A Model worth Sharing: A Community Mental Health Clinic with an Award Winning Integrated Physical Health Program

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Abstract - 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). 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)

The paper provides an overview of the innovative nurse led Physical Health Program which has successfully integrated into the core business of a community mental health clinic within Melbourne's public health service and created working partnerships with primary care and community health.

The Program received recognition as Gold Winner in the Excellence in Person Centred Care category at the Victorian Public Health Awards in 2014 and has been in place for three years, providing physical health screening, signposting and individual evidence based interventions to consumers with severe mental illness.

Dedicated nursing roles and the development of a unique approach provides a barrier free long term care model which has returned high rates of engagement with consumers in addressing their physical health needs and goals.

The model, which has been promoted for replication across the service, showcases best practice, the value of collaborative working with our community health and primary care partners, and the substantial progress and effective outcomes that can be achieved when a mental health nurses takes the lead in innovation and change.

Keywords - Mental health, physical health, metabolic monitoring, Health Belief Model

I. INTRODUCTION

In general, people with serious mental illness consistently have a shorter life span than the general population – up to 25 years and have much higher rates of morbidity and mortality from chronic physical illness, compared to the population in general. This is predominantly due to their higher prevalence of cardiovascular risk factors including smoking, obesity, diabetes and dyslipidaemia. (*Happel et al 2013).* Whilst the general population has improved in these areas, those who experience severe mental illness have maintained this level of prevalence for 30 years, with substantial under diagnosis of co morbid conditions contributing to a significantly greater mortality risk *(Crump 2013).* This clearly indicates that a high level of priority is required in relation to improving the physical health of people living with severe mental illness. It is also important to note that people living with a mental illness often find navigation of the primary care and community health or specialist services difficult and littered with systems and processes that often serve as barriers. Therefore, there is a need for additional and continual support to assist with accessing the appropriate services to enable screening for metabolic and other physical health issues followed by barrier free and successful access to appropriate health interventions and treatment. This dedicated continuous support is essential to overcome any unintentional barriers that often prevent or deter the individual from doing so independently.

II. THE PHYSICAL HEALTH PROGRAM

NAMHS Community Team North recognize this as a significant issue and area of need and have responded by developing, implementing and evolving an innovative nurse

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led Physical Health Program. The Program is a fully integrated and long-term initiative that is now core business in the daily functioning of the clinic and has been introduced and maintained as a cost neutral change to the previous model of care. This significant change in clinical practice has been borne out of a desire to actively and effectively promote good physical health, prevent the development of chronic disease and, in doing so, reduce overall mortality of our consumers.

III. COMPREHENSIVE PHYSICAL HEALTH ASSESSMENT

The program, now commencing its fourth year, offers comprehensive physical health assessment and metabolic screening to all consumers of the service. This provides a framework and opportunity for the consumer to engage in conversation regarding all aspects of physical health, allowing identification of current health issues and risk factors for chronic disease and serious health conditions. This is delivered with an emphasis on detection and early intervention and is offered to all consumers within the first 3 months of treatment, and annually thereafter.

A total of 450 comprehensive physical health assessments have been offered to consumers during the first two years of the program, with 266 (61%) of those completed. Those who did not attend (DNA), in total, 67 (15%), are actively engaged and re-offered the opportunity to participate in the assessment at a later date with the opportunity routinely offered on an annual basis. The method of re-approaching the consumer has assisted in a reduction of the non attendance rate and our aim is to continue this trend and reduce this further from 15% to <5% of the current consumer list. The comprehensive physical health assessment is then used to inform the consumer's physical health needs and is a useful framework for setting behavior change goals to enable essential lifestyle changes or create a barrier free pathway into required treatment. Individualized and intensive support is then provided by the nurse coordinator or enrolled nurse to assist the consumer in their chosen journey to better physical health.

TABLE I: COMPREHENSIVE PHYSICAL HEALTH ASSESSMENTS

Number of Consumers Completing Comprehensive Physical Health Assessment	
At the outset	30
At the end of year 1	185
At the end of year 2	266
At the end of year 3	346

IV. METABOLIC MONITORING

Metabolic screening has been established within the clinic as a role undertaken by all members of the multidisciplinary team. This sharing of responsibility across the disciplines has enabled establishment and maintenance of a 90-95% consumer engagement in metabolic screening, with many consumers now actively participating in repeat screens every 3-6 months. For some, this level of engagement has been continuous since commencement of the Program.

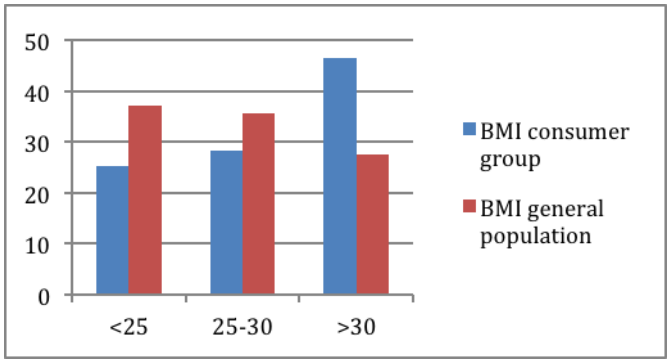
TABLE II. METABOLIC MONITORING

Number of Consumers Engaged in Metabolic Monitoring	
At the outset	**35**
At the end of year 1	**311**
At the end of year 2	**455**
At the end of year 3	**499**

(accumulative totals)

These high levels of engagement have allowed confirmation of several cardio-metabolic risk factors, including the ability to identify that 77 of our consumers have metabolic syndrome and 44 are diagnosed with type II diabetes mellitus. In addition, collation and comparison of risk factors is possible, for example 46.5% of consumers have obesity (BMI >30) in comparison to 27.5% in the general population (Australian Health Survey, 2011-2013) and this highlights the disproportionate excess of cardiovascular and metabolic risk factors in those with severe mental illness (Figure 1).

