

# BEING EQUALLY WELL

**A NATIONAL POLICY ROADMAP TO BETTER PHYSICAL  
HEALTH CARE AND LONGER LIVES FOR PEOPLE LIVING  
WITH SERIOUS MENTAL ILLNESS**

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## ABOUT THE PROJECT

This has been a collaborative project between the Mitchell Institute at Victoria University, the Australian Health Policy Collaboration and Equally Well Australia. The project aim was to answer the question: *“What needs to change at the front lines of clinical care and how can the changes be supported?”* to reduce the premature mortality and high rates of poor physical health of people living with serious mental illness.

## ABOUT US

The Mitchell Institute for Education and Health Policy at Victoria University is one of the country’s leading education and health policy think tanks and trusted thought leaders. Our focus is on improving our education and health systems so more Australians can engage with and benefit from these services, supporting a healthier, fairer and more productive society.

The Australian Health Policy Collaboration is led by the Mitchell Institute at Victoria University and brings together leading health organisations and chronic disease experts to translate rigorous research into good policy. The national collaboration has developed health targets and indicators for preventable chronic diseases designed to contribute to reducing the health impacts of chronic conditions on the Australian population.

Equally Well Australia brings together more than 90 organisations in a collective impact strategy to make the physical health of people living with mental illness a priority at all levels: national, state and territory, and regional. Supported by the National Mental Health Commission, Equally Well Australia undertook an extensive consultation process to develop and launch, in July 2017, the Equally Well National Consensus Statement to guide the strategy. Subsequently, Equally Well has become a priority action of The Fifth National Mental Health and Suicide Prevention Plan.

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# **BEING EQUALLY WELL: A NATIONAL POLICY ROADMAP TO BETTER HEALTH CARE AND LONGER LIVES FOR PEOPLE LIVING WITH SERIOUS MENTAL ILLNESS**

## **Current health care services are simply and starkly failing to provide adequate physical health care for people with serious mental illness.**

People with serious mental illness have high rates of physical illness, particularly chronic diseases, and a far shorter life expectancy than the general population.

This *Being Equally Well Roadmap* comprises implementable, evidence-based changes that are feasible, affordable, and practical.

The *Roadmap* has been designed by mental and physical health practitioners working collaboratively with consumers and carers. It is a map based on their professional and personal front line experience and addresses the frustrations that both professionals and consumers experience from current ill-designed health service arrangements.

This report is intended for practitioners in primary care, for mental health professionals and services, for primary health networks and for local hospital and health districts and networks. It provides guidance and resources for practitioners and proposes the development of tools for effective, proactive, quality assured shared care between general practice and mental health services.

This is also a map for governments and health system administrators as front line health professionals cannot bring about sustainable change without system improvements to support them. Achieving the level of system change that is required to reduce the higher rate of premature mortality for people living with serious mental illness requires significant policy and practice attention and effort.

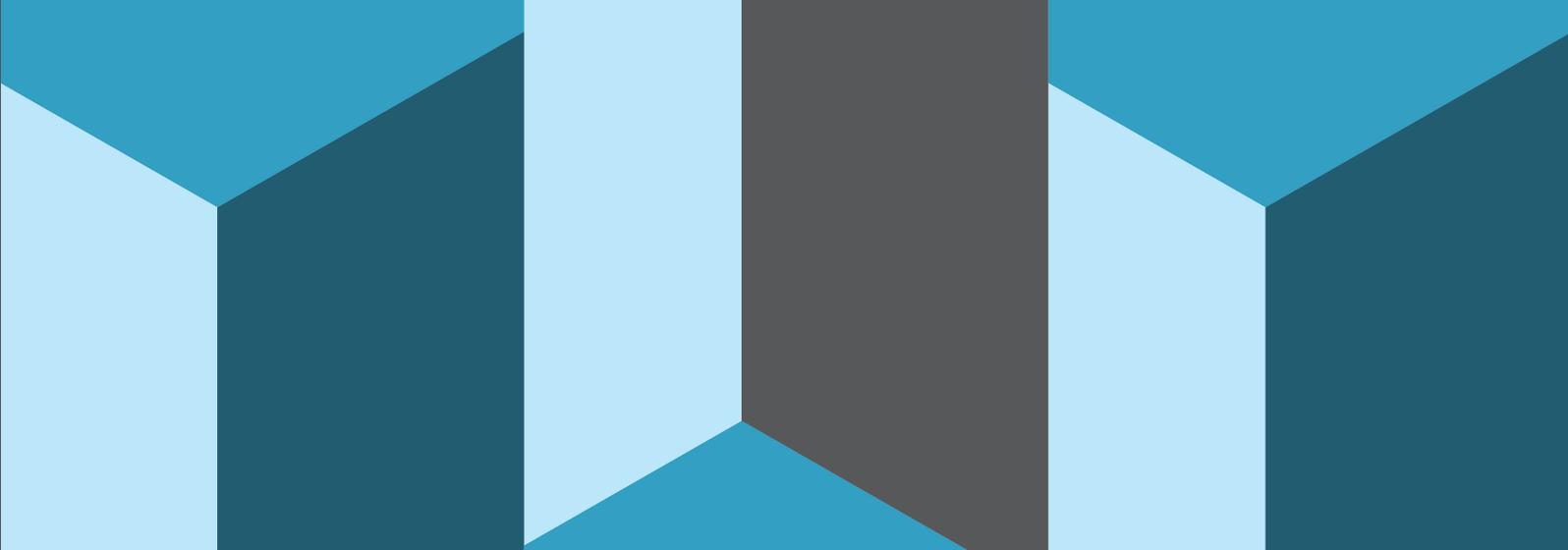
The role of primary care is crucial to achieving better physical health for people living with serious mental illness. General practice needs purpose designed

resources to support individuals with serious mental illness. Community pharmacies and pharmacists are readily accessible health services that are under-utilised in their capacity to provide medication support and management to individuals with high needs.

