Living Well, Living Longer Program Evaluation

Five year evaluation of an integrated care initiative to improve the physical health of people living with severe mental illness

Andy Simpson, Program Manager, Living Well, Living Longer

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Equally Well Consensus Statement: People living with severe mental illness are

6x

More likely to die from
Cardiovascular Disease

5x

More likely to
Smoke

4x

More likely to die from
Respiratory Disease

14-23

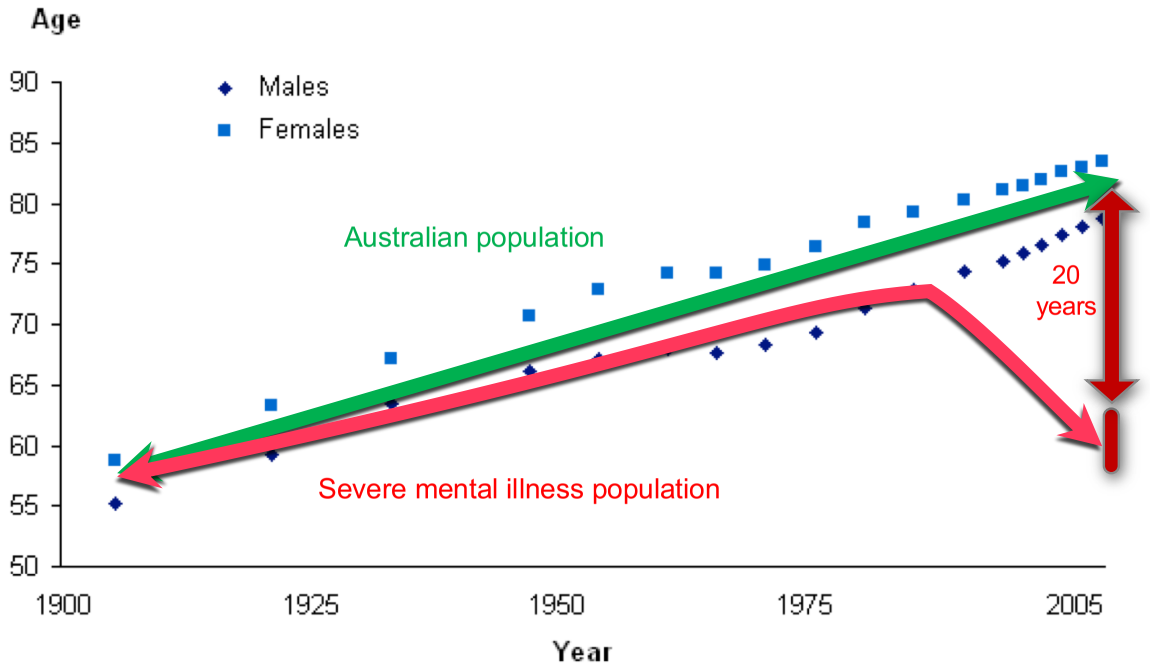
Years of lost life
Early Mortality

EQUALLYWELL

National Mental Health Commission. *Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia*. Sydney NMHC, 2016.

The Context: Early Mortality

Australian life expectancy at birth by gender, 1900 - 2005



Adapted from Prof Tim Lambert © 2008 - 2018

Average age of death 1980 - 2010

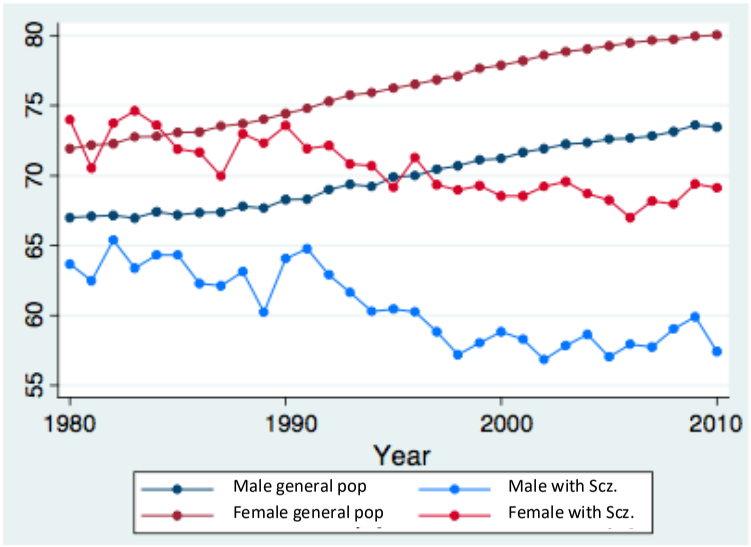


Fig. 2. Average age of death by year for the schizophrenia and general population over three decades with intentional self-harm excluded as cause of death.

Nielsen et al. SchizRes 2013; 146(1-3):22-7

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Sources: ABS Cat No. 3302.0; ABS Cat. No. 3105.0.65.001 (green line); the age of death in schizophrenia imputed from literature (ibid). See also: Saha S, Chant D, McGrath J. A Systematic Review of Mortality in Schizophrenials the Differential Mortality Gap Worsening Over Time?. *Arch Gen Psychiatry.* 2007;64(10):1123-1131

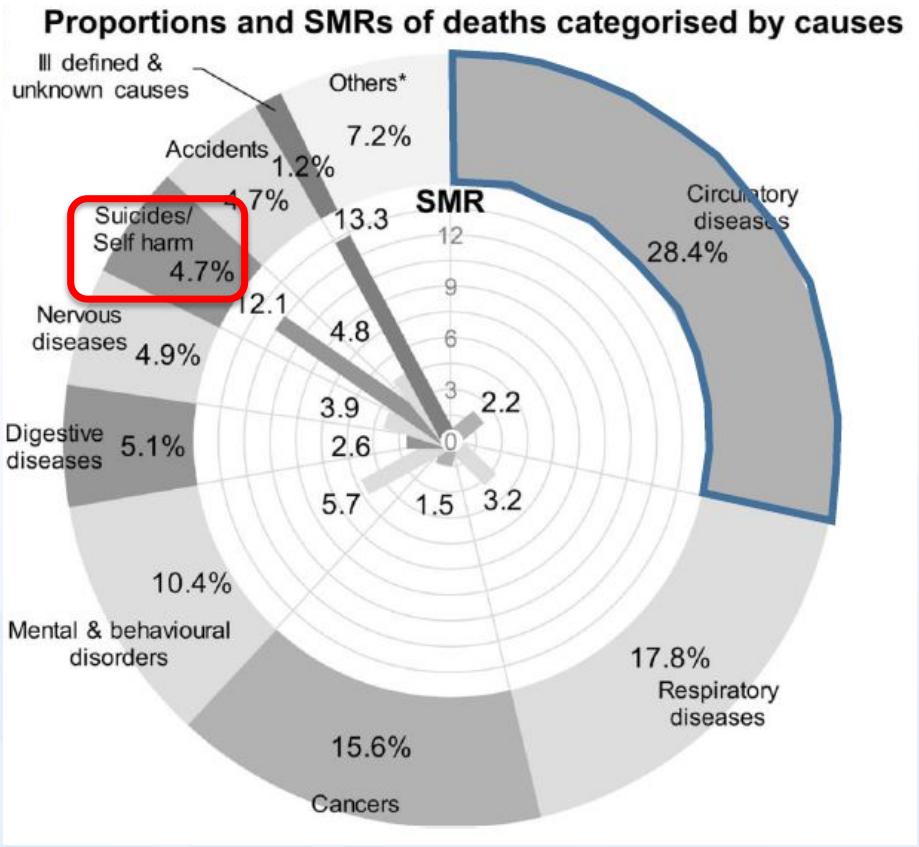
The Context: Early Mortality

Around two thirds of premature deaths are from circulatory & respiratory diseases or cancer

Schizophrenia Research
Volume 199, September 2018, Pages 154-162

Premature mortality among people with severe mental illness — New evidence from linked primary care data

Ann John [a, b, ⁂], Joanna McGregor [a, b], Ian Jones [b, c], Sze Chim Lee [a, b], James T.R. Walters [b, c], Michael J. Owen [b, c], Michael O'Donovan [b, c], Marcos DelPozo-Banos [a, b], Damon Berridge [a], Keith Lloyd [a, b]



Australian Government
National Mental Health Commission

"…a national disgrace and it should be a major public health concern"

National Mental Health Commission. A Contributing Life, the 2012 National Report Card on Mental Health and Suicide Prevention. Sydney: 2012.

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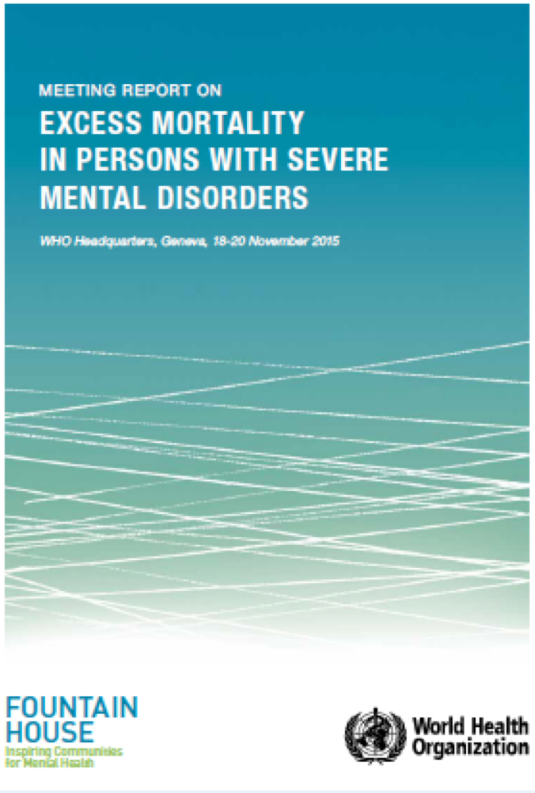
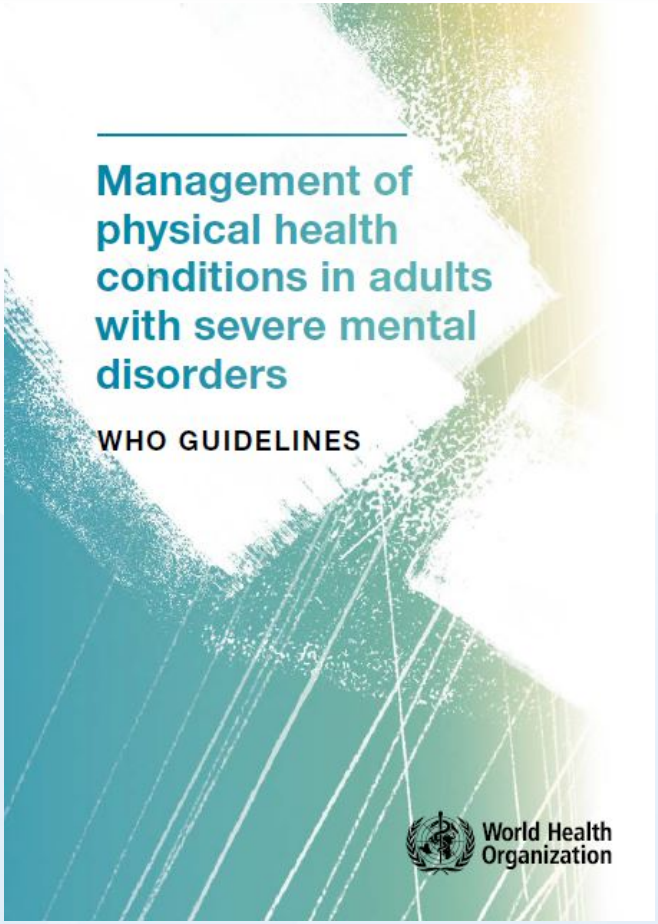
Avoidable Tragedy?



