Improving the physical health of people living with serious mental health problems in regional South Australia

Associate Professor Martin Jones Director University of South Australia Department of Rural Health (DRH)
Sandra Walsh Research Assistant (DRH)
Mellissa Kruger DRH Manager (DRH)
Co-Morbidity: Improving Access To Services For People Living With Serious Mental Health Problems

The development of the serious mental illness physical Health Improvement Profile

J. WHITE1 RN BSC (Hons) PGCert, R. GRAY2 RN PhD & M. JONES1 RN PhD

1Lecturer in Mental Health Nursing, University Teaching Fellow, University of Hull, Hull, 2Professor of Research Related to Nursing, University of East Anglia, Norwich, and 3Associate Director of Nursing, Surrey and Borders Partnership NHS Foundation Trust, Surrey, UK

Using the serious mental illness health improvement profile [HIP] to identify physical problems in a cohort of community patients: A pragmatic case series evaluation

Francis Shuel1, Jacqui White2, Martin Jones3, Richard Gray4

1 Wishaw General Hospital, Lanarkshire, Scotland, United Kingdom
2 Faculty of Health and Social Care, University of Hull, Hull, England, United Kingdom
3 Surrey and Borders Partnership NHS Foundation Trust, Surrey, England, United Kingdom
4 Faculty of Health, University of East Anglia, Norwich, England, United Kingdom
Co-Morbidity: Improving Access To Services For People Living With Serious Mental Health Problems

The serious mental illness health improvement profile [HIP]: study protocol for a cluster randomised controlled trial

Jacquie White1,2*, Richard J Gray3, Louise Swift3, Garry R Barton2 and Martin Jones4

Abstract
Background: The serious mental illness Health Improvement Profile [HIP] is a brief pragmatic tool, which enables mental health nurses to work together with patients to screen physical health and take evidence-based action when variables are identified to be at risk. Piloting has demonstrated clinical utility and acceptability.

Methods/Design: A single blind parallel group cluster randomised controlled trial with secondary economic analysis and process observation. Unit of randomisation: mental health nurses [MHNs] working in adult community mental health teams across two NHS Trusts. Subjects: Patients over 18 years with a diagnosis of schizophrenia, schizoaffective or bipolar disorder on the caseload of participating MHNs. Primary objective: To determine the effects of the HIP programme on patients’ physical wellbeing assessed by the physical component score of the Medical Outcome Study (MOS) 36 Item Short Form Health Survey version 2 (SF-36v2). Secondary objectives: To determine the effects of the HIP programme on: cost effectiveness, mental wellbeing, cardiovascular risk, physical health care attitudes and knowledge of MHNs and to determine the acceptability of the HIP Programme in the NHS. Consent nurses (and patients) will be randomised to receive the HIP Programme or treatment as usual. Outcomes will be measured at baseline and 12 months with a process observation after 12 months to include evaluation of patients’ and professionals’ experience and observation of any effect on care plans and primary-secondary care interface communication. Outcomes will be analysed on an intention-to-treat (ITT) basis.

Discussion: The results of the trial and process observation will provide information about the effectiveness of the HIP Programme in supporting MHNs to address physical comorbidity in serious mental illness. Given the current unacceptable prevalence of physical comorbidity and mortality in the serious mental illness population, it is hoped the HIP trial will provide a timely contribution to evidence on organisation and delivery of care for patients, clinicians and policy makers.

Trial Registration: ISRCTN: ISRCTN41137900

Background
Serious mental illness and physical comorbidity
Improving the physical health of people with serious

Metabolic disorders such as diabetes, hyperlipidemia and hypertension are highly prevalent, exceeding 50% in some studies [5]. Cardiovascular disease [CVD] is the
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A quarter of the health checks were completed by CMHNs

Invited to take part, (reported as eligible by team leader):
198 MHNs

Excluded: 135 MHNs
Did not respond to invitation: 131
Consented but withdrew before randomisation: 7
(personal, workload and new job reasons.)

Invited to take part, (on consented nurse caseload and reported as eligible):
642 patients

Excluded: 439 Patients
Did not meet inclusion criteria: 52
Refused to participate: 177
Recruitment window closed: 210

Randomised 60 MHNs, 173 Patients

Analysis Follow up Allocation

Hip Programme Group

29 MHNs allocated
4 Did not recruit any patients
26 received HIP training (n=24 patients)
3 withdrew before training (n=3 patients)
27 (93%) completed baseline adapted PHASE

26 MHN

0 LTFU
0 withdrew
9 (35%) completed adapted PHASE (n=24 patients)

25 MHN clusters

90 Patients allocated
1 withdrew (after consent & before baseline)
86 completed baseline SF36v2 PCS
42 (47%) completed baseline HIP
(n=14 MHNs)

70 patients

60 Patients
(PCS at BL and follow-up)

Treatment as Usual

31 MHNs allocated
5 Did not recruit any patients
24 (77%) completed baseline adapted PHASE

30 MHN

1 (3%) LTFU (n=3 patients)
0 withdrew
13 (42%) completed adapted PHASE

24 MHN Clusters

83 Patients
82 completed baseline SF36v2 PCS

62 Patients
13 (15.9%) LTFU
8 (9.8%) withdrew
61 (74.7%) completed SF36v2 PCS

60 Patients
(PCS BL and follow-up)

MHN-Mental Health Nurse, PHASE-adapted Physical Health Attitude Survey, (adapted includes knowledge questions), LTFU-Lost to follow-up, SF36v2 PCS-Short Form 36 version 2 Physical Health Component, ITT-Intention to Treat.
Co-Morbidity Physical Health and Serious Mental Problems Future Direction?