Figure 1



V. EVIDENCE BASED DEVELOPMENTS

The ideal position that we have placed ourselves in, whereby longitudinal data has been collated, will serve well in ascertaining not only health status of our consumers, but

also efficacy of any intervention that we source or provide. Thus far, we have been able to evidence significantly higher metabolic screening for consumers who have newly commenced attending our clinic (77%) compared to a comparative site without the dedicated physical health nurse roles (3%). (McKenna *et al* 2014). The provision, identification of, and participation in evidence-based interventions that may prove efficacious in improving the physical health of our consumers is our current aim at Team North.

Careful collation and retrieval of data provides ongoing measurement of health outcomes for our consumers, and enables the Program to access the barrier free resources that are essential in meeting the specific physical health needs of our consumer population.

An excellent example is the recent implementation of dietician sessions within the Physical Health Program. High levels of obesity and elevated fasting blood glucose within our consumer population raised concern however engagement with dietician was low. As a result of collaboration with Plenty Valley Community Health (PVCH) and Hospital Admission Risk Program (HARP) the provision of a barrier free alternative arrangement whereby the dietician was placed and provided dietetics within our clinic premises has been enabled. This change to the existing model of service provision has proved to be extremely popular with our consumers and provides the barrier free option that they were seeking. Initial evidence suggests that, as a direct result of the implemented changes, referrals to the dietician have increased ten to twenty fold and attendance rates have dramatically improved.

VI. THE MODEL

The model in place has been intentionally developed to be in keeping with the Health Belief Model with the intention of providing dynamic and varied but continuous 'cues to action' in multiple accessible formats. This is accompanied by health coaching and goal setting as modes to deliver assistance to the consumer to identify their 'perceived susceptibility' to their health risk. This in turn enables them to identify and rectify (with assistance) their 'perceived barriers' to accessing the treatment or service that they need. Translation of these individual consumer perceptions into a recovery focused consumer driven approach has been a main feature of the Program success.

Engagement is enhanced by the promotion and use of the 'one stop shop' approach whereby the consumer can access multiple interventions consecutively within the clinic venue. Removal of cumbersome referral process allows for ease of engagement when motivation is at its highest, and marries with the Health Belief Model action cues. The model directly draws on a set of approaches that consumers promote as most helpful to them, reducing the elements that they perceive and identify as barriers to accessing physical health care and advice.

Significant progress with opportunistic engagement has also contributed to the high rates for completion of the Comprehensive Physical Health Assessment and Metabolic screening. This has been possible due to the designated physical health nurse positions within the Program and allows for flexibility to actively pursue consumer participation without the constraints of set appointments. This approach neutralizes the previous difficulties that those consumers who are less organized and regularly miss their arranged medical reviews and other related appointments.

VII. SUSTAINABILITY

If we are to take this issue seriously and actively attempt to reduce the mortality of our consumers, programs such as ours need to be a long-term initiative with dedicated resources assigned and one that grows and flourishes over the passing of time. Many of our consumers have multiple risk factors and these require the passage of time to afford any meaningful progress.

There are many competing priorities in mental health services, therefore, to ensure that consideration of the physical health needs of our consumers remains a priority, all of our clinicians are expected to, and require to, play a role. Through sharing of knowledge, and education sessions from key stakeholders, the involvement of our clinicians has been able to grow and expand and many of our clinicians now feel confident to signpost and refer consumers independently. This is a key indicator that the Program is fully integrated into core business. Instilling sustainability in the program, and for the clinic as a whole, will remain as one of our key development areas as we need to ensure that we can provide the continual support required to enable favorable mortality outcomes.

The culture at Community Team North has now changed to one of inclusion and acceptance that physical health is part of our core business and we can evidence a significant reduction in the barriers that had previously deterred our consumers from accessing mainstream health services and wellbeing facilities. As clinicians and consumers join the clinic, they are made aware at the outset that we provide this inclusive and responsive new model of

care as our core business. Engagement with the consumer is now holistic and many of the interactions that the consumer encounters at the clinic are intended as a platform for engagement in conversation around their physical health – an element of mental health care that was previously sporadic or missing entirely.

VIII. CONCLUSION

At Community Team North, we believe that we have a model of care that is inclusive, innovative, collaborative and responsive and has been implemented through true partnerships with consumers and with internal and external stakeholders. A model that set an essential foundation to enable improved cardiovascular health and reduction of mortality in our consumer population. The intended model and implementation of the Program successfully challenges and has altered the culture to one of acceptance that physical health is our core business. This culture change has influenced the practice of our primary and community care colleagues, the mental health service as a whole, and supports the work of our research colleagues.

Pivotal in achieving these outcomes are the dedicated Physical Health Program nurse roles. The provision of a cost neutral and effective model of care would have been impossible without this very small but targeted resource. The mental health nurse as clinical leader and change agent provides an effective solution to an under resourced and often ignored issue. The Physical Health Program showcases maximum impact from a minor change to the packaging of mental health nursing and evidences truly innovative and effective outcomes for the physical health of our consumers living with severe mental illness

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AUTHOR'S PROFILE

Elizabeth Wallace is a registered mental health nurse currently in the position of Clinical Nurse Coordinator at Melbourne Health. She completed her mental health nurse qualification with Ayrshire and Arran Health Board in Scotland in 1992. She has since completed BSC in

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