

# The Health-Wise Project

L I V E R P O O L  
E A R L Y P S Y C H O S I S  
I N T E R V E N T I O N P R O G R A M

- EPIP uses an assertive case-management approach to recovery from first-onset psychotic illness for young people ages 12 to 25 years living in the Fairfield/Liverpool region of the SSWAHS.
- Biopsychosocial framework.
- Multidisciplinary team

Tim Mar RN [timothy.mar@sswahs.nsw.gov.au](mailto:timothy.mar@sswahs.nsw.gov.au)

Natasa Milinkovic RN

[natasha.milinkovic@sswahs.nsw.gov.au](mailto:natasha.milinkovic@sswahs.nsw.gov.au)

## AIM

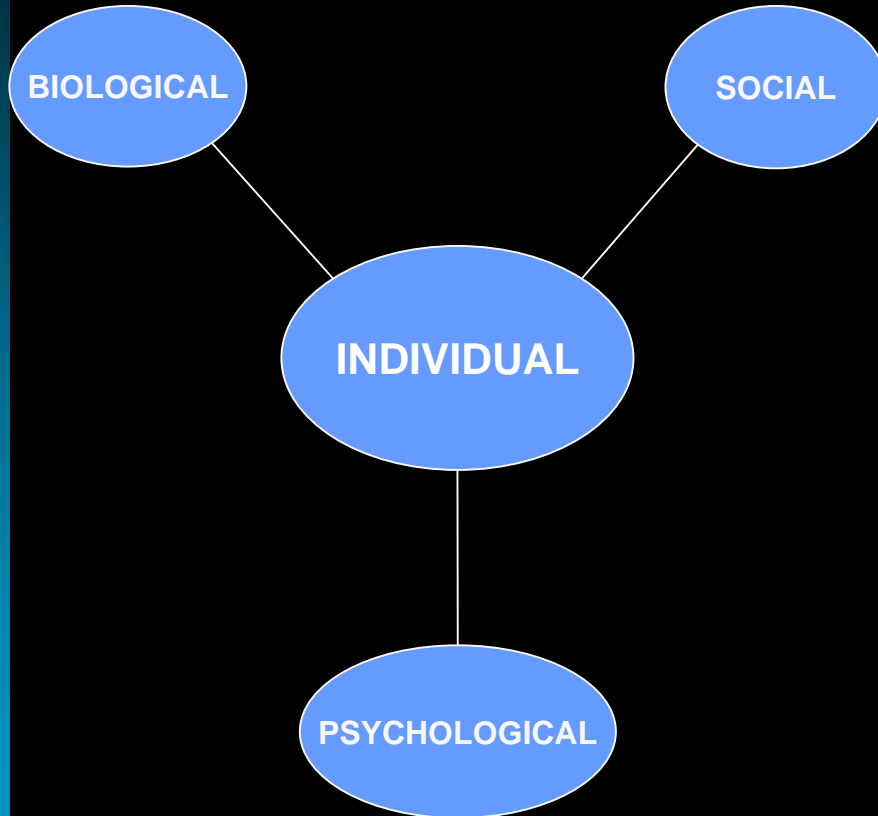
- To improve the mental and physical health of EPIP clients through the development of an integrated service
- To identify and monitor physical health problems and promote healthy lifestyle knowledge and behaviours.

# The EPIP team

- Multidisciplinary team
  - Including nurses, social worker, psychologists, psychiatric consultant and registrar
- Based in Liverpool Hospital
- Clients
  - Community outpatients
  - Inpatients – mainly sub-acute youth unit at Campbelltown, but also Gnakalun, Liverpool MHUs, Roselle

# Population Health

- People with mental illness have higher prevalence of:
  - Mortality/morbidity CVD, diabetes, metabolic syndrome
  - Co-morbid substance use, eg alcohol, smoking
  - Lack of moderate exercise
  - Lower socio-economic background
  - Poor diet / Hyperlipidaemia
  - Overweight & obesity
  - Suicide & risky behaviours
  - Infectious disease
  - Lower health-related quality of life
- = High impact/burden on health system