Shared care, that is, care of people with serious mental illness by general practitioners and psychiatrists working collaboratively and with the informed and supported participation of individual consumers, is necessary. Intercollegiate clinical guidelines for psychiatrists and general practitioners to work collaboratively with patients and consumers to manage antipsychotic medications are strongly endorsed. Investment in a workforce of community mental health nurses or nurse navigators to actively integrate and facilitate clinical care between primary care and specialist mental health services is proposed. Consumers want to see the role of peer workers developed to help support people with serious mental illness as they connect with health services and professionals.

Shared care arrangements are not new to health care in Australia. They are in place in other aspects of health care where specialist care and care by general practitioners need to work together and where patient or consumer engagement is recognised as essential to good health care and health outcomes.

A better coordinated model of care is proposed for serious mental illness through a community-focused system with supports that should be the responsibility of primary health networks (PHNs) and local health and hospital networks and districts (LHN/Ds). The 31 PHNs are independent primary health care organisations throughout Australia that commission services and support to primary health care and general practice. LHN/Ds are independent organisations that directly manage groups of public



hospital services and their budgets and are directly responsible for hospital performance. The model proposed includes locally appropriate arrangements to support shared care service provision by individual general practices and district mental health services; to support engagement of general practices in the health care of people with serious mental illness in their local areas; to design locally relevant supports for the most vulnerable in PHN and LHN/D communities such as people who are homeless or without social supports; and to provide health professionals with locally accessible resources and training.

Structural support of PHNs and monitoring of retooled, fit-for-purpose funding of service provision with cohesive, committed leadership is essential.

The *Roadmap* proposals draw on the latest and strongest evidence of how to reduce mortality and preventable poor health through continuous quality improvement. The proposals include the establishment of an annual national report on improvements in the morbidity and mortality of people with serious mental illness. Data for the annual report would be compiled from a National Clinical Quality Registry that should be established and supported with ongoing funding, and from PHN-aggregated GP data and from quality improvement Collaboratives that are strongly supported as the critical resource to ensure ongoing quality improvement. Quality improvement Collaboratives would be established nationally and resourced and guided by a national centre of excellence, with local facilitators potentially based in PHNs and LHN/Ds. Collaboratives have been shown to support rapid improvements in processes and clinical outcomes, adaptation to local community contexts and needs and continuous measurement of performance.

Supporting infrastructure would be provided by the Australian Commission for Safety and Quality in Health Care (ACSQHC) and the Australian Council of Health Ministers (Health Ministers). Collaboratives would be resourced and guided by a national centre of excellence based in ACSQHC.

Previous attempts to tackle the challenge of the health and life expectancy gap for people living with serious mental illness have had limited effect. These *Roadmap* proposals are different because they have been shaped by the combined knowledge and experience of those involved at the 'coalface' of health care delivery: consumers, carers and front line clinicians, working together to find feasible, evidence-informed and implementable solutions to seemingly entrenched, systemic problems. These proposals, if implemented fully, will bring to an end the low expectations and system dysfunction that contributes to the shorter life expectancy of people with serious mental illness.

Similar national, state and territory enhancements to health care services have reduced deaths and disability from stroke and have provided tailored shared care health services and support for cancer patients with their physical and mental health care through treatment and its consequences. People with serious mental illness need the same commitment and attention to reduce preventable deaths and serious physical illness.

# A STARK DIVIDE: THE FACTS

**There are high rates of physical illnesses among people living with serious mental illness in Australia and elsewhere. This compounds the disadvantages already experienced by people with mental illness and is associated with a far shorter life expectancy.**

Lives of both men and women with serious mental illness may be up to 30% shorter than those of the general population and the gap appears to be increasing (Roberts, 2019). The life expectancy gap is larger for men and women are more likely to live with multiple comorbidities and to be sicker and more disabled (Australian Inst of Health and Welfare 2017).

Just under 80% of excess deaths of people with serious mental illness result from physical health conditions, not mental illness (Lawrence et al., 2013). These deaths are mostly caused by illnesses that, in the general population, are commonly prevented and treated effectively in general practice – particularly heart disease, respiratory disease and some cancers. The most common causes of early death for people who have accessed mental health-related Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Schedule (PBS) treatments in Australia are ischemic heart disease and lung cancer (Australian Bureau of Statistics, 2017; Roberts, 2019).

The gains in treatment of these conditions seen in recent decades have not resulted in reduced morbidity or mortality for people living with mental illness.

## People with a serious mental illness are:

- **Six times** more likely to die from cardiovascular disease
- **Five times** more likely to smoke
- **Four times** more likely to die from respiratory disease
- **Likely to die** between 14 years and 23 years earlier than the general population and account for approximately one-third of all avoidable deaths (National Mental Health Commission, 2016)

Mental illnesses in interaction with other chronic diseases (comorbidities) represent one of the biggest challenges to public health systems in Australia.

People living with serious mental illness have lower rates of screening for cardiovascular risk factors such as blood pressure and cholesterol, and lower rates of participation in national screening programs like mammography. There are lower rates of prescribed cardiovascular medications especially lipid lowering and antihypertensive agents, and lower rates of surgical interventions, radio- and chemotherapy with poorer outcomes. Dental health is poor.

Based on estimates from the Global Burden of Disease report in 2010, a 2016 report for the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the AHPC estimated that there were 407,938 people living with serious mental illness in Australia in 2014 (The Royal Australian and New Zealand College of Psychiatrists, 2016).

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‘The high rate of physical comorbidity, which often has poor clinical management, drastically reduces life expectancy for people with mental illness, and also increases the personal, social and economic burden of mental illness across the lifespan.’

(Firth et al., 2019, p.676).

