | | | | | | Relationship: | | | | | Phone number 1:  Phone number 2: | | | | | | Yes | | | | No | | |
| **Schooling (if applicable)** | | | | | | | | | | | | | | | | | | | | | | | |
| **Current school level** | | | |  | | | | **Name of school/pre-school** | | | | | | | |  | | | | | | | |
| **Salient school factors**  Consider:   * Prior disruption to schooling * Current frequency of school attendance * Ability to start and finish homework * Peer relationships * Bullying * Traumatic school community events | | | |  | | | | | | | | | | | | | | | | | | | |
| **Patient/guardian consent to discuss GPMHTP with the following members of school community:** | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Role** | | | | | | | | **Name(s)** | | | | | | | | | | **Phone** | | | | |
| Yes | **Principal** | | | | | | | |  | | | | | | | | | |  | | | | |
| Yes | **Assistant Principal(s)** | | | | | | | |  | | | | | | | | | |  | | | | |
| Yes | **Teacher(s)** | | | | | | | |  | | | | | | | | | |  | | | | |
| Yes | **School Counsellor(s)** | | | | | | | |  | | | | | | | | | |  | | | | |
| Yes | **Other** | | | | | | | |  | | | | | | | | | |  | | | | |
| **SALIENT COMMUNICATION AND CULTURAL FACTORS** | | | | | | | | | | | | | | | | | | | | | | | |
| **Language spoken at home** | | | | | | | English | | | | | Other: | | | | | | | | | | | |
| **Interpreter required** | | | | | | | No | | | | | Yes, Comments: | | | | | | | | | | | |
| **Country of birth** | | | | | | | Australia | | | | | Other: | | | | | | | | | | | |
| **Other communication issues** | | | | | | |  | | | | | | | | | | | | | | | | |
| **Other cultural issues** | | | | | | |  | | | | | | | | | | | | | | | | |

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| **PATIENT ASSESSMENT – MENTAL HEALTH** | | | | | |
| **Reasons for presenting**  Consider:   * What are the patient’s current mental health issues? * Behavioural issues * Requests and hopes | |  | | | |
| **History of current episode**  Consider:   * Symptom onset, duration, intensity, time course | |  | | | |
| **Implications of symptoms on child’s daily activities** | |  | | | |
| **Patient history**  Consider: | |  | | | |
| * Mental health history | |  | | | |
| * Salient social history | |  | | | |
| * Salient medical/biological history * ♀ - menarche, menstruation, pregnancy | |  | | | |
| * Salient developmental issues | |  | | | |
| **Family history of mental illness**  Consider:   * Family history of suicidal behaviour * Genogram | |  | | | |
| **Current domestic and social circumstances**  Consider:   * Living arrangements * Siblings * Custodial arrangements * Social relationships * Engagement with peers | |  | | | |
| **Salient substance use issues**  Consider:   * Nicotine use * Alcohol use * Illicit substances * Is patient willing to address the issues? | |  | | | |
| **Current medications**  Consider:   * Dosage, date of commencement, date of change in dosage * Reason for the prescription * Are there other practitioners involved in the prescription of medication? * Are there issues with compliance or misuse? | |  | | | |
| **History of medication and other treatments for mental illness**  Consider:   * School counselling and other school interventions * Past referrals * Effectiveness of previous treatments * Side-effects and complications associated with previous treatments * Patient’s preference for medications | |  | | | |
| **Allergies** | |  | | | |
| **Relevant physical examination and other investigations** | |  | | | |
| **Results of relevant previous psychological and developmental testing** | |  | | | |
| **Other care plan**  e.g. GP Management Plans and Team Care Arrangements;  Wellness Recovery Action Plan | | Yes, Specify:    No | | | |
| **Comments on Current Mental State Examination** | | | | | |
| **Consider:**   * Appearance, cognition, thought process, thought content, attention, memory, insight, behaviour, speech, mood and affect, perception, judgement, orientation. |  | | | | |
| **Risk assessment**  **If high level of risk indicated, document actions taken in Treatment Plan below**  Consider:   * Does the patient have a timeline for acting on a plan? * How bad is the pain/distress experienced? * Is it interminable, inescapable, intolerable? |  | | **Ideation/ thoughts** | **Intent** | **Plan** |
| **Suicide** | |  |  |  |
| **Self harm** | |  |  |  |
| **Harm to others** | |  |  |  |
| **Comments or details of any identified risks** | | | | |
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| **Assessment/outcome tool used,**  except where clinically inappropriate.   * e.g., Strengths and Difficulties Questionnaire * Note: K-10 is not validated for minors | | |  | | |
| **Date of assessment** | | |  | | |
| **Results** | | | Copy of completed tool provided to referred practitioner | | |
| **Provisional diagnosis of mental health disorder**  Consider conditions specified in the ICPC, including:   * Anxiety co-morbid with Autism * ADD/ADHD * Conduct disorder * Oppositional defiant disorder * Mood disorder * Separation anxiety * Phobias * Elective mutism * Reactive attachment disorder * Nonorganic enuresis and encopresis * Eating disorder * Adjustment disorder (e.g. grief/loss/ parental separation/trauma/medical condition) * Depression * Anxiety * Unexplained somatic disorder * Mental disorder not otherwise specified | | |  | | |
| **Case formulation**  Consider:   * Predisposing factors * Precipitating factors * Perpetuating factors * Protective factors | | |  | | |
| **Other relevant information from carer/informants**  Consider:   * Specific concerns of carer/family * Impact on carer/family * Contextual information from members of patient’s community * Other content from individuals other than the patient | | |  | | |
| **Any other comments** | | |  | | |