## EPIP PHYSICAL HEALTH & PSYCHOSIS RISK FACTORS

- Biological
  - The illness itself
  - Side effects of Neuroleptic medications
  - Rapid weight gain
  - Use of weight-loss medications & laxatives
  - Medication compliance
  - Family history
  - A tendency for MH clinicians to overlook physical health
- Social
  - accommodation/housing
  - family and social relations
  - unemployment, limited finances
  - cultural issues
  - stigma
  - developmental disruption
  - poor preventative physical health care in clients with psychotic illness
- Psychological
  - Residual positive psychotic symptoms
  - Persistent negative psychotic symptoms
  - Cognitive deficits, disorganisation
  - Stage of recovery, ie timing
  - Co-morbid symptomology

# METHOD 1

- Develop internal systems
  - Roles
  - Linkages
  - Promotion
  - documentation

# METHOD 2

- Screening & monitoring
  - Healthwise clinic:
    - Physical observations
    - Substance use
    - Range of movement
    - Activity
    - Interests/motivation
    - Diet
    - Sexual health
    - GP
    - Pathology
    - GAF
    - Family history
    - Side-effects
- Linkage with inpatient units and/or GP

# METHOD 3

- Develop clinical guidelines
  - Clinicians toolkit
  - Clinical decision-making algorithm
- Client Psycho-education
  - Individual
  - Family
  - CALD

## ALGORITHM FOR SCREENING and MONITORING WEIGHT-GAIN and WEIGHT-RELATED PHYSICAL PROBLEMS IN PEOPLE WITH FIRST-EPISEDE PSYCHOSIS

Inpatient

Outpatient

**PATIENT TO BE COMMENCED ON or AS SOON AS POSSIBLE AFTER COMMENCEMENT OR SWITCHING of ANTIPSYCHOTIC MEDICATION**

### Assess risk factors

- Family history: medical & psychiatric
- Demographic details
- Cardiovascular disease or other cardiovascular risk factors
- Current medication and medication history
- Ethnic predisposition (eg, Indigenous Australian, Pacific Islander, Asian, African American)
- Poor diet
- Diabetes
- Lack of exercise/activity
- Obesity

### Obtain baseline measurements

- Weight, Height, & Body Mass Index
- Waist measurement
- Blood glucose level (random or fasting)
- Blood investigations: Urea & Electrolytes (UEC), Liver function tests (LFTs), Thyroid function tests (TFT), Glucose, Lipid profiles, Full blood count (FBC), Prolactin
- Blood pressure and pulse
- Dietary assessment

### Monitoring schedule - after commencing or changing antipsychotics or adding mood stabilizer

- At baseline & 4, 8, & 12 weeks and quarterly thereafter**
- Blood pressure and pulse
- Weight, Height, & Body Mass Index
- Waist measurement
- Monitoring schedule - At baseline & 12 weeks and each 6 months thereafter**
- Blood glucose level (random or fasting)
- Monitoring schedule - At baseline & 12 weeks and each 2 years thereafter**
- Blood investigations: Urea & Electrolytes (UEC), Liver function tests (LFTs), Thyroid function tests (TFT), Glucose, Lipid profiles, Full blood count (FBC), Prolactin

- Weight: BMI 18.5 to < 25 or age adjusted to 18 years age
- Waist: < or = 94cm (male), < or = 80cm (female)
- Blood Pressure: < 130/<85 mmHg
- Blood glucose: < 5.5 mmol/L (random or fasting)
- Lipids: Total cholesterol < 5.5 mmol/L, Triglycerides ≤ 1.7 mmol/L, HDL-C (men) ≥ 1.03 mmol/L, HDL-C (women) ≥ 1.29 mmol/L

Normal

**Outside normal range or weight increased by 5% of baseline**

- Consult specialist
- Intensify monitoring

# METHOD 4

- Identify Barriers
  - Internal
  - Linkages
  - client

# METHOD 5

- Design & implement Interventions (individual & group)
  - Health risks & monitoring
  - Psycho-education – attitudes to treatment & associated side-effects
  - Sexual health
  - Drugs & alcohol
  - Psychological aspects & attitudes to eating
  - Safe weight loss & maintenance
  - Healthy diet and activity
  - Lifestyle activity
  - Structured activity/exercise
  - Goal setting/motivation