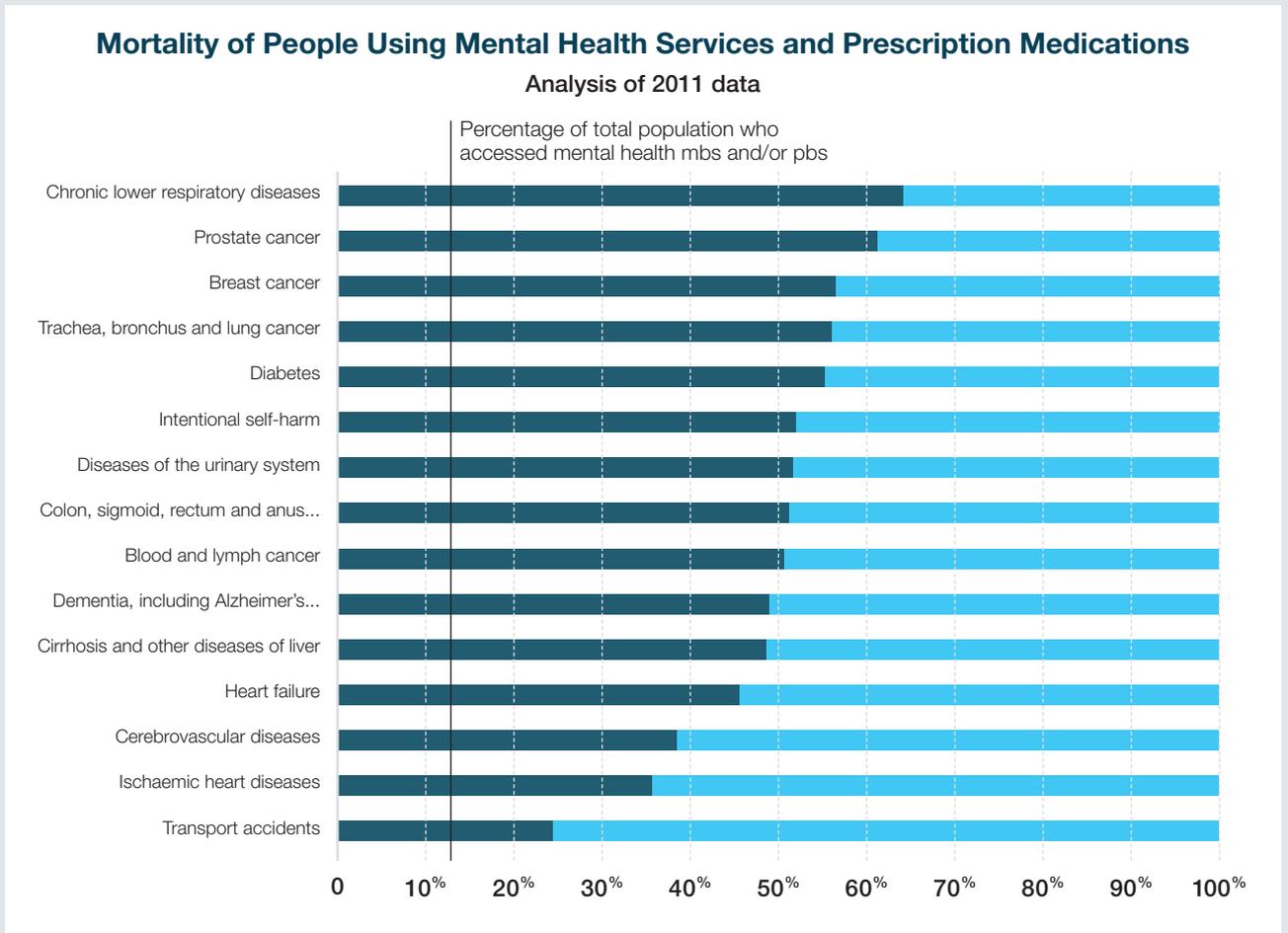


Figure 1. Mortality of People Using Mental Health Services and Prescription Medications

Inserted from "Mortality of People Using Mental Health Services and Prescription Medications: Analysis of 2011 data" by Australian Bureau of Statistics, 2017. Retrieved from Canberra: <https://www.abs.gov.au/ausstats/abs@.nsf/productsbyCatalogue/EB5F81AAC6462C72CA2581B40012A37D?OpenDocument#:~:text=The%20standardised%20death%20rate%20for%20males%20who%20accessed%20mental%20health,deaths%20per%201%2C000%20population%20respectively>.

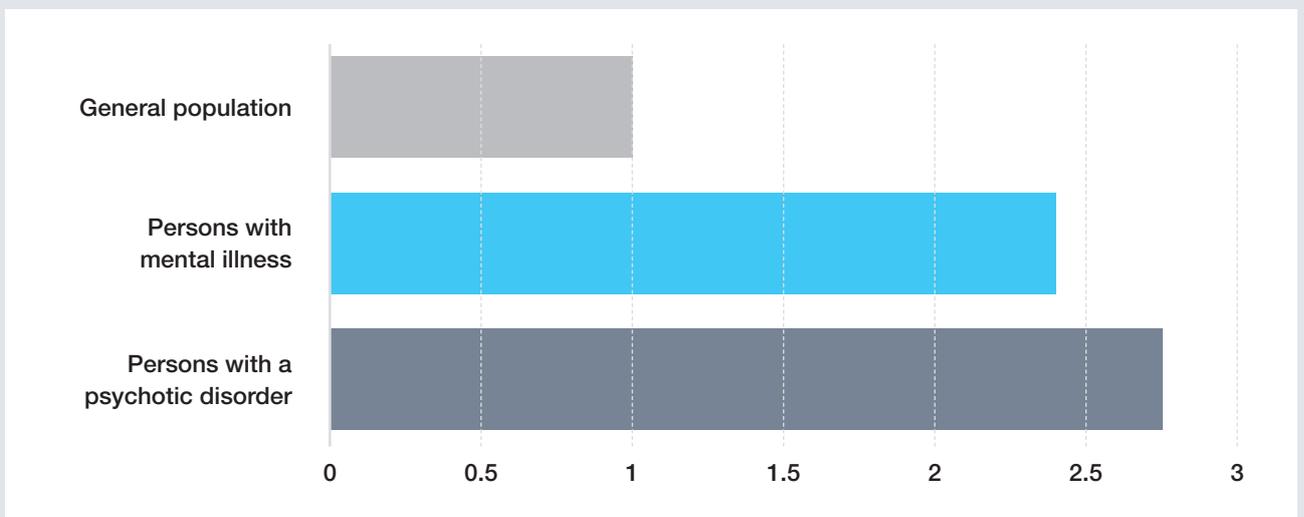


Figure 2. Risk of Premature Death: Ratio of risk

Inserted from "Equally Well The physical health of people living with a mental illness: A narrative literature review" p.6; Figure 2, by R. Roberts, 2019. Retrieved from NSW: <https://www.mentalhealthcommission.gov.au/getmedia/49fed7c5-29ea-49f6-927f-3063c81880a9/Literature-review-EquallyWell>. Reprinted with permission.