World Health Organization

*"**Preventable** physical health conditions lead to premature mortality in people with severe mental disorders… (which are) commonly overlooked, not only by themselves and people around them, but also by health systems."*



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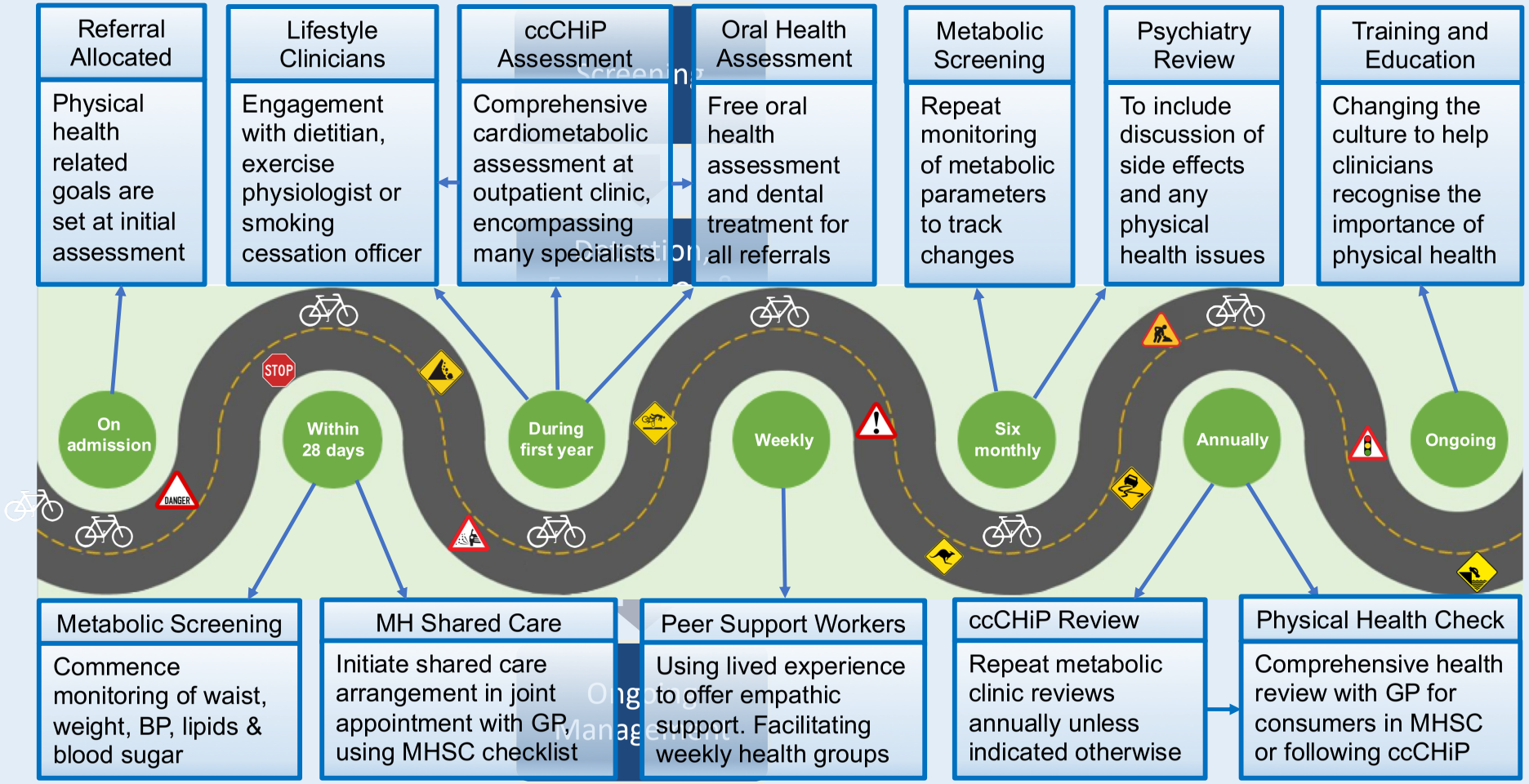
The Living Well, Living Longer Program



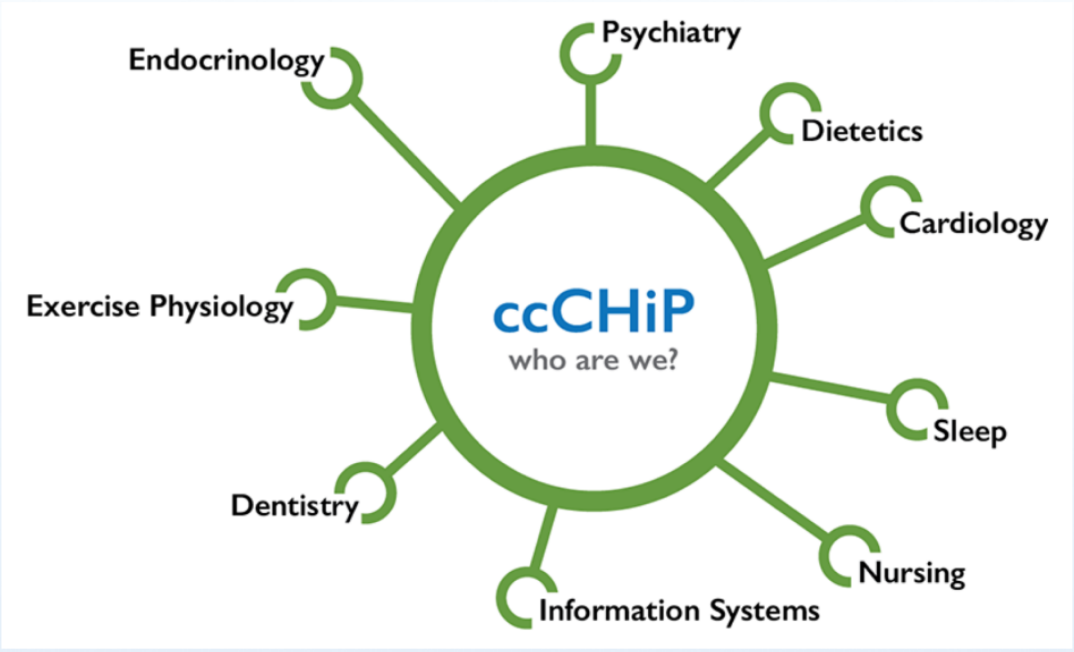
Outpatient Clinic
at the CRGH Medical Centre

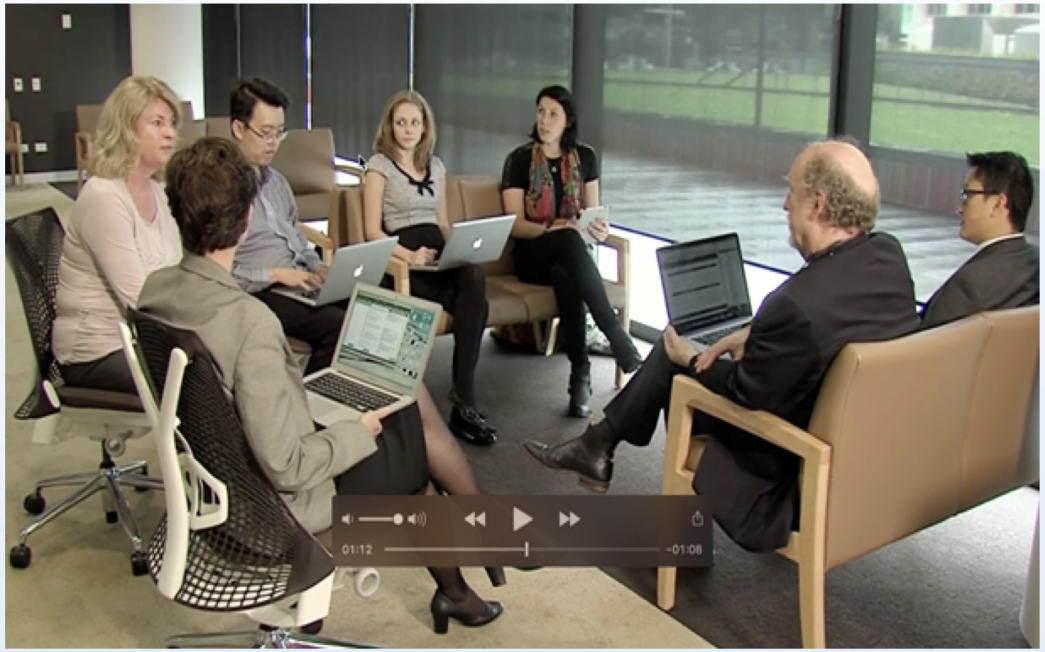
Outpatient Clinic
at Charles Perkins Centre