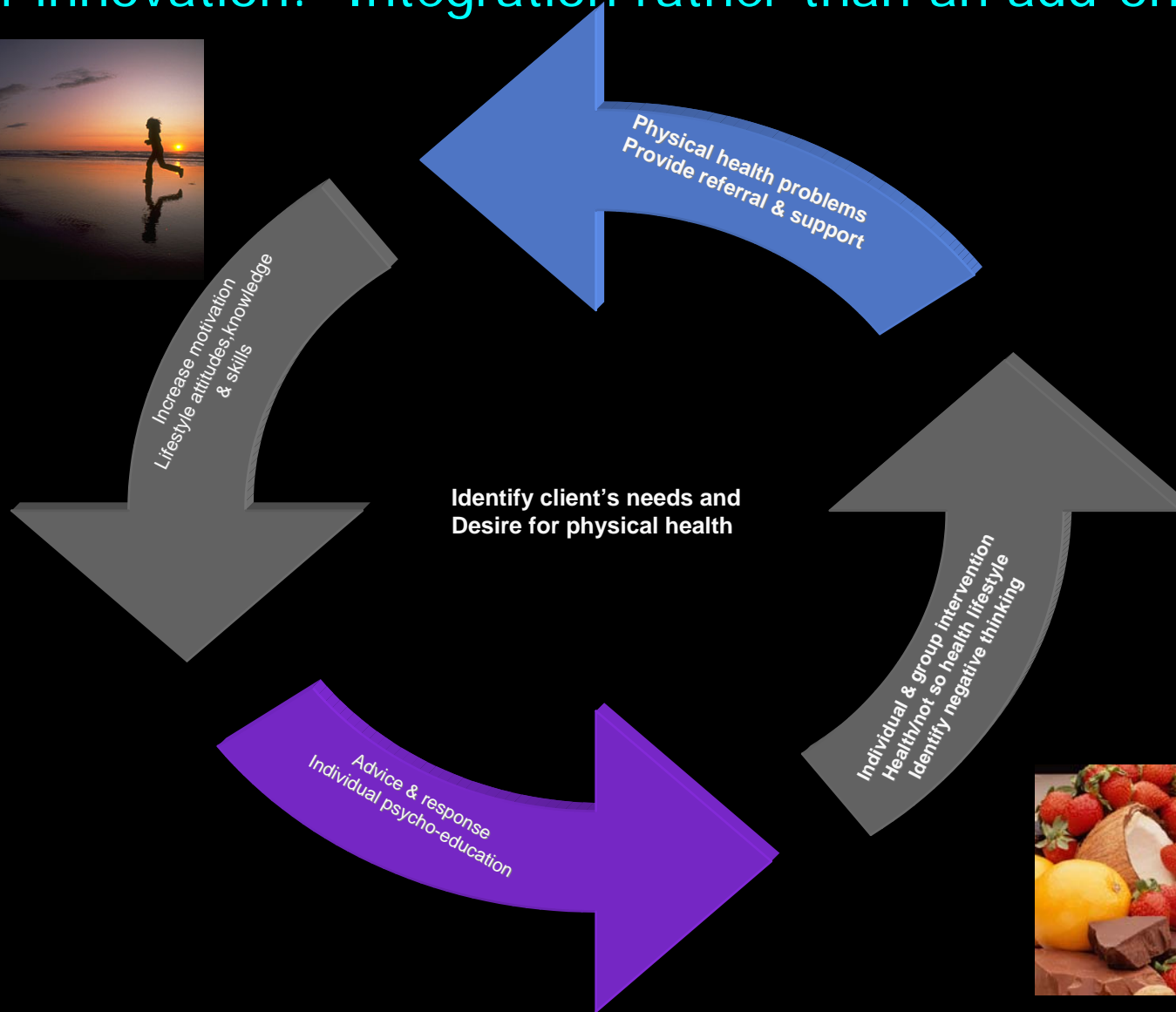
# Outcomes and Evaluation

- Include comparison data collected from initial and subsequent clinics.
- Treatment compliance
- Participation in clinics, individual and structured group programs
- Participants appraisals/level of functioning change
- Staff feedback
- Practice development: opportunities & barriers

*Progress report 31/5/07*

*Final evaluation report 31/1/08*

# Level of innovation: Integration rather than an add-on



# Impact on nursing practice & consumer outcomes

- Nursing
  - Need to re-skill & re-focus
- As part of team
  - Need to lead
- As part of health service
  - Advocate
  - How much do we do & how much collaborative?
- Consumers
  - Participation in process
  - Increased quality of life

# FUTURE SCOPE

- Identifies opportunities, barriers and gaps in practice development model
- To continue & improve existing program
- To further develop collaborative service arrangements