Preventing non-government organization workers to conduct health checks for people with serious mental illness in regional Australia

MARTIN JONES 1 BM, MSc, PhD, MELISSA KRUGER 3 BSc, GradCertPublicSecMgmt, GradCert, Mas, & SANDRA M. WALSH 2 B Psych, B(ions), GradCert

1 Associate Professor and Director, 2 Manager, and 3 Research Assistant, Department of Rural Health, University of South Australia, Whyalla, SA, Australia

Keywords: health checks, physical comorbidity, serious mental illness

Accessible summary

What is known on the subject?
- People diagnosed with schizophrenia or bipolar disorder have a life expectancy 10–15 years less than the general population.
- In rural and remote Australia, there is a shortage of health care professionals to provide physical health care for people living with a serious mental illness (SMI).
- A large proportion of the care for people living with a SMI is provided by non-government organizations (NGOs), often employing workers without formal qualifications.
- There has been minimal research regarding the experiences of NGO workers who have been trained to conduct health checks to help people living with SMI to access primary care services.

What this paper adds to existing knowledge?
- This is the first study to examine the experiences of preparing NGO workers to conduct health improvement profiles (HIPs) to support the physical health of people with SMI.
- It builds on previous studies that examined the use of HIPs by trained/qualified staff.

What are the implications for practice?
- This study highlights that NGO employees may have an important role in helping people with a SMI to address their physical health.
- Engaging lay workers to use the HIP increases their awareness of the importance of providing good physical health care for people with SMI.
- The use of a tool, such as the HIP, prepares NGO workers to support the physical health needs and enables them to describe meaningful improvements in the health of people with a SMI.
Aims

• Insights into experiences of using the HIP

• Helpful and unhelpful aspects of the HIP

• Refine the HIP for application in a regional setting
Method

• HIP training & participant selection
  – 1 full day
  – 5 x 1 hour supervision

• Reflexivity and bias
Data Collection and Analysis

- Focus groups
- Thematic analysis
- Theme validation
Results

Four themes emerged
• Taking control
• Accessing services
• Guiding my conversation
• Working with others
Results

Theme 1: Taking control

When I did the assessment with my client, she invited me to go to the GP with her. I was given the opportunity to speak to the GP about numerous issues. This particular client goes to her GP regularly but wasn’t speaking about certain issues. Some changes were able to be made due to my presence. (Female, NGO Worker)

The assessment opens the door to discuss issues like weight that are often hard to bring up with the consumer. (Male, Team Leader)
Results

Theme 2: Accessing Services

‘Sometimes we found some consumers were neglecting health issues, like a pap smear, that we wouldn’t have expected that consumer to neglect. We also found some consumers were marijuana users when we wouldn’t have thought so, hence we then helped them to go and see somebody who could help with this’ (Female, NGO Worker)

‘The best outcome I had was the consumer taking me to the GP. This was a consumer that had never normally let anyone go with her to the GP’ (Female, NGO Worker)
Results

Theme 3: Guiding my conversation

‘We were able to have discussions around obesity. Doctors often just say to lose weight. We were able to have a discussion about the importance of losing weight and create a plan……we can identify the problem together and follow through’ (Female NGO Worker).

‘We feel like we bridge the gap. If we have been in the role long enough, we are able act as an advocate for the consumers and plan our conversations with them’ (Female, NGO Worker)
Results

Theme 4: Working with others

‘It helped if you had to go to other organisations with issues with a client. For one client we were able to go through and write a list from the HIP assessment of what she needed from each organisation’ (Female, NGO Worker)

‘She was able to use this list with her doctor. It made it easier talking to other organisations regarding consumers. It was clearer than discussing the client from case notes’ (Female, NGO Worker)
Results

Meta-Theme: Lay workers can seemingly work effectively to address physical health problems

“We think it worked because we weren’t clinically trained. We can relay to the consumer in terms that they can understand and never assume they know things like clinicians sometimes do” (Female, NGO Worker)

“One consumer had ignored her lipid level problem. This was addressed and she went to her GP and was retested and obtained medication” (Female, NGO Worker)

“One consumer had quit smoking” (Male, Team Leader)
Discussion

- Insights and Experiences
- Unhelpful and unhelpful aspects of the HIP
- Application within a regional Australian context
- Next Steps
Conclusion

• Important Role for NGO
• Physical Health Care Awareness
• Meaningful Improvements in Physical health
• Workforce Solution
• Where to from here
Questions