# WHAT NEEDS TO CHANGE

**Consumer and carer experts described the key issues that influence the physical health of people living with serious mental illnesses as:**

- discrimination and stigma – the diagnosis of mental illness means that physical health is not as important, physical health issues are often disregarded as a symptom of mental illness
- a narrow focus on mental illness and not on whole-of-person health
- reliance on medication as the principal or sole form of treatment and support with mental illness
- choice and control about health care isn't respected - informed consent is often compromised or disregarded in focus on urgent treatment
- lack of respect for individuals' concerns about and experience with medication impacts on weight and physical health - options of alternative treatments are not common or usual
- financial barriers prevent consumer access to GP care and to private health care and prevent access to physical health supports such as gym membership or fresh food and good nutrition
- lack of care and services integration including:
  - lack of post-acute care follow-up
  - lack of coordination between acute care and primary health care

- unrealistic expectations that people with serious mental illness will cope with multiple medical and associated appointments and manage their daily life needs
- lack of mental health services concern about diet and physical activity health needs for individuals
- lack of recognition of critical needs for support, particularly navigation and peer worker support, to engage with physical health care, social support services, education and employment
- a chasm between healthcare and available support through the National Disability Insurance Scheme (NDIS).

At the primary care (micro-system) level, experts agreed that contributing factors influencing the poorer physical health of people with serious mental health conditions include:

- fragmented care experienced by patients where responsibility for physical health needs falls into cracks between specialist mental health teams and general practice
- absence of a coordinated, proactive and planned system of care for people with serious mental health conditions
- physical health impacts of psychiatric medication - not informing the choice, dose and duration of medication
- the lack of support for consumers and their carers to navigate the health system and to benefit from community and peer groups
- mal-distribution of psychiatrists especially in rural and remote Australia.

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'I feel I have had to choose between improving my physical health over my mental health, an impossible choice. Not really a choice at all.'

At the secondary (meso-system) level of care, across specialist and community mental health services together with primary care, contributing factors identified are:

- lack of information sharing between health services and health professionals to enable integration of information and care
- lack of aggregating structures at the meso-system level:
  - local area mental health services often don't collaborate with each other
  - fragmentation of care that arises from funding as well as the fragmented and small scale nature of services
- lack of access to complementary allied health services that would support interventions to reduce risk factors and improve physical health for people with complex physical and mental health conditions; access is inhibited by low funding of these services and by financial barriers preventing individual access to private services
- low rates of screening for cardiovascular risk factors in people with a mental illness are partly due to barriers to help seeking, partly to diagnostic overshadowing, and partly to lack of systematised coherent approaches that emphasise that it is 'everyone's business' and that everyone (individual consumers, families, clinicians, non-clinical support staff) has an important role to play
- major gaps in translation of findings from screening to actual intervention.

At the tertiary level of health system operation and management (macro-system), factors contributing to poor physical health care for people living with serious mental illness include:

- little or no purposeful service integration arrangements for this high risk population that needs to access multiple services and clinicians over time
- little or no data collection in both public and private mental health services to inform health service provision and resourcing and to measure and evaluate health care and health care outcomes for this high risk population
- lack of appropriate and integrated services; long inpatient stays can arise because of lack of step-down care options and frequent readmissions occur because of lack of community support options
- specialisation of inpatient psychiatric services excludes a focus on physical health conditions and illness
- lack of comprehensive funding for known and predictable care needs for this high risk population is a major barrier
- complete lack of continuous case management and care support service provision for individuals who have to navigate, or not, multiple clinical services regardless of their health and capacity and in the face of an ongoing health condition with predictable risk factors for poor physical health and the associated elevated risk of premature mortality arising from poor physical health.

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'Stigma and discrimination is alive and well; navigation can be overwhelming – where do you go and how do you get there; there is a lack of accountability and coordination – a confusion of care – with little or no visibility of what is provided, how it is provided and what the outcomes are for the individual.'

# DESIGNING THE ROADMAP

**The quality, safety and value of care produced by a large healthcare system can be no better than the services generated by the small systems of which it is composed.**

This *Roadmap* is the result of a collaboration of people with lived experience – those living with serious mental illness and carers for people with serious mental illness – with chronic disease and primary care experts and mental health experts. The project design used a structured working method known as the Clinical Microsystem Approach (Institute for Healthcare Improvement, 2021).

Clinical Microsystems are the small, functional front line units that provide most healthcare to most people. They are the essential building blocks of larger organisations and of the health system – the places where patients, families and care teams meet.

This project design was chosen because the quality, safety and value of care produced by a large healthcare system can be no better than the services generated by the small systems of which it is composed. The efficacy and quality outcomes of larger organisations are dependent on the capability of the clinical microsystems within them.

In healthcare – the system levels of care are:

- **micro-system:** the teams at the front lines of care where patients and their families meet the health system – these teams include General Practice, acute and community mental health services
- **meso-system:** the organisations that support or provide micro-system services – in Australia these are Primary Health Networks (PHNs) which provide support to general practice, Local Health Networks/Districts (LHN/Ds) which provide hospital and associated health services as well as professional and industrial bodies

- **macro-system:** the funding and administrative structures that support both micro- and meso-system organisations – particularly, for this project federal, state and territory governments; the National Mental Health Commission (NMHC); the Australian Health Council (AHC); the Australian Commission on Safety and Quality in Health Care (ACSQHC) and private health insurance.