Collaborative Centre for Cardiometabolic Health in Psychosis

ccCHiP

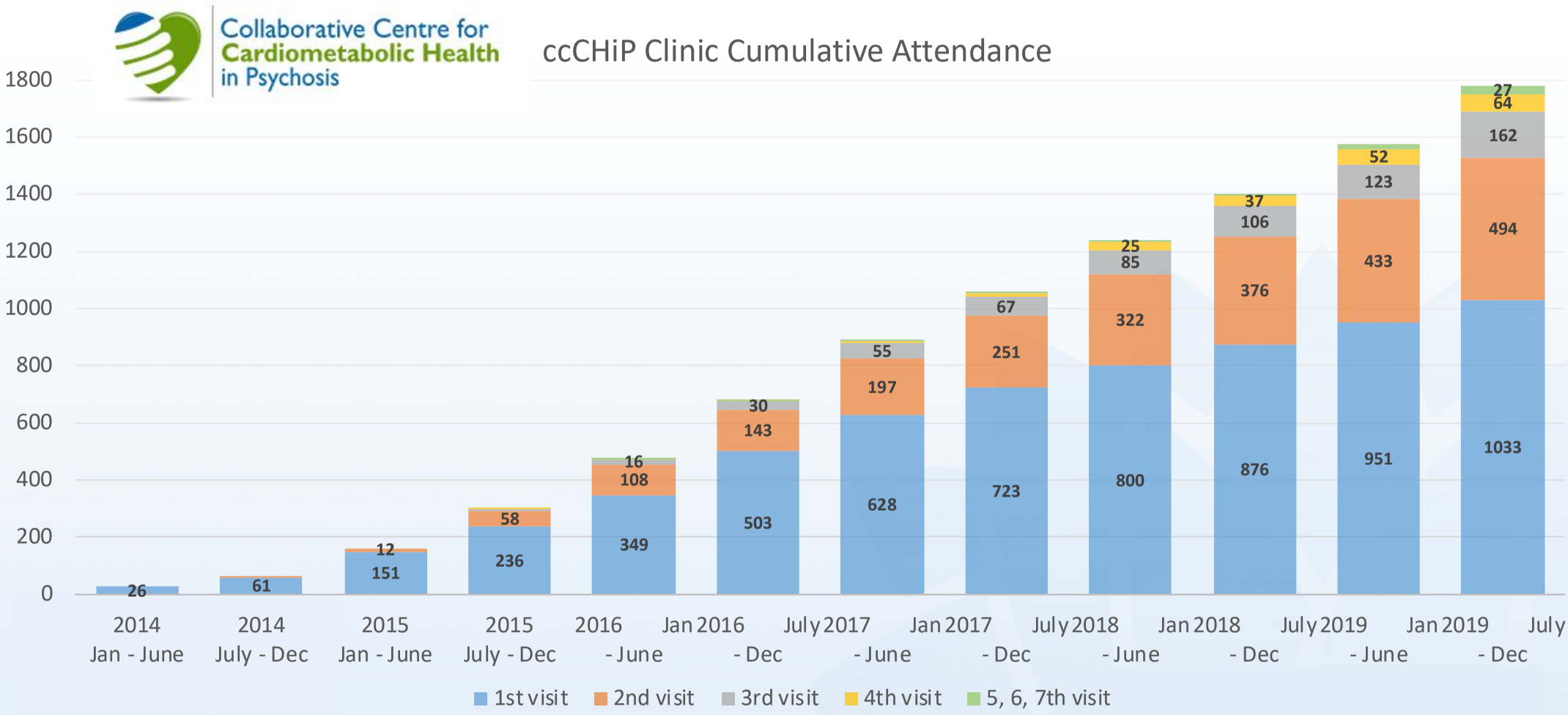
- ✓ World leading cardiometabolic health clinic
- ✓ Consumer sees 8 specialists in one afternoon
- ✓ Full formulation of cardiometabolic health
- ✓ Recommendations sent to GP for follow-up





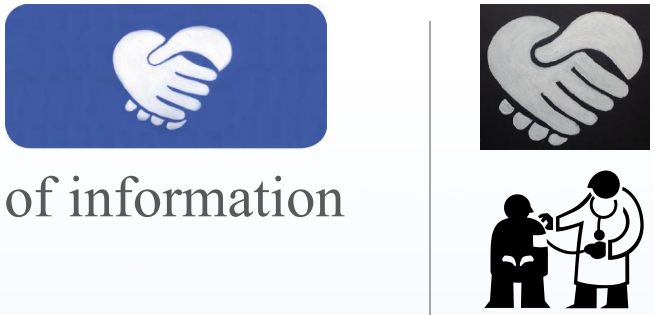
ccCHiP: Process Outcomes

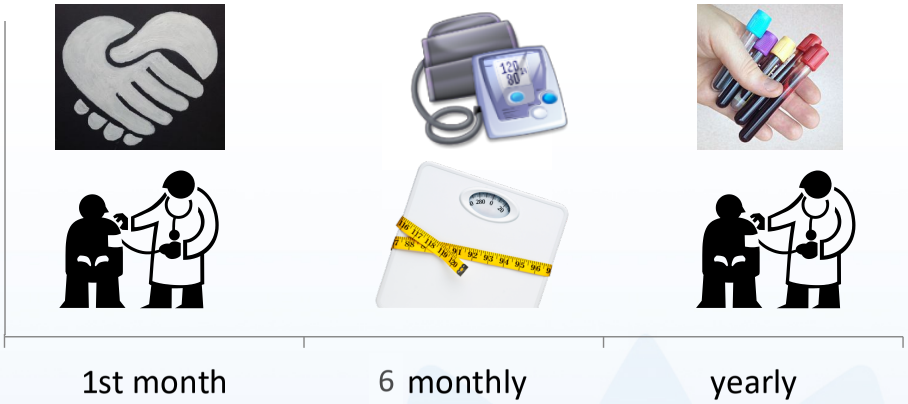
Collaborative Centre for Cardiometabolic Health in Psychosis



Mental Health Shared Care

- ✓Checklist assigning tasks to GP and care coordinator
- ✓Agreement around exchange of information
- ✓Annual cycle of care
- ✓Supported by Sector based CNCs

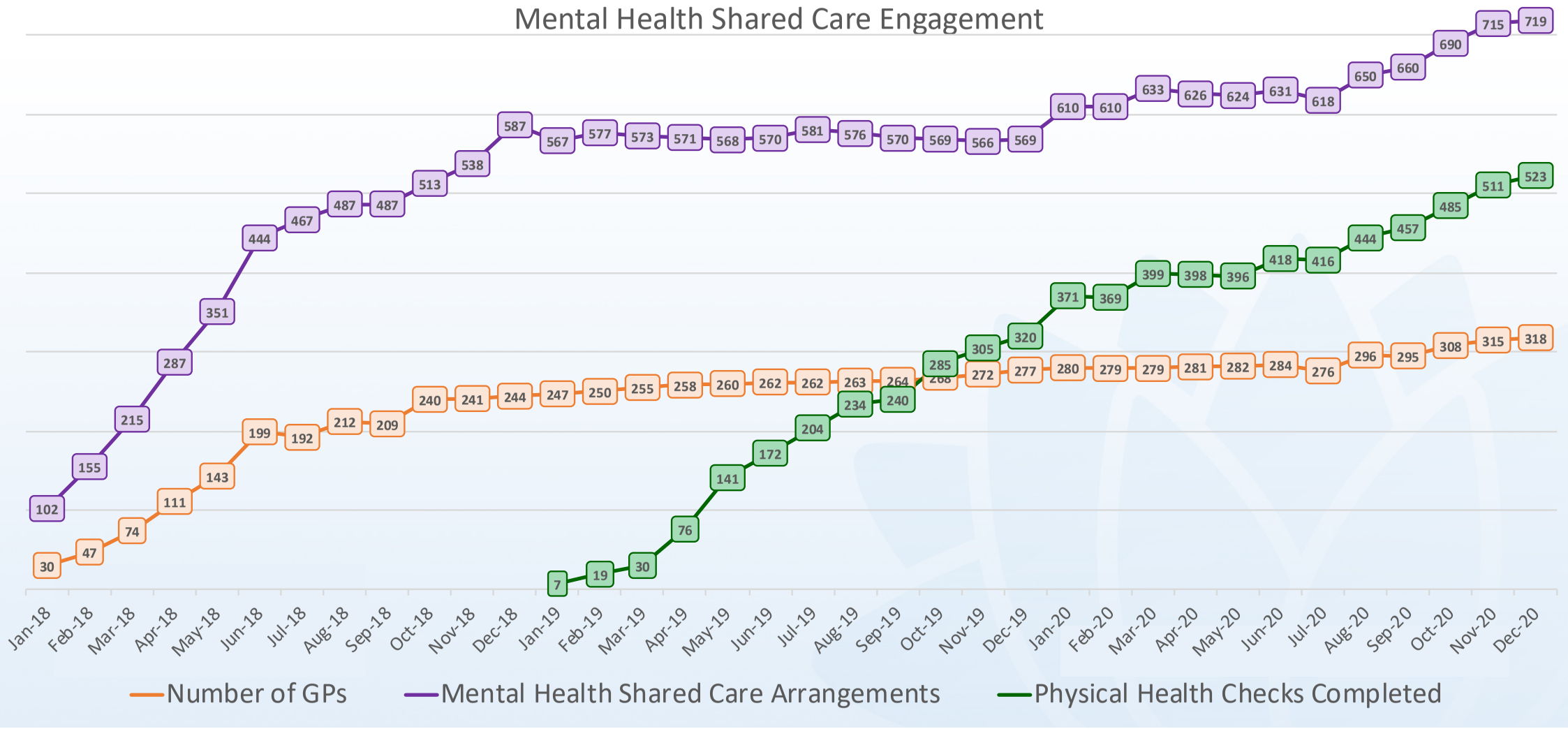




Action	Frequency	Responsible	Date Completed
Complete annual physical health check and copy results to MHS[1]	Yearly	GP	☐ __/__/__
Review following ccCHiP[2] appointment [May double as yearly physical health check]	Ad hoc	GP	☐ __/__/__
Complete scripts – physical health medications	6 monthly	GP	When required
Order/review other preventative screening e.g.: cervical screening, mammogram, bowel screening, prostate check, skin check.	Yearly	GP	When required

Action	Frequency	Responsible	Date Completed
Complete metabolic monitoring: Blood pressure, waist circumference and weight	6 monthly	MHS[1]	When required
Complete scripts – mental health medications	6 monthly	MHS	When required
Complete ccCHiP referral [GPs may refer directly to ccCHiP – referral form available on website: http://ccchip.clinic]	Yearly	MHS	☐ __/__/__
Organise GP review post ccCHiP attendance	4 weeks post ccCHiP	MHS	☐ __/__/__
Complete pathology screen and copy results to GP	Yearly[3]	MHS	☐ __/__/__

