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		

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			

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	

PLAN

		Actions		
Identified issues/problems Consider: • As presented by patient • Developed during consultation • Formulated by GP	**<u>Goals</u>** 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	**<u>Treatments & interventions</u>** Consider: • psychological interventions • face to face • internet based Program – The Brave Program (anxiety only) Websites – Reach Out – BITE BACK – Eheadspace Mobile Applications – Smiling Mind – Mind the Bump – Worry Time – The Desk • 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	**<u>Referrals</u>** 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 (anxiety only) Websites • Reach Out • BITE BACK • Eheadspace Mobile Applications • Smiling Mind • Mind the Bump • Worry Time • The Desk • 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:				
<u>Intervention/relapse prevention plan</u> (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				
<u>Psycho-education provided if not already addressed in “treatments and interventions” above?</u>			☐ Yes ☐ No	
Plan added to the patient’s records?			☐ Yes ☐ No	

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**

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**

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)*

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	