International Journal of Integrated Care ISSN 1568-4156
Volume 14, 8 December 2014
Publisher: Igitur publishing
URL: http://www.ijic.org
Cite this as: Int J Integr Care 2014; WCIC Conf Suppl; URN:NBN:NL:UI:10-1-116684

Conference Abstract

Living Well, Living Longer: Working together for better health in people with mental illness

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Abstract

It has long been known that people living with severe mental illness (e.g. schizophrenia, schizoaffective disorder, or bipolar disorder) have a life expectancy that is 15-25+ years earlier than that of the general population, mostly due to physical health problems such as cardiovascular disease (1-4). However, access to and uptake of appropriate screening and intervention for physical illness is less common in this population (5,6). There is now increasing recognition that this represents an unacceptable inequity in service access and health outcomes (7,8).

The Sydney Local Health District is working to address this inequity by improving access to mainstream health services for those with severe mental illness. The Living Well, Living Longer program is an integrated health care framework that aims to have all mental health consumers appropriately screened and treated for cardiovascular and metabolic disease within five years.

The program involves a district-wide strategy across mainstream and mental health services. Importantly, it is governed by a steering committee comprising key decision-makers from across the district and its partner organisations, including clinical stream heads, facility managers, senior mental health staff, population health, NGO partners including, the Inner West Medicare Local and General Practice.

Key activities include:

- GP and Mental Health Collaborative Care: Linking mental health consumers with GPs, and developing/implementing a model of collaborative care to strengthen the working relationship between GPs, Community Mental Health staff and consumers to support management of their health care.

- ccCHIP Cardiometabolic Clinic: Providing interdisciplinary specialist review of general health and risk factors for illness, comprising psychiatry/psychopharmacology, endocrinology, dental, dietetics, and sleep. Fast-track referral to specialist care arranged as indicated.

- Healthpathways providing overview of managing physical health in people living with mental illness. Additional pathways to be developed to provide local primary care services with advice on e.g. GP and mental health collaborative care model.

- Education and training of mental health staff in screening and arranging follow up for cardiovascular and metabolic health conditions.

- Awareness-raising across mainstream health services.

- A district-wide smoking cessation strategy.

- Healthy lifestyle groups and health promotion activities to support healthy diet, exercise, and social connectivity.

Health outcomes for this vulnerable population are expected to include better access to appropriate and timely care, improved patient experience when interacting with the health service,

and reduced avoidable hospitalisation as health concerns are more closely managed in the community. In the longer term, the program aims to deliver better health outcomes and reduce early death in people living with severe mental illness across the district.

Keywords

mental health; schizophrenia; cardiovascular; metabolic; equity

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PowerPoint presentation

https://www.conftool.net/integratedcare2014/index.php?page=downloadPaper&form_id=247