Mental Health Shared Care: Process Outcomes



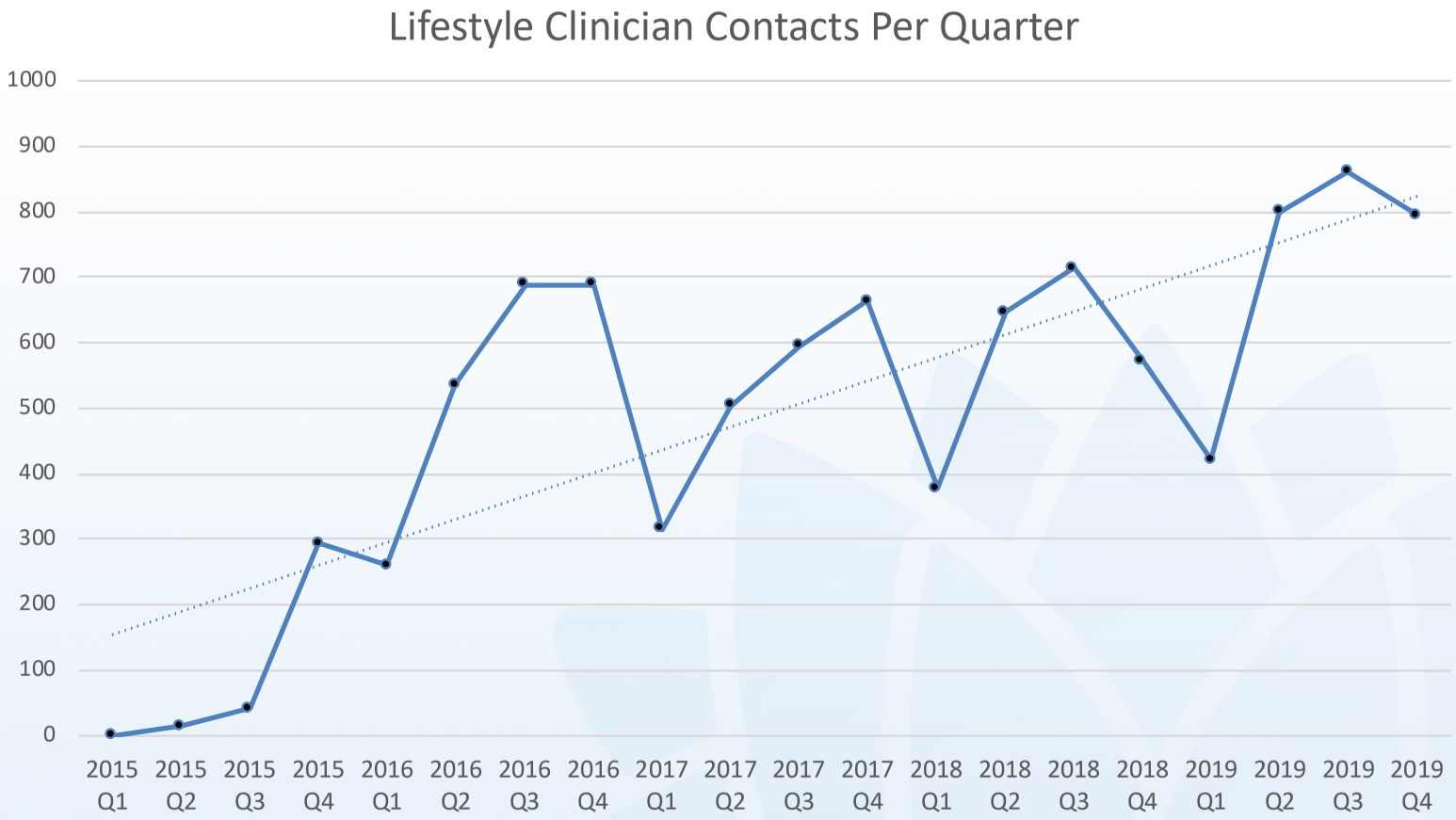
Lifestyle Clinicians

Working with consumers to develop individualised achievable and relevant health behaviour change goals and supporting the practical strategies required to achieve these

Direct referral for care coordinators via:
SLHD-MHLifestyle@health.nsw.gov.au

- ✓ 1.8FTE dietitian, 1.8FTE exercise physiologist
- ✓ 0.6FTE smoking cessation officer
- ✓ District wide positions offering individual tailored consults, or combined diet & exercise consults
- ✓ Integration with ccCHiP clinics
- ✓ Evidence based 12-week lifestyle group programs
- ✓ Partner with local aquatic centre for Gym/Swim

Lifestyle Clinicians: Process Outcomes



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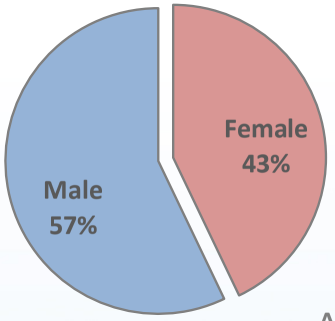
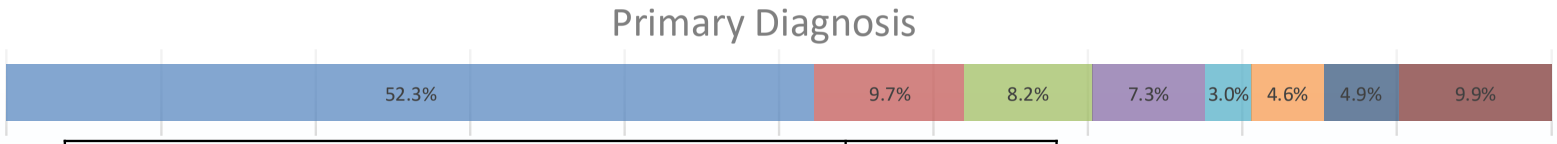
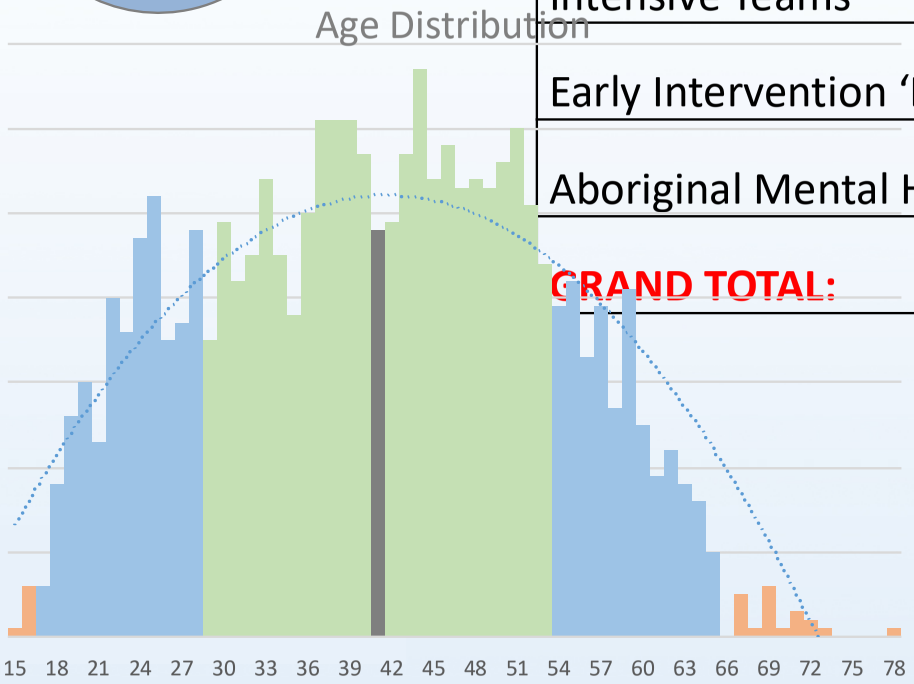
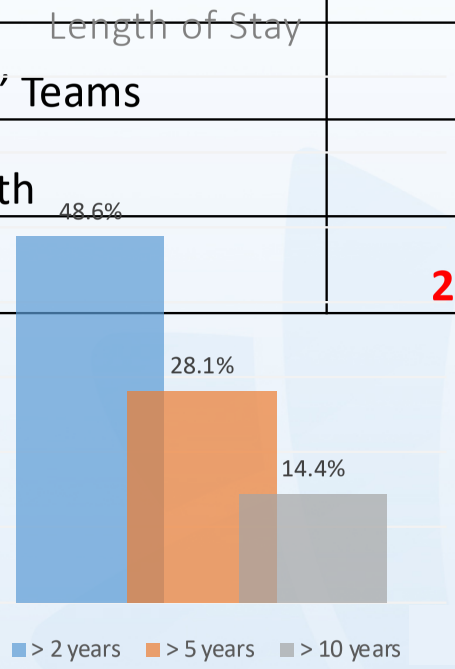
Our Consumers: Care Profile

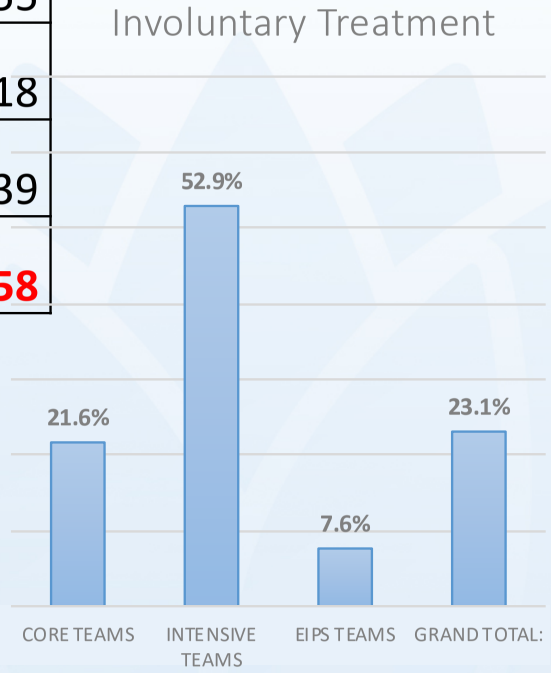




Community MH 'Core' Teams	1746
Intensive Teams	155
Early Intervention 'EIPS' Teams	118
Aboriginal Mental Health	39
GRAND TOTAL:	**2058**







Our Consumers: Metabolic Profile

Measure	NSW Health Sydney Local Health District	Australia	Comparison NSW to Australia
Average Waist	102.3cm	92.5cm	+9.8cm
'Concerning' Waist %	80.6%	62%	+18.6%
Average Weight	83.5kg	78.5kg	+5.0kg
Body Mass Index	28.4kg/m^2	27.5kg/m^2	+0.9kg/m^2

