A Model Worth Sharing. A Community Mental Health Clinic with an award winning integrated Physical Health Program

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Today’s Session

• Background to the Physical Health Program

• Overview of the Physical Health Program at Community Team North

• The model and the benefit it brings to our consumers

• The Physical Health status of our consumers

• What we have learned

• Future goals and plans
Why do we need a Physical Health Program within a Community Mental Health Clinic?

- The lifespan of people with severe mental illness (SMI) is shorter compared to the general population. This excess mortality is mainly due to physical illness. (De Hert et al 2011)

- International studies indicate people with severe mental illness die an average of 25 years earlier than the general population.

- This is mainly due to their higher prevalence of cardiovascular risk factors including smoking, obesity, diabetes and dyslipidaemia. (Happel et al 2013)

- The main hospital for our catchment reports that the most prevalent disorders currently accessing ambulatory care include diabetes complications, COPD, congestive heart failure, angina and, asthma. (The Hospital admission risk program (HARP) Community-hospital interface working party report (March 2003)

- Mental Health services should be able to provide at least a standard routine assessment of their patients, in order to identify or suspect the presence of physical health problems. (Maj, M 2009)

- The first step in addressing the gap between psychiatric and health management is to integrate physical health into mental health planning. (Miller, H 2008)

*Docs.health.vic.gov.au/.../improving-the-physical-health-of-people-with-severe-mental-illness-no-mental-health-without-physical-health.doc*
How Community Team North are addressing this Issue
How Community Team North are addressing this Issue
Physical Health Program
Our Initial Aims

• Build on the aspects of the pilot that were helpful and effective

• Assist our consumers to improve their health outcomes

• Facilitate seamless pathways for our consumers to access GPs and other healthcare providers – reduce the barriers and increase the enablers

• Be inclusive and responsive to ensure that all consumers have access to the program at a time of their choosing

• Assist clinicians to understand the relevant/specific physical health issues for our consumers

• Source and use evidence based tools and interventions and be able to measure our progress
So What Is The Physical Health Program?

• Nurse led program with dedicated clinicians and resources.
• Offers all consumers of our service comprehensive assessment of their physical health needs
• Offers all consumers assistance to access medical, community health and healthy lifestyle facilities and groups via signposting, health advice, health interventions, advocacy,
• A long term program within our service which is now seen as a normal function within the clinic
• Collaborative
• Evolving and growing
Physical Health Program
The Model
Enabling Growth
Physical Health Program
The Model
Removing the barriers
Physical Health Program
The Model
Timely Prioritised Access
Physical Health Program
The Model
Health Belief
Physical Health Program
The Model
Evolve and Develop
Physical Health Status of Our Consumers

Collation of health information using the database allows to establish a baseline
to inform the need for resources and interventions
- for the individual
- for specific groups e.g. gender, risk factors, age
- for the clinic as a whole

The ability to measure progress towards our long term aims
- changes in health status
- trends
Total Number of clients having Metabolic Monitoring

- 2012: 35
- 2013: 311
- 2014: 455
- 2015: 499
Total number of Physical health Assessments completed

- 2012: 86
- 2013: 185
- 2014: 266
- 2015: 346
Health Data – BMI

- average BMI is **31**.
  31 consumers have BMI of 40+

BMI recorded as at March 2015

NAMHS Community Team North
-44 consumers have abdomen of 120cm+
-average waist size is 105cm

Normal Waist 18%
13%
abdominal obesity 69%

NAMHS Community Team North. Waist Measurements recorded as at March 2015
Health Data – Lipids

- currently we have only **56** consumers with confirmed normal lipid profile

**Dislipidaemia**
- 78%

**Normal Lipids**
- 22%

NAMHS Community Team North. Lipids recorded as at March 2015
Health Data - other

Glucose Intolerance – 105 consumers have abnormal glucose levels. *(44 of these are in diabetes range)*
- 50 clients have newly detected glucose intolerance
- 11 have been newly diagnosed with diabetes
- average blood sugar is 5.8 *(in the pre diabetes range)*

Metabolic Syndrome – 77 consumers meet the criteria for metabolic syndrome.
- A further 61 already have 2 risk factors

We have completed 346 Comprehensive Physical Health Assessments since commencement of the Program. We have maintained approx 60% uptake rate

We now average 90 – 95% of consumers engaging in metabolic monitoring
Referral Pathways.

- GP
- Dental
- Diabetic Educator
- Dietician
- Exercise Physio
- Cooking Classes
- Podiatrist
- Volunteer Fitness Instructor
- Exercise program
- Well Woman Group
- Smoking Cessation

NorthWestern Mental Health
Evidence of Progress

• Retrospective cross-sectional comparison study undertaken

• Community Team North were compared with another typical Community Mental Health Team

• Rates of metabolic monitoring were compared for consumers who had entered the service during the period Sept 2012 – Aug 2013.

• Community Team North = (77%) of metabolic monitoring undertaken
• Comparison team= (3%) of metabolic monitoring undertaken

The Effectiveness of Specialist Roles in Mental Health Metabolic monitoring: A Retrospective Cross-sectional Comparison. B McKenna; T Furness; E Wallace; B happell; R Stanton; C Platana-Phung; K Edward; D Castle Biomed Central Psychiatry – Accepted for Publication Aug 2014.
What We Have Learned - Collaborative Working
What We Have Learned-
Change The Culture
Future Goals and Plans

• Continue to review the effectiveness of the program – research and audit

• Pursue the resourcing of interventions which are evidence based, and promote ourselves as a pilot site to trial interventions which may provide evidence of efficacy

• Share our model and assist other services to develop a similar model

• Actively encourage consumers participation and ownership of the program.

• Full co-location with community health and primary care
A Few Closing Points…..
GOLD

Winners, Victorian Public Health Awards (2014)
Excellence in Patient Centred Care

Left to right: Prof Suresh Sundram; Lizi Wallace; Patrick Roe; David Davis (Health Minister)
Thank You

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