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| **PLAN** | | | | |
|  |  | **Actions** | | |
| **Identified issues/problems**  Consider:   * As presented by patient * Developed during consultation * Formulated by GP | **Goals**  Consider:   * Goals made in collaboration with patient * What does the patient want to see as an outcome from this plan? * Behavioural or symptomatic goals * Wellbeing, function, occupation, relationships * Any reference to special outcome measures * Time frame | **Treatments & interventions**  Consider:   * psychological interventions * face to face * internet based   Program   * [The Brave Program](https://brave4you.psy.uq.edu.au/) (anxiety only)   Websites   * [Reach Out](http://au.reachout.com/) * [BITE BACK](http://www.biteback.org.au/) * [Eheadspace](https://www.eheadspace.org.au/)   Mobile Applications   * [Smiling Mind](http://smilingmind.com.au/?gclid=CO3qj72N68YCFQaXvQod8HII8g) * [Mind the Bump](http://www.mindthebump.org.au/?gclid=CMWjhduN68YCFVMAvAodIrkN1w) * [Worry Time](http://au.reachout.com/reachout-worrytime-app?gclid=CKuXweiN68YCFVAIvAodZywM6w) * [The Desk](https://www.thedesk.org.au/login?login) * pharmacological interventions * Key actions to be taken by patient and by guardians * Support services to achieve patient goals * Parent Management Training * Role of GP * Psycho-education * Time frame | **Referrals**  Consider:   * Practitioner, service or agency—referred to whom and what for * Specific referral request * referral to internet mental health programs for education and/or specific   psychotherapy  Program   * [The Brave Program](https://brave4you.psy.uq.edu.au/) (anxiety only)   Websites   * [Reach Out](http://au.reachout.com/) * [BITE BACK](http://www.biteback.org.au/) * [Eheadspace](https://www.eheadspace.org.au/)   Mobile Applications   * [Smiling Mind](http://smilingmind.com.au/?gclid=CO3qj72N68YCFQaXvQod8HII8g) * [Mind the Bump](http://www.mindthebump.org.au/?gclid=CMWjhduN68YCFVMAvAodIrkN1w) * [Worry Time](http://au.reachout.com/reachout-worrytime-app?gclid=CKuXweiN68YCFVAIvAodZywM6w) * [The Desk](https://www.thedesk.org.au/login?login) * Opinion, planning, treatment * Case conferences * Time frame | **Any role of carer/support person(s)**  Consider:   * Identified role or task(s), e.g. monitoring, intervention, support * Discussed, agreed, negotiated with carer? * Any necessary supports for carer * Time frame |
| **Issue 1:** |  |  |  |  |
| **Issue 2:** |  |  |  |  |
| **Issue 3:** |  |  |  |  |
| **Intervention/relapse prevention plan** (if appropriate at this stage)  Consider:   * Identify warning signs from past experiences * Note arrangements to intervene in case of relapse or crisis * Other support services currently in place * Note any past effective strategies | |  | | |
| **Psycho-education provided if not already addressed in “treatments and interventions” above?** | | | Yes No | |
| **Plan added to the patient’s records?** | | | Yes No | |

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| **Other healthcare providers and service providers involved in patient’s care**  (e.g. psychologist, psychiatrist, social worker, occupational therapist, other GPs, other medical specialists, case worker, community mental health services, ) | | | |
| **Role** | **Name** | **Address** | **Phone** |
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| **COMPLETING THE PLAN** | |
| On completion of the plan, the GP may record (tick boxes below) that s/he has:  discussed the assessment with the patient  discussed all aspects of the plan and the agreed date for review  offered a copy of the plan to the patient and/or their carer (if agreed by patient) | **Date plan completed** |
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| **RECORD OF PATIENT CONSENT** | | | | | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(name of patient or guardian)*, agree to information about my/my charge’s health being recorded in my medical file and being shared between the General Practitioner and other health care providers involved in my/his/her care, as nominated above, to assist in the management of my/my charge’s health care. I understand that I must inform my GP if I wish to change the nominated people involved in my/my charge’s care.  I understand that as part of my/my charge’s care under this Mental Health Treatment plan, I/he/she should attend the General Practitioner for a review appointment at least 4 weeks after but within 6 months after the plan has been developed.  I consent to the release of the following information to the following carer/support and emergency contact persons: | | | | | |
| **Name** | **Assessment** | | | **Treatment Plan** | |
|  | **Yes** | | **No** | **Yes** | **No** |
|  | with the following limitations: | |  | with the following limitations: |  |
|  | with the following limitations: | |  | with the following limitations: |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Signature of patient or guardian)* | | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  *(Date)* | | | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have discussed the plan and referral(s) with the patient.  *(Full name of GP)* | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Signature of GP)* | | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  *(Date)* | | | |

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| **REVIEW** | |
| **MBS ITEM NUMBER:**  2712  2719 | |
| **Planned date for review with GP**  (initial review 4 weeks to 6 months after completion of plan) |  |
| **Actual date of review with GP** |  |
| **Assessment/outcome tool results on review.**  except where clinically inappropriate |  |
| **Comments**  Consider:   * Progress on goals and actions * Have identified actions been initiated and followed through? e.g. referrals, appointments, attendance * Checking, reinforcing and expanding education * Communication * Where appropriate, communication received from referred practitioners * Modification of treatment plan if required |  |
| **Intervention/relapse prevention plan** (if appropriate)  Consider:   * Identify warning signs from past experiences * Note arrangements to intervene in case of relapse or crisis * Other support services currently in place * Note any past effective strategies |  |