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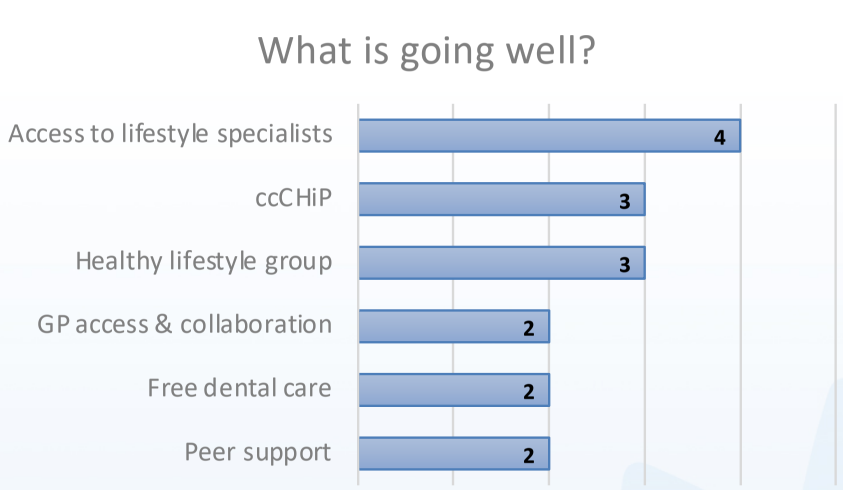
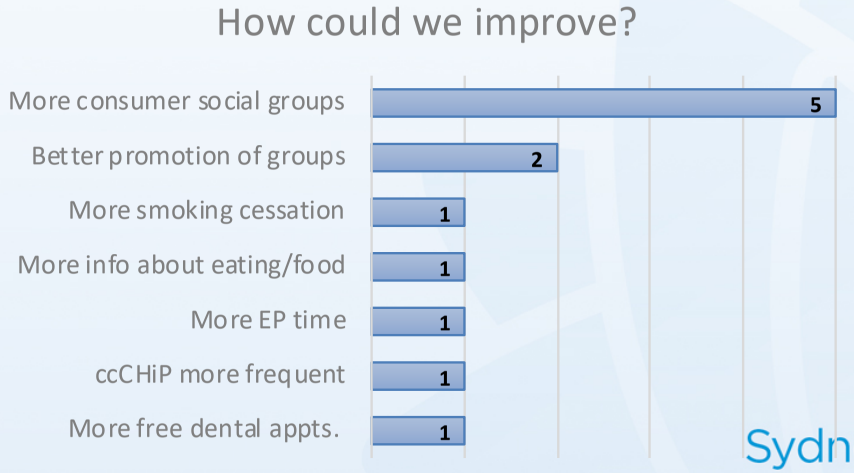
Evaluation: Asking our Consumers



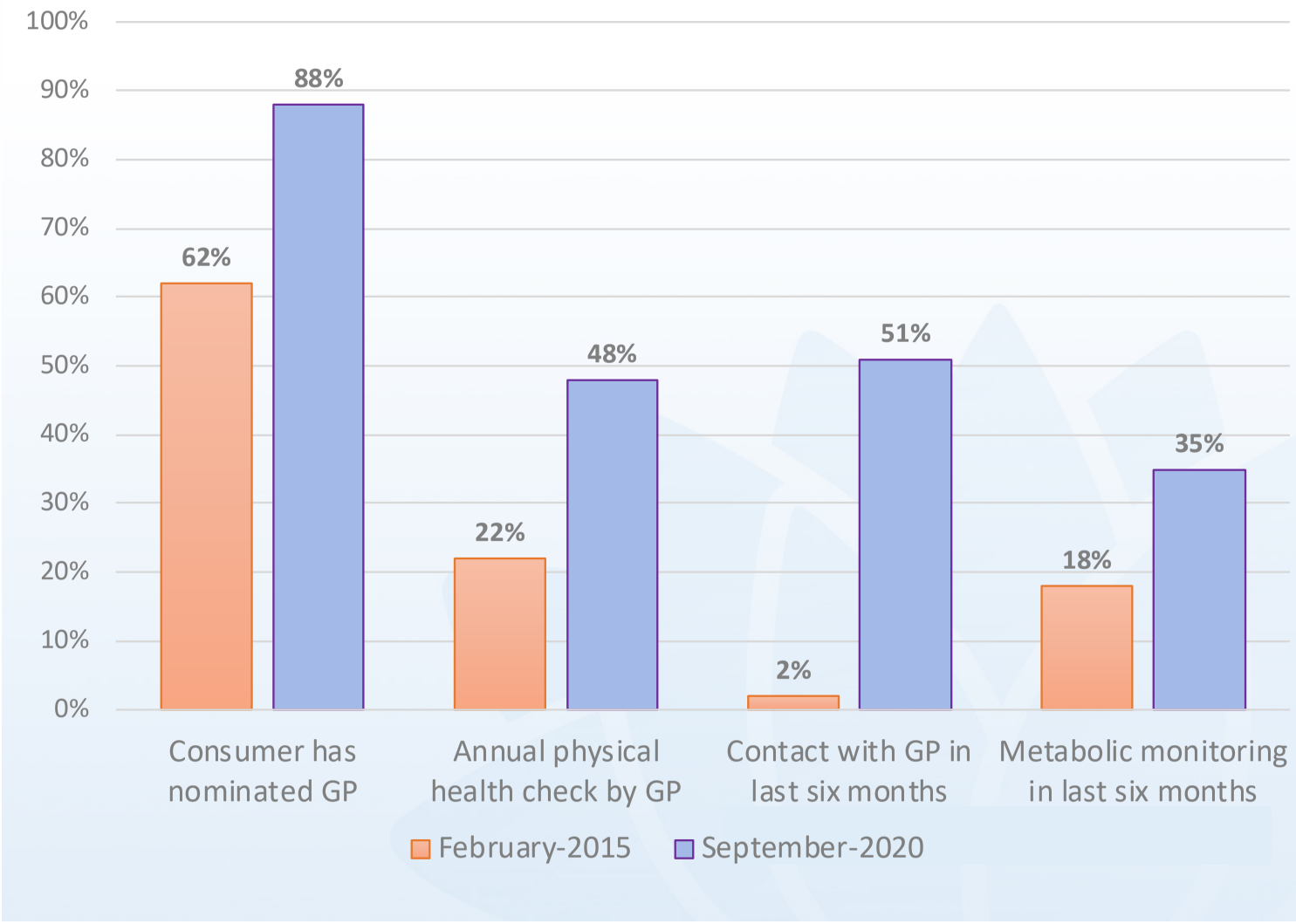


ACTIONS:

A database of all local physical health projects across the community will be compiled and shared with all teams, and more groups will be encouraged.

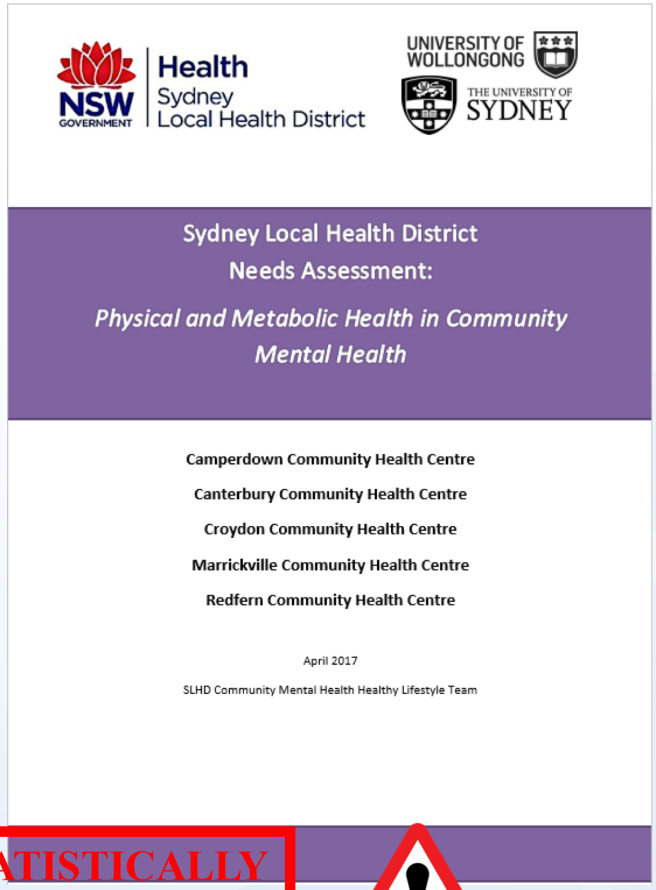
Evaluation: Auditing our Clinicians

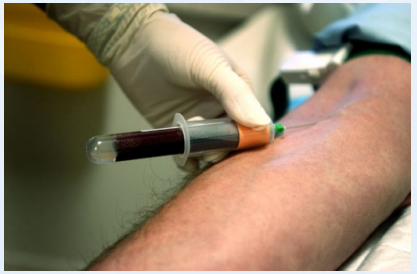
"A spreadsheet on a memory stick would have been fine."



Evaluation: Health Outcomes

	Needs Assessment	
Measure (average)	**n**	**2015-16**
Waist (cm)	*144*	107
Weight (kg)	*183*	89
BMI (kg/m^2)	*160*	30.6
Blood Pressure	*163*	123/80
Fasting BGL	*179*	5.8
Total Cholesterol	*200*	4.89
Metabolic Syndrome	*128*	74%





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NOT STATISTICALLY SIGNIFICANT!

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Evaluation: Health Outcomes

Anthropometry	n	2016	2020
Waist Circumference (cm)	30	103	104.7
Weight (kg)	59	86.2	87.6

Measure	n	2016	2020	P-value
Blood Pressure	79	122/80	118/79	0.012

Lipid Profile		2016	2020	P-value
Total Cholesterol	70	4.89	4.64	0.04
Triglycerides	68	2.05	1.8	0.13
High Density Lipoproteins	69	1.2	1.2	0.76
Low Density Lipoproteins	62	2.9	2.5	0.004

108 of the 251 consumers remain linked to service

63% male. Median age 50.
79% Schizophrenia.
80% Metabolic Syndrome.