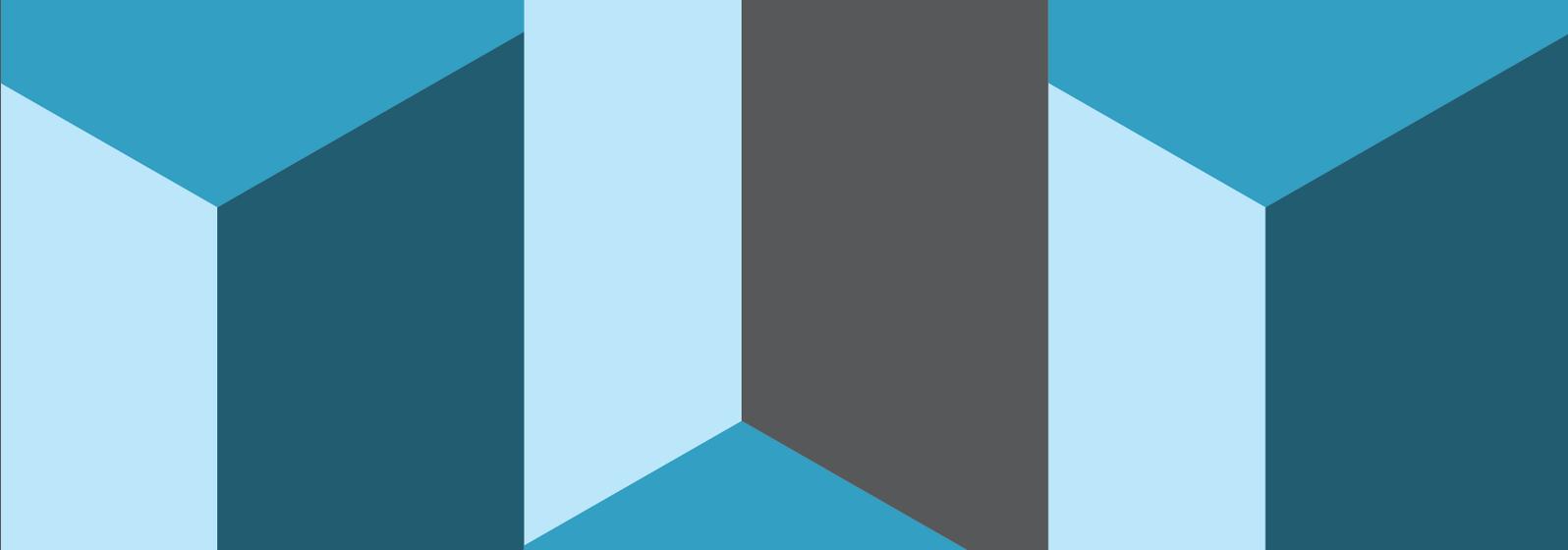
The project also emphasised the centrality of quality improvement – a systematic approach to designing, testing and implementing changes using real-time measurements for improvement.

Project participants met in working groups focused on each system level of care, on quality improvement and on the lived experience and aspirations of consumers and carers. Each of the groups met in a sequence that enabled the outcomes of each group meeting to be shared with others in an iterative and developmental process.

Each group began with a review of what were the weaknesses, limitations and failings of care they as practitioners and as consumers and carers experienced.

The consumers and carers group then established what success would look like for them. Those measures of success were discussed in a joint meeting with the chairmen (as they were) for each of the system level and quality improvement working groups. The measures of success informed subsequent meetings of each of the working groups which focused on what needed to change or to be established and how to achieve these changes at each system level and in quality improvement measures.

The iterative and complex process was time intensive and participants gave a remarkable amount of time commitment to the project. Working group chairmen and rapporteurs put in many hours in preparation for



meetings; in discussion records, evidence gathering and group reports as the project process developed.

To ensure that the richness and complexity of detail was captured and utilised, a thematic analysis was undertaken of recorded discussions of all meetings. The development of themes and priority issues through the discussion processes was relayed back to working groups as the project progressed, with a final discussion of the overall outcomes at the conclusion of the meetings program of working groups.

The strength of the outcomes of this project, and the quality and value of the recommended policy and practice improvements, is based on the equity of participation and contribution of each of the stakeholder groups in this significant health issue: those living with and supporting people with serious mental illness; experts in mental health treatment and services and primary care medical and health professionals.

This method and supporting evidence are discussed in detail in the accompanying Technical Report, Volumes 1 and 2 (Morgan et al., 2021).

## Implementable health policy

The project set out to develop proposals for change that are practical, feasible within current health service system infrastructure and designed on the basis of high-quality evidence. The recommended initiatives are designed to be readily understood, supported and capable of implementation by front line staff.

Health policy is the means to health system improvement. Health policy is defined by the [World Health Organisation](#), as decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society and, “defines a vision for the future; ...

outlines priorities and the expected roles of different groups; and it builds consensus and informs people.”

However, the successful implementation of policy initiatives are influenced by their context (Furst et al., 2019; Hudson et al., 2019) and particularly by contexts that are geographically, socioeconomically or culturally distinct from those of the majority of the population, notably rural environments (Perkins et al., 2019). This often means that, when government enacts new policy to achieve policy aims and, even when legislation shifts vital underpinning systems such as financing, it does not automatically follow that the policy will be implemented exactly as the government intends. Those working at the front lines are ultimately the determining element in the translation of the policy intention into changed practice and who, by their advocacy for the change, can most influence the opinions, experiences and outcomes of patients and communities (Gilson, 2016). This is the premise of the ‘bottom-up’ school of thought on policy implementation. Engagement of the ‘street level bureaucrat’ is vital in implementing public policy (Hudson 1993 cited in Hudson et al., 2019). This front line actor has “discretionary power that can prove instrumental in determining the success or failure of a policy” (Lipsky, 2010).