Evaluation: Health Outcomes

Anthropometry	2016	2020	P-value
Waist Circumference Male (cm)	108.9	104.5	0.055
Waist Circumference Female (cm)	104.1	100.3	0.055

Lipid Profile	2016	2020	P-value
Low Density Lipoproteins	2.88	2.60	0.014

Blood Sugar	2016	2020	P-value
HbA1c (mmol/mol)	6.11	5.77	0.124
Proportion HbA1c 'at risk'	45%	30%	0.025

Measure	2016	2020	P-value
Body Mass Index (kg/m^2)	30.6	29	0.047
Metabolic Syndrome	74%	51%	<0.005

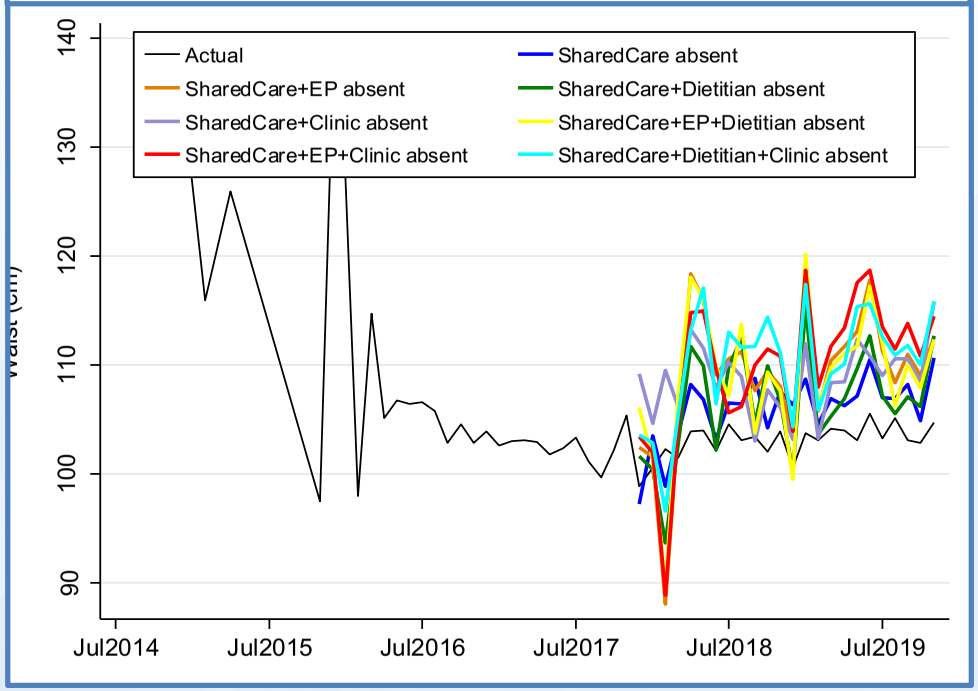
Analysis group of **251** resampled to ensure clozapine proportionate:
108 original -36 clozapine +179 new

Evaluation: Looking at the ‘big data’, 2014-2019

Teaming up with health econometrician to analyse big data sets over five years, including 12,671 Metabolic Screening, 10,239 lifestyle contacts, 1780 ccCHiP attendances, 732 MHSC…

Engagement with LWLL (of the 1877…)	n
Cardiometabolic Health Clinic - ccCHiP	472
Mental Health Shared Care - MHSC	367
Dietitian	423
Exercise Physiologist	404
ccCHiP + MHSC	263
ccCHiP + Dietitian/EP	179
MHSC + Dietitian/EP	112
ccCHiP + MHSC + Dietitian/EP (all!)	97

Observed changes in waist at the aggregate level following introduction of shared care + other interventions



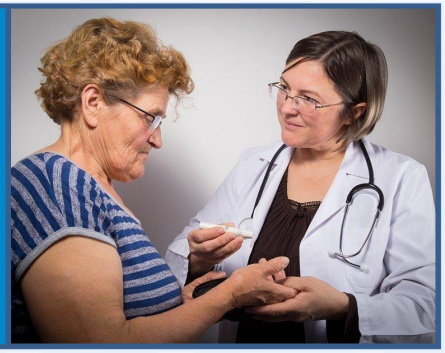
Future Directions

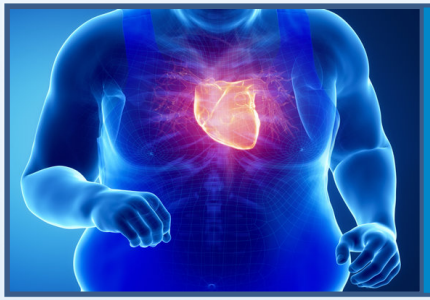
Enhancing the Shared Care Model: Embracing new technology solutions

Understanding the consumer experience: Peer workers to share success stories

Economic evaluation of ccCHiP clinic

Introducing nurse practitioners for chronic disease management





Developing metabolic risk stratification tool

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Conclusions

The Living Well, Living Longer Program may be starting to have a positive impact on health outcomes

Improving the health of people living with severe mental illness is **ACHIEVABLE!**

Thanks for listening!

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Acknowledgements
Dr Andrew McDonald, A/Clinical Director, MH Services, Sydney LHD
Prof Tim Lambert, Director ccCHiP, USyd/Sydney LHD
Lisa Parcsi, Director Integration & Partnerships, Sydney LHD
Ang Li, Research Associate, Health Econometrics, Usyd
Erikka Hennessy, Senior Dietitian, MH Services, Sydney LHD
Laura Garcelon, GP & PHN Partnerships Coordinator, Sydney LHD
Richard Tippett, GP & MH Shared Care Liaison Clinician, Sydney LHD
Petrina Rimmer, GP & MH Shared Care Liaison Clinician, Sydney LHD

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Community treatment orders: an in-depth exploration of care planning in this space

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BAppSc (OT), PGDip in CBT, MClinSc, PhD candidate

Professor Eimear Muir-Cochrane
Professor Sharon Lawn

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Acknowledgements

Study participants

Supervisors

Professor Eimear Muir-Cochrane

Professor Sharon Lawn

Professor Alan Simpson

Family and friends

Community Treatment Orders (CTOs)

“The Mental Health Act 2009 provides Community Treatment Orders as the legal way of giving you treatment against your will when you have a mental illness and are at risk but can remain at home. You can continue to live, work and study in the community as long as you follow the requirements of your order”.

CTOs: a contentious intervention

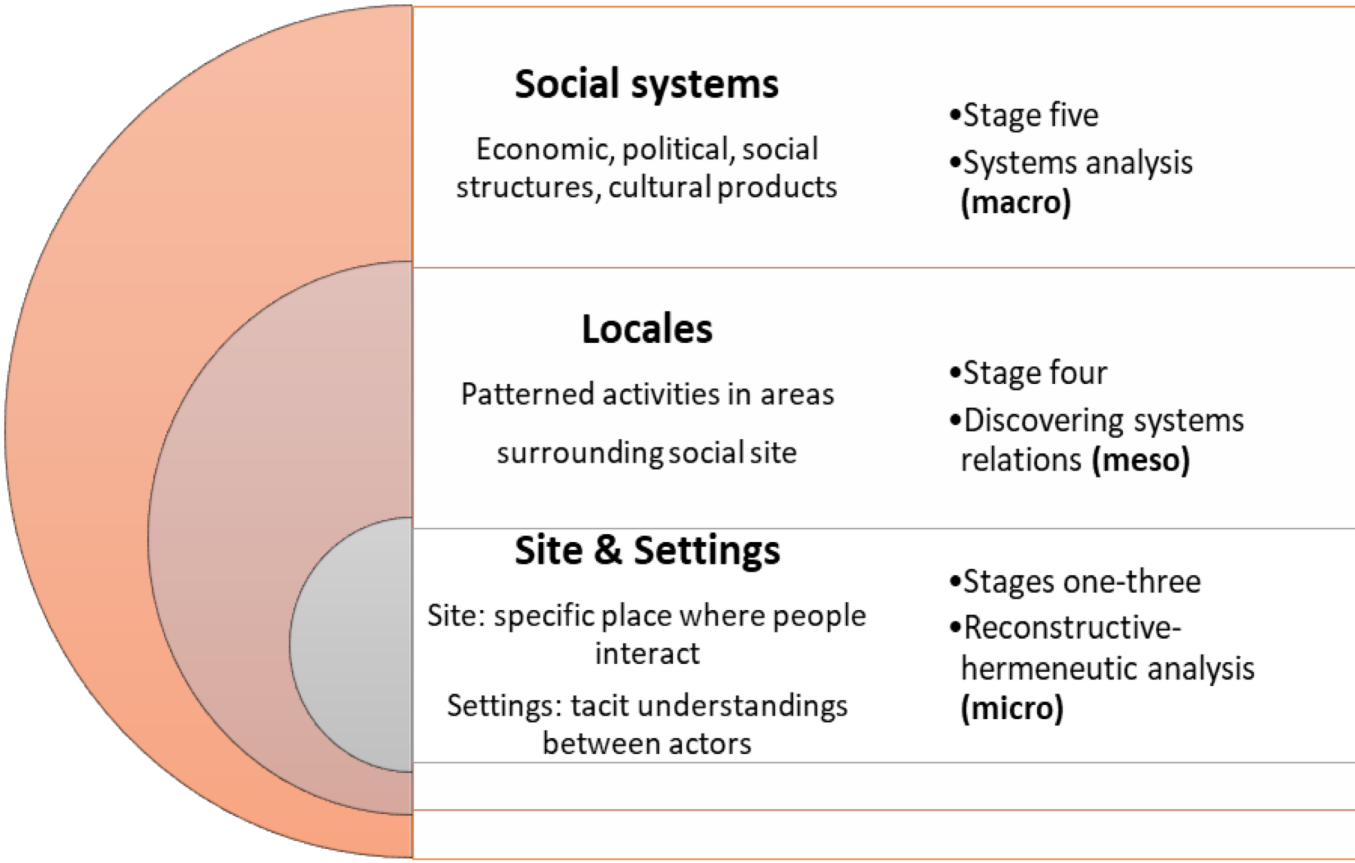
- Advocates for and those who oppose CTOs
- Lack of evidence regarding effectiveness
- High and increasing rates of use in Australia
- Legislation stating treatment and care should be recovery-focused

Research Questions

1. What is the culture of care planning for consumers on CTOs?
2. What are the micro (relational), meso (organisational) and macro (cultural) factors impacting upon the care planning process?
3. How do the concepts of risk and recovery impact upon care planning?

Methodology

Critical Ethnography



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Methods

Ethnographic

- Ethics
- Study site
- Locating the researcher
- Data collection and analysis

Observation and Interviews (18 months)

Contact Setting	Number
Urgent Clinical Reviews	15
Routine Clinical Reviews	25
Outpatient medical appointments	33
Other (e.g. home visit, CTO hearing)	3
Interviews	35
Focus groups	3

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Observation of care planning contexts (6 months)

Participants	**Care coordinator**	**Treating doctor**	**Multi-disciplinary team members**	**Consumer**	**Carer**	**Other treating or care agency**
Contact type						
Clinical reviews • 3 monthly • Urgent	Y	Y	Y	N	N	N
Outpatient appointments with doctors	P	Y	Y	Y	P	P
Other contacts • Face: face • Phone	Y	P	P	Y	P	P

Focused Observation & Interviews (12 months)

Caleb **Team A**	Medical review 22.11.17	Clinical Review 29.11.17	Medical review 21.03.18	Medical review April	Consumer Interview April	CC Interview (SW) 11.05.18	Doctor Interview 19.09.18					
Wu **Team A**	Clinical Review 6.09.17	CC Interview (SW) prior to a home visit for detention	Medical review 27.11.17	Medical review 18.12.17	Medical review Jan 2018	Urgent Clinical Review Feb 2018	Consumer Interview 15.05.18	CC Interview (SW) 21.05.18	Doctor Interview 25.05.18	Medical review 23.08.18		
Sam **Team A**	Medical review 4.08.17	Medical review April 2018	Consumer Interview 1.05.18	CC Interview (nurse) 28.05.18	Doctor Interview 12.06.18	Medical review 13.08.18	Medical review 27.09.18	Carer Interview 7.10.18				

Findings: A culture of risk

Risk: differing understandings

Clinicians focussed on risks such as harm to self or others, functional and cognitive decline

Carers were concerned with broader issues that related to the persons lived experience and impacts on daily life

Consumers were concerned with broader and immediate issues impacting on their wellbeing and daily life

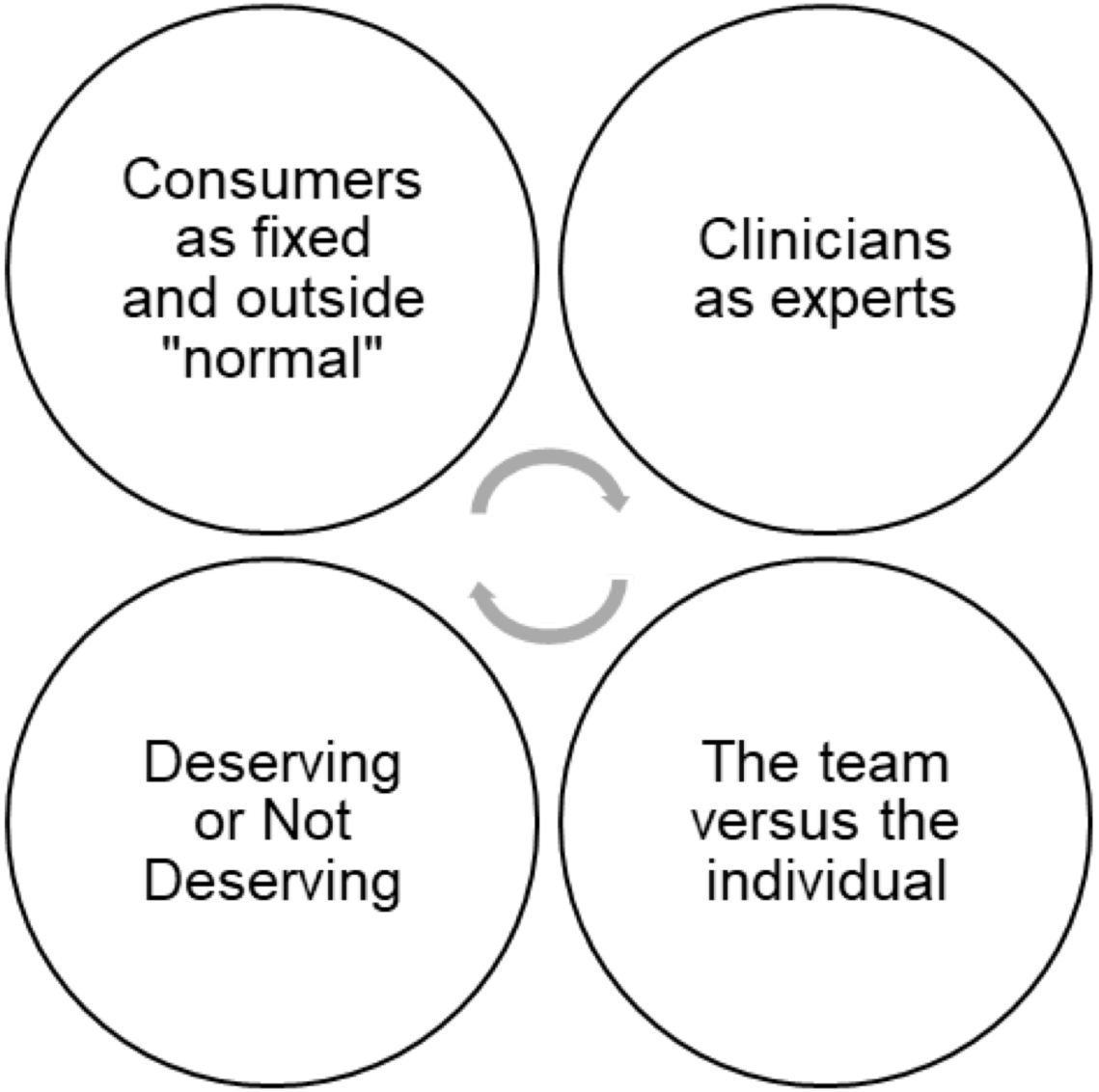
A preoccupation with insight

- Insight as a label
- Insight linked to capacity

As a principle I suppose, people have the right to be unwell…people have that choice...He still has no real insight or his awareness of the need to prepare for prevention. That is one area that we have to work with him.

[Psychiatrist-Mark, IV]

Positionings of the care planning participants



Risk, responsibility and blame

***Junior doctor**: So, you're on a CTO, and part of the responsibility therefore falls on the team that you take your medication. So, we've had a discussion with the team...and we suggest changing to orals rather than the jab…I've done this in good faith and trusted you that you would take the medication …*

***Father**: You're the doctor, you tell him what's best to do…*

***Junior doctor**: I do need you to take medication and attend medical appointments. As you're on a CTO, the minimum is that you do this...We don't have a choice in terms of us following this up. I know we've had issues in the past, but the benefit for you is I've taken you off the injection. But it's up to you, if you don't attend appointments.*

***Jim**: Yea, yea, I know that's the deal. You don't have to say that.*

[Medical Review]

I think [what's important to her]…it's the usual things of a young person. She wants to have friendships with people her age... she wants to get an education…She wants to do some form of work in the future. And I think down the track she'd be wanting to move out of home.

[Nurse- Amanda, Interview]

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The impact of power and positioning on care planning

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Jo: Medical Review

Jo: Speaking of medications, I've got an opinion on this. I've been putting on a lot of weight. Before I was on a depot, and they substituted it with a tablet, and I lost weight.

Psychiatrist: Well its 80% diet and 20% what you're doing. And medication? What are on you at the moment?

[Jo listed his medications with minimal prompting]

And you've got a CTO at the moment? I think we'd like to keep it going because you've done well on treatment, and when things go wrong for you, it goes very wrong. How do you feel about that?

Jo: I prefer not, but I understand why. I can't really determine any difference mentally or physically on the medications. The only difference I can see is I've put on weight.

Psychiatrist: So you're putting on weight. We could look at changing the medication. Paliperidone depot is probably the worst. Have you been on Abilify depot?

Jo: Medical Review cont.

Jo: I don't want an injection at all. Can't you look at tablets?

Psychiatrist: We're too nervous to do it at this stage as we don't know if you take it every day.

Jo: Well they know I take it everyday as they come around every morning and watch me take it.

Psychiatrist: At some later point we could look at changing to tablets.

Jo: [sighs] Oh, Ok then.

Psychiatrist: Look I'll talk to [your care coordinator] about switching. We don't want you to get unwell, as when you get unwell you seem to get in trouble with the police.

Jo: Yea [sighs].

Care planning discussions over time

May 2018	June 2018	August 2018
Wu: *The experience with [the team], is pretty good, as long as you follow what you have to do.* Researcher: *What does that mean?* Wu: *I accept the services.*	*His insight is really good now and it's a combination of his very settled mental state… the input of some of the staff and the peer worker…This is the kind of person you trust to not be on a CTO eventually. Because if he can maintain the routines…if he can sustain his wellness…he's going to be a candidate for no CTO.* [Care coordinator]	Doctor: *What are your thoughts [about the CTO expiring]?* Wu: *I'm hoping to make it voluntary.* Doctor: *I agree. You've done really well. I'm going to let it lapse and it's up to you to show us it's the right decision. I think everyone would be in agreement.*

Amanda: Care informed capacity

Nurse: If things could get better where would it be now? Because things are going really well.

Amanda: Probably being more independent.

Nurse: So what is that?

Amanda: Going to the gym, getting to TAFE.

Nurse: And in the next year?

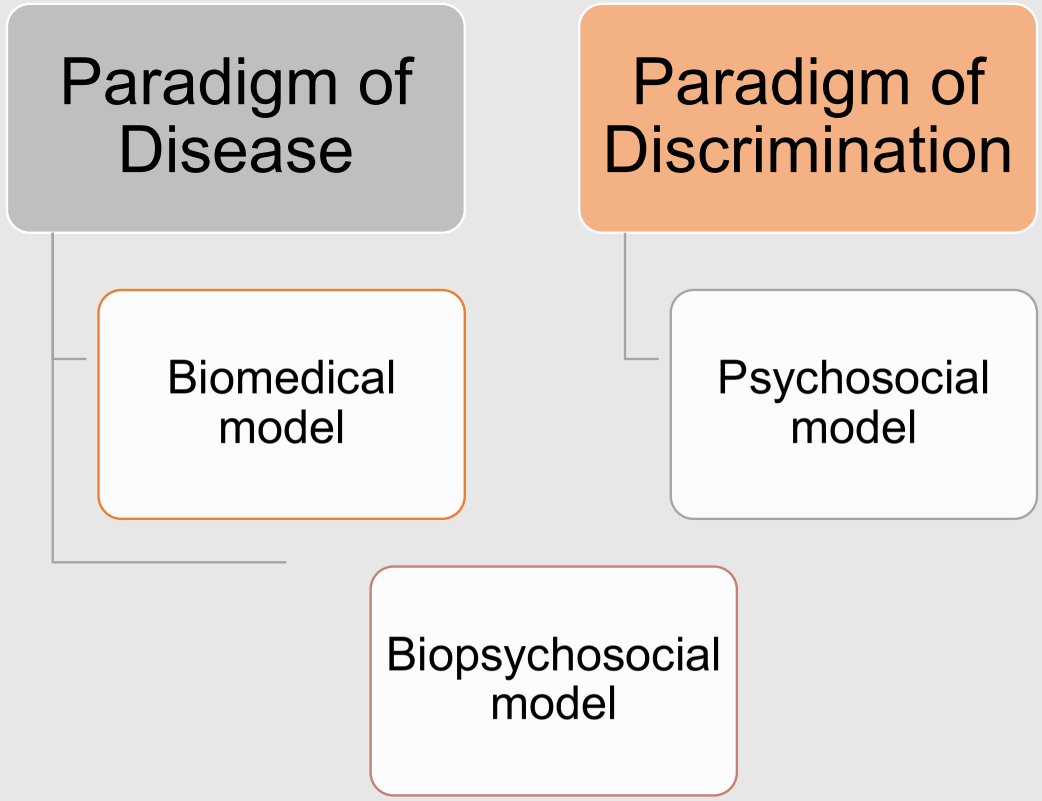
Amanda: Getting my drivers license.