These ideas have shaped the method chosen to develop the *Being Equally Well Roadmap* proposals. This has involved the recognition that policy makers and managers operating at a remove from the point of healthcare delivery cannot succeed without having some grasp of what happens on, or close to, the front line. It is increasingly recognised that “the micro practices of power exercised by front line providers influence the experience and consequences of policy implementation, helping to explain the policy implementation gap, and represent a core element of health system complexity” (Gilson et al., 2014).

# THE DESTINATION

## Measures of success for consumers and carers

The goal of the *Roadmap* is to reduce high levels of avoidable physical illness and premature deaths amongst people with serious mental illness. The *Roadmap* is based on the evidence of what works to improve the physical health of people living with serious mental illness, and on the experiential and

professional knowledge of consumers, carers, and health professionals. It is the sum of the measures developed by experts who considered how each level of the health care system needs to be improved to support each of the other levels to do better. These measures are mapped against the destination described by consumers and carers – measures of success they agreed would meet the needs and aspirations of people living with serious mental illness.

### The *Roadmap* Destination: Measures of success for consumers and carers

Improved physical health	<ul style="list-style-type: none"> <li>• Good quality of life; able to keep on top of SMI; living long healthy lives</li> <li>• Can have physical health checks swiftly and effectively</li> <li>• Long term success will be reducing the life expectancy gap between people with SMI and the rest of the population to zero</li> </ul>
Management of medication impact	<ul style="list-style-type: none"> <li>• Recognition of harmful impacts of medications with other options prioritised</li> <li>• Health professionals understand the person first, not the diagnosis</li> <li>• When medications are necessary, health professionals and health services recognise any potential negative side effects</li> </ul>
Relationships with health professionals	<ul style="list-style-type: none"> <li>• Trusting relationships between individuals with SMI and treating practitioners, especially their GP</li> <li>• A relational recovery approach to address the impacts of trauma</li> <li>• Health professionals listening to, believing and acting on the physical health concerns of individuals with SMI</li> </ul>
System navigation, support/equity of access and care quality	<ul style="list-style-type: none"> <li>• Swift access to physical health checks and treatment</li> <li>• Support to navigate the system for both mental and physical health</li> <li>• Tailored motivational strategies for people with SMI to be physically healthy</li> </ul>
Peer support	<ul style="list-style-type: none"> <li>• Investment in peer support services</li> <li>• People with lived experience and carers are involved in quality and performance reviews</li> <li>• Consumer and carer led national service quality audits</li> </ul>

Table 1. The *Roadmap* destination: the perspective of consumers

## A consumer's experience

During my childhood and adolescence, I experienced severe trauma including sexual abuse and also spent two years in a children's hospital undergoing tests, operations and treatment.

I was constantly afraid and lonely as I was away from my rural home and family. I first considered suicide when I was 10. From the age of 14 I started hearing voices and feeling constantly afraid. I was able to hide the voices but not the depression. The GP put me on anti-depressants. They made me feel really unwell and lethargic. I was a long distance runner and committed to my fitness so I stopped taking the medication.

In my mid-thirties, after an extensive period of debilitating depression, I was diagnosed as having bipolar schizoaffective disorder. Within two months of being placed on lithium I had put on 22 kilos in weight and experienced continual tremors in my hands and legs. Over time my physical health declined but managing my mental health was given priority over my physical health. I had no say in this.

Blood tests indicated that the lithium was negatively impacting my thyroid, liver and kidneys along with increased disabling neurological effects. Over time I became pre-diabetic and struggled with continuous discomfort in my joints, feeling constantly exhausted, like I was walking through wet concrete and had a terrible feeling of heaviness and fog in my brain and behind my eyes. My memory and executive functioning were negatively impacted and I suffered from terrible insomnia.

In my mid 50s I moved to a rural area and my new GP expressed concern for my physical health and referred me to a general physician. After weeks of tests my physician concluded that my physical health had reached such a poor standard that he advised me that I should cease taking psychiatric medications. He gave an undertaking to support me through the process of weaning off lithium and staying out of hospital even if my mental health declined. I was fearful of becoming mentally unwell and we thought that might be likely but that I needed the opportunity to go through that stage.

The general physician worked with my GP and together they supported me to start using medical cannabis oil (CBD) to manage neurological symptoms that he and a professor of neurology considered

had been caused by the lithium. After 4 days on the medical cannabis, the severe tremors settled down. We hoped that stopping lithium may stop the unwanted neurological effects, however, this has not been the case. The neurological condition has symptoms similar to Parkinson's and Multiple Sclerosis and without CBD oil I am severely disabled by the tremors, with lack of control over my hands and eyes, difficulty swallowing and frequent falls. I weaned off lithium slowly over 6 months. About two months after lithium was ceased all together, my physical health began to improve. I started to feel better in my body and mind. I had more energy, less pain and my blood tests were returning positive results.

Now, three years after ceasing lithium I have also been able to stop taking other medications that were added over the years to manage unwanted side effects. My physician, GP and pharmacist have worked together and with me to do this. The physician suggests the changes in medication, writes to my GP who then monitors the effects through blood tests, blood pressure etc. He feeds this information to my physician; next step decisions are made. Improvement in my health enabled me to be more proactive with my physical health. I have been able to exercise again. I have lost 11 kilos. I am no longer pre-diabetic, my bad cholesterol has dropped from 9.4 to 5.4 and my doctors have indicated that my risk of heart disease has shifted from being in the high-risk range to now being at low risk. My mind and memory are clearer, my energy levels have increased, I am exercising every day and my relationships with the people I love have improved. I have been able to continue to work as an executive and an advocate and have started drawing and painting again.

I do still have times when my mental health feels a bit precarious but these times are short lived and I can manage this so much more easily than the continuously heavy and grey feelings I had while being treated with psychiatric medications.

Before these changes, my husband and I planned only for his older age; now we are making plans for our older age together and I am a contributing member of my family and community.

Isn't this physical and mental wellbeing what we all want?

# THE ROADMAP

The chart below describes what the proposed system of care will look like. It aggregates the recommendations of the working groups and is designed with the clear intention of measurably improving the physical health of people with severe mental illness and closing the life expectancy gap between this group and other Australians.

**None of the elements proposed are optional or unimportant. They are interdependent and need to be put into place together.**

## Roadmap components

### Resources for general practice

To improve the physical health of people living with serious mental health conditions, general practices would create a register to periodically recall people for health checks and reminders to participate in the national screening programs for breast, bowel cancer and cervical screening. The purpose of reminder and recall services would be to reduce deaths from cardiovascular disease, diabetes, lung and other preventable cancers.

Blood pressure, cholesterol and smoking are multiplicatively (accumulating) related risk factors for

cardiovascular disease and account for about 70% of prevalence (Jousilahti et al., 2016; Milne et al., 2003). GPs can use absolute cardiovascular risk charts to predict the 5 year risk of a cardiovascular event based on gender, presence of diabetes or not, blood pressure, cholesterol, and smoking.

Individuals at high risk can be supported to take action to reduce cholesterol levels by reducing fat intake, saturated fat intake and increasing fibre, and to reduce high blood pressure by reducing alcohol and salt intake. For others, medicines in current use are safe and effective. Use of the charts facilitates prescribing of statins to reduce cholesterol and antihypertensive medication in addition to lifestyle improvement.

General practice will need additional resources and capability to ensure best practice, evidence-informed and quality assured support for people living with serious mental illness. The recommended enhancements for general practice are:

**Practice-based registers:** GP practice registers of people with serious mental illnesses should be established that would enable automated recall and alert arrangements to actively engage and support people to participate in screening and monitoring investigations and health checks.

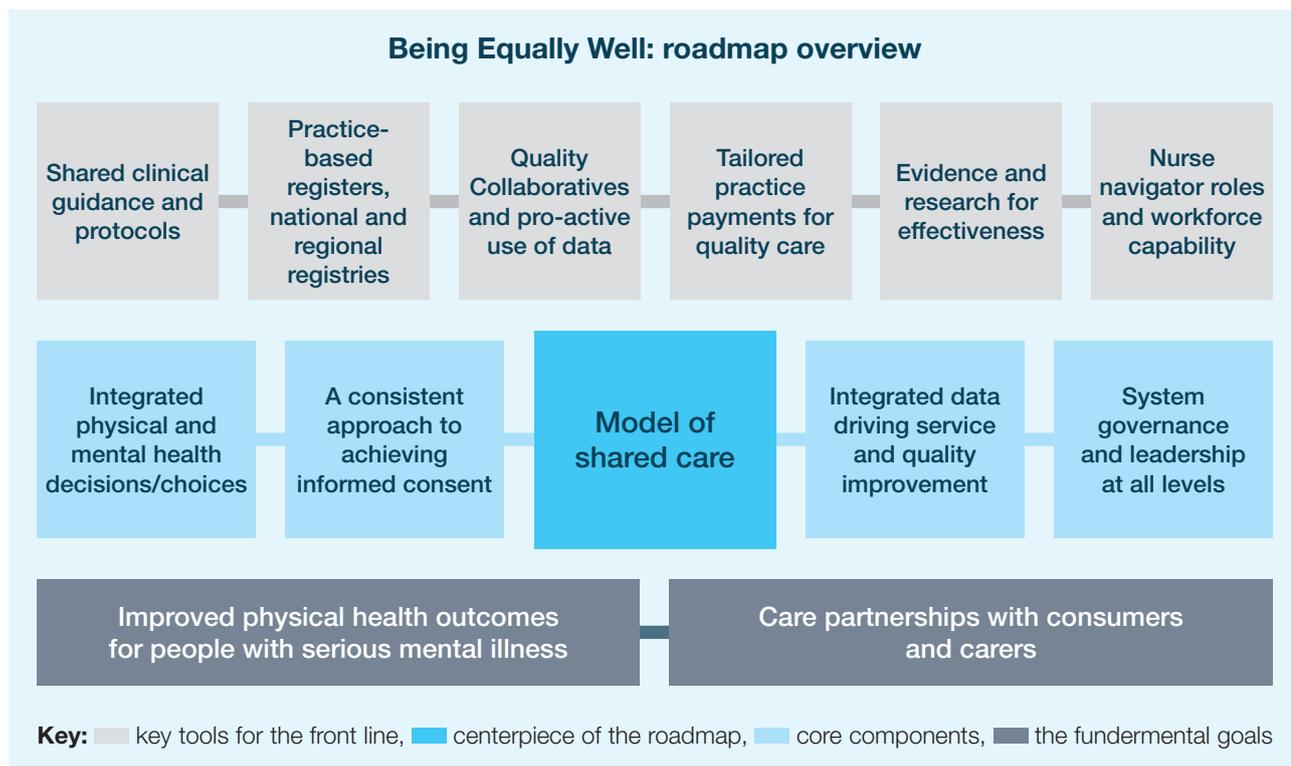


Figure 3. Being Equally Well Roadmap

**Nurse navigators in general practice:** Establishment of a community mental health nurse workforce (Nurse Navigators) embedded in GP clinics to support the health care needs of people with complex biopsychosocial needs is proposed. The focus of this role would be on care navigation, management, lifestyle coaching and engagement with carer, community and peer supports. This new workforce would assist consumers in navigating a complex and fragmented health system across different levels of healthcare and would work with consumers and carers to empower them in managing their own health conditions (Freund, 2017). The Nurse Navigator system that has been successfully implemented in the Gold Coast Integrated Care Program could serve as a blueprint for wider implementation across the country (McMurray et al., 2018; Spooner et al., 2019).

**Peer support:** Consumers and carers urge the establishment of a peer worker role within general practice on the basis of established recognition of the role of peer workers in mental health care and service navigation, to support consumers to engage in their health care. Clinical systems working groups support research into the role of peer support for physical health improvement.

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‘Because of Peer Health Coaching, I have definitely got into more of small goals where I will go for a walk’

Neami Active8 Peer Coaching participant

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‘You came to me, you helped me start out walking more, gave me the confidence to build up to getting more and more walking, it was really great’

Neami Active8 Peer Coaching participant

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**Clinical information and support:** Routinely collected clinical information and computer decision support should be optimised within general practice and through aggregation and feedback of anonymised patient data by PHNs inform and achieve quality improvement towards equitable physical health for patients with serious mental illness.