Constrained by the system

What opportunity do the clients get to improve when they are seen once a month by a care coordinator or one of the doctors?... to show they can improve in a number of areas so they don't need to be on a CTO?... what happens in between all that…where's the recovery in that? What's in between?

[Nurse]

Models of illness informing care



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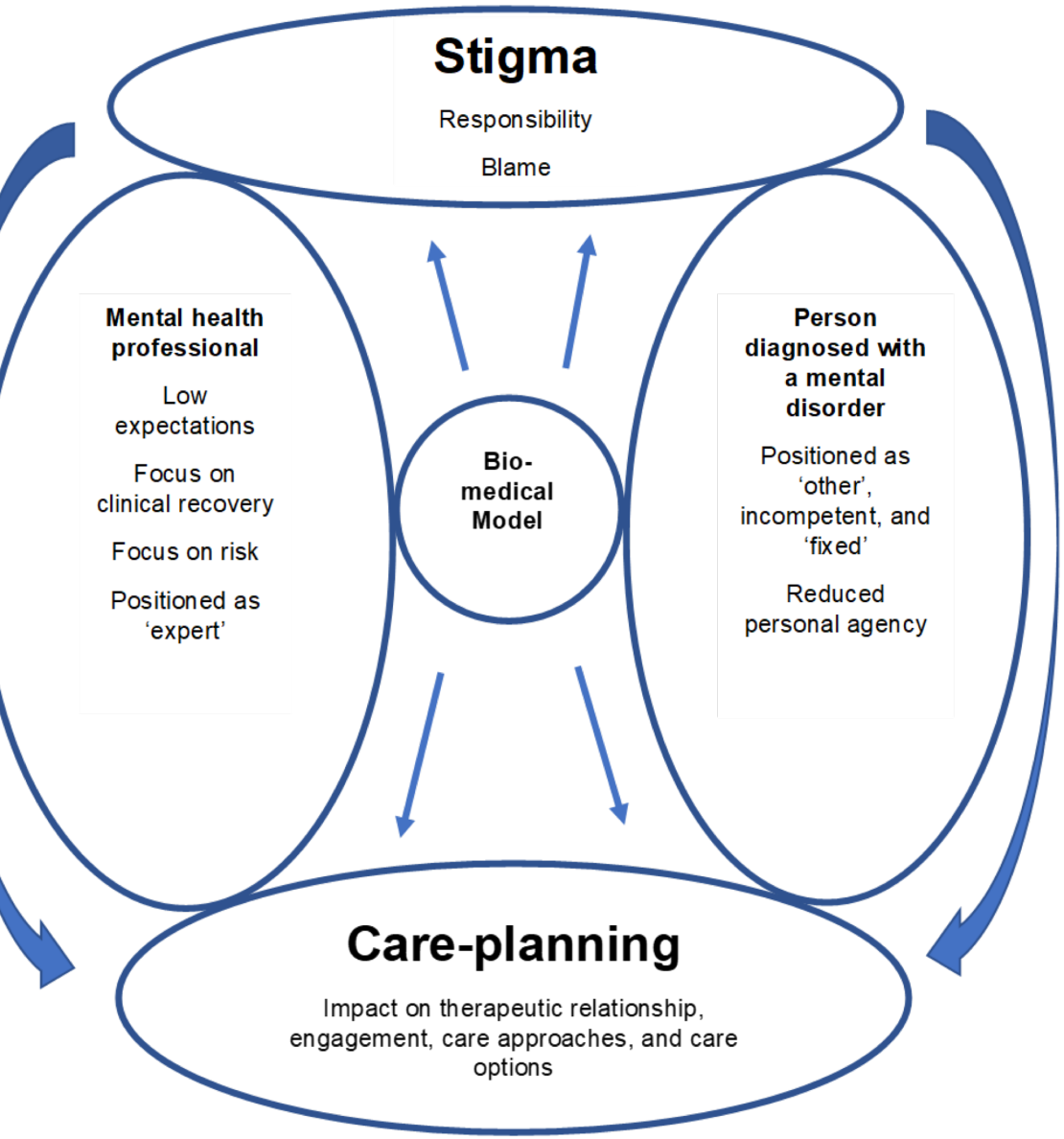
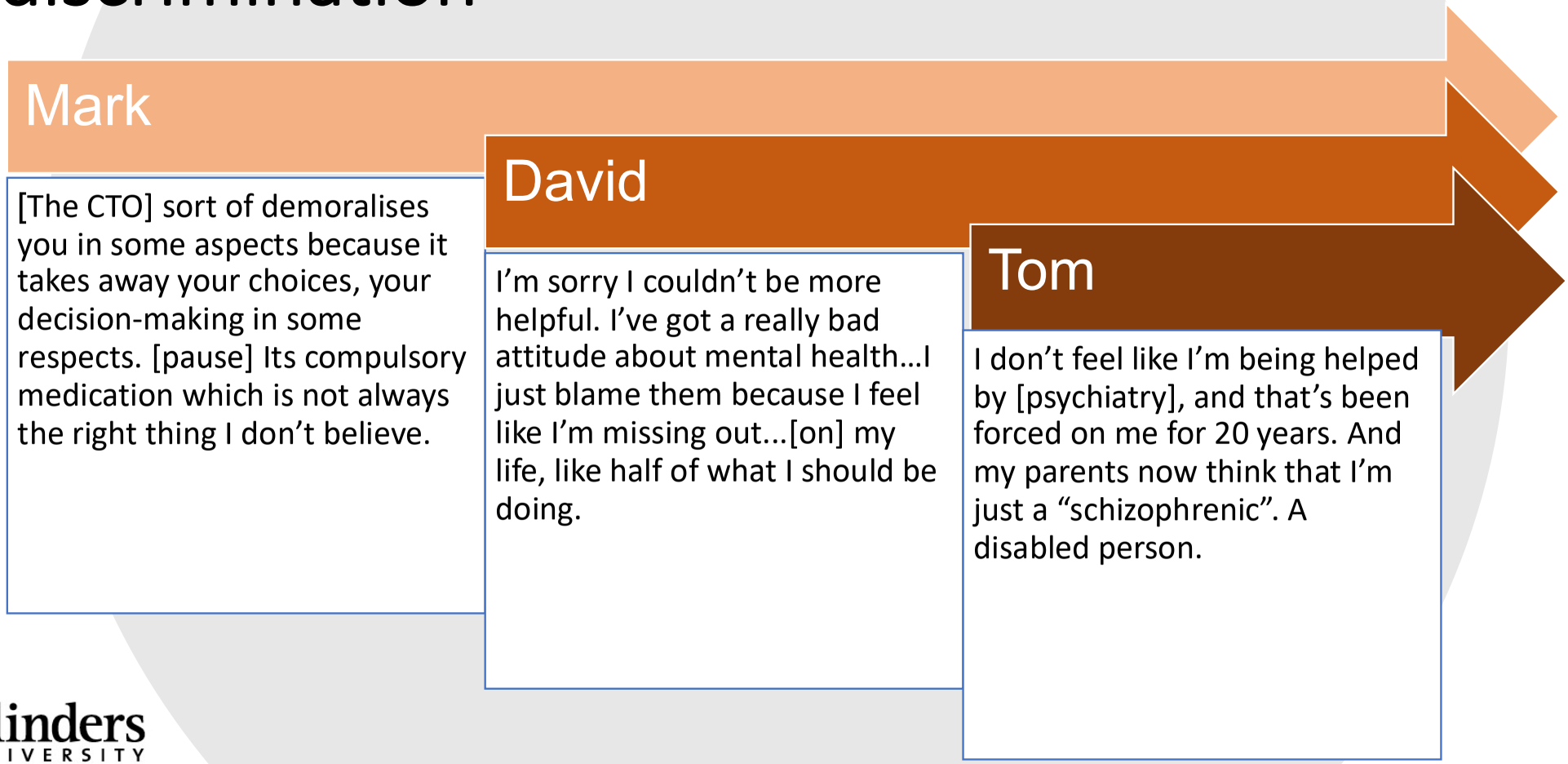


Services perpetuating stigma

Services perpetuating harm and discrimination



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Care Planning Constrained: Not as Intended

Risk and risk management: concepts that are unhelpfully inexact

- Foregrounding risk and service risk assessments: missing what is relevant

Insight: a hindrance to meaningful care planning

- Consumers untrusted as knowers

Care planning relationships undermined by the system

- Interpersonal trust
- Systems trust

Consumers and carers absence in care planning

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Care Planning from the Personal to the Social

Reframing risk and recovery
Uncoupling from the biomedical and emphasising the psychosocial
Reframing of identities in the care planning relationship
Is an emphasis on the psychosocial enough?

Summary and Recommendations

- Broadening of clinician conceptualisations and understandings of risk
- Routine implementation of interventions and approaches that are recovery-orientated and trauma-informed
- Research on the impact of implementation of recovery tools and interventions on care planning relationships and processes

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Concluding comments

"As a service we talk about recovery … but mainly what we do is diagnose, medicate, and treat…the whole medicalisation of people's lives, has meant that we have focused on that, and we haven't maybe focused as much on [employment] and that's why we're having to find our way again. Because we lost our way a bit when it came to treating people in the community for mental health conditions, if it meant not just using medication, orders, diagnostic criteria…I think it's [IPS] quite important for those reasons"

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Dawson, S., Muller, J., Renigers, V., Varona, L., & Kernot, J. (2020). Consumer, health professional and employment specialist experiences of an individual placement and support programme. *Scandinavian Journal of Occupational Therapy,* Advance online publication, 1-13. doi:10.1080/11038128.2020.1714719

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