## Local area integration and support: the roles of Primary Health Networks (PHNs) and Local Health and Hospital Networks/Districts (LHN/Ds)

The Equally Well National Consensus Statement 2016 (National Mental Health Commission, 2016) provides guidance to health service organisations on what is required to provide health care that is safe, collaborative and effective in recognizing and responding to the health needs of people with serious mental illness. Subsequently, the Fifth National Mental Health and Suicide Prevention Plan (Commonwealth of Australia, 2017) cited the Consensus statement as strong guidance for how governments “can work together to better address the physical health of people living with mental illness”.

The Plan states that:

*‘systems are needed to measure continuity of care between primary care and specialist services, the quality of physical health care for people with severe and complex mental illness, and experiences of stigma or discrimination in general health settings. Better information is needed on the full range of clinical and community supports which underpin a connected and contributing life. New data collections established by PHNs and the NDIS may allow development of additional indicators on these issues, and priority will be given to ensuring that these collections align with existing state and territory data collections.’*

**Establishment of live local area data sharing platforms** is recommended to improve communication and enhance shared-care arrangements between different components of the service system that can enhance or inhibit the achievement of improved shared care.

PHNs could facilitate the coordination, rollout and maintenance of such a platform. Practice-based registers (of consumers) with serious mental illnesses should be established that would enable an automated recall and alert system for general practice to improve the regular uptake of screening and monitoring investigations and health checks.

Some process measures are reported to PHNs by practices. These measures should be the basis for quality improvement coordinated by PHNs. PHN performance data should be shared in a transparent manner with all stakeholders to improve clinical performance, to quantify the significant variation in performance between PHNs and to enable targeted support and funding to reduce these disparities.

This will be a step toward better utilising the currently existing PHN framework to achieve better physical health outcomes for people living with serious mental illness. Transparency of performance metrics can ensure that funding is appropriately utilised and that services commissioned remain cost effective.

## A purposeful system of shared and coordinated care

‘Implementing a model of shared care is a critical step to overcome barriers to consumers accessing and receiving appropriate care for their physical health. At a minimum, it would include clear channels of communication between health providers and, ideally, would include structured multidisciplinary care’

(Firth et al., 2019).

Shared and coordinated care are both important components of the *Roadmap*. All groups see this as an essential improvement if the goal to reduce premature mortality and improve physical health is to be achieved.

The recommended service model would expand and enhance the approach already in place for some people receiving treatment for serious mental illness. This was described by the Macro-system group as follows:

*‘To improve coordination between different levels of health care and allocate appropriate responsibility, the enhanced care coordination provided to people taking antipsychotic medication should be scaled up and implemented for all people with SMI. This model involves the health system taking responsibility for proactive physical health monitoring, multidisciplinary coordination of care, facilitating attendance to physical health checks, and ensuring care plans are followed through. Primary care is an appropriate setting from which to implement a coordinated approach to care as it is the key access point to the health service system for the majority of people with a mental health condition (Mai et al., 2010). A key element would be coordination between primary care and other health providers, including specialist public mental health services, the private sector, allied health professionals, and non-government organisations. This model of care should appropriately acknowledge that people with SMI may access both public and private care, and that physical health care should be coordinated across these sectors.*

*To achieve this objective, changes are required to enhance the effectiveness of:*

- *funding arrangements to compensate and incentivise shared care*
- *service models to structure and support the delivery of shared care*
- *national and state governance arrangements of health service provision; and*
- *training to establish a workforce equipped to meet this need.’*

## Clinical guidelines

Clinical guidelines are statements based on systematic reviews of the evidence to assist clinicians and patients make decisions about appropriate health care for specific clinical circumstances. Protocols are the local implementation of guidelines. Guidelines currently exist for the risk factors and for medicines used in treatment, particularly antipsychotics, but are not coordinated between psychiatrists and GPs.

The development of intercollegiate care guidelines would lead to a protocol for shared care of those on medication for serious mental illness including antipsychotic medication and monitoring of cardiometabolic risk factors. Development of these guidelines would be led by the Royal Australian College of General Practitioners and the Royal Australian & New Zealand College of Psychiatrists.

A shared care protocol for the prescribing of antipsychotic medications is proposed, to enable the person with serious mental illness, their GP and psychiatrist to better monitor any side effects of antipsychotic medication. Implementation of shared care guidelines requires funding support through the Medicare Benefits Schedule for shared care including asynchronous case conferences. Consumers and carers consider this should be extended to other mental health medications.

An existing guideline, the NSW Health Education and Training Institute Positive Cardiometabolic Health algorithm (Curtis, 2014), which has been adapted in the UK to support collaborative care by general practitioners and psychiatrists, will be updated through funding from the NSW Mental Health Commission to the *Mindgardens Neuroscience Network* for the project: *Keeping the Body in Mind: Physical Health Clinician Resource package*. This project could inform and support the development of shared joint guidelines for Australian implementation.

# MAKING IT WORK: THE INFRASTRUCTURE

## System-wide continuous improvement

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This will achieve the change of the whole system and not just some, probably uneven, changes within a system.

The system-wide changes proposed at the front line of care by the *Roadmap* must be supported by system-wide efforts towards quality improvement. This is to integrate continuous improvement into daily clinical practice and professional development (Batalden, 2018). Current thinking about quality has evolved to recognise the importance of co-producing improvement with patients, acknowledging that the 'health' that requires improvement 'belongs' to the consumer and not the clinician. Batalden (2018) suggests that this inclusive form of quality improvement requires:

- *Patient/consumer participation and engagement*
- *Continuous, systematic learning for professionals and consumers*
- *Professional development* – drawing on several analytical frames including science informed practice, recognition of the experiences of individuals, and knowledge that integrates good design principles and daily practice.
- *Assessment and measurement* – measuring the process and results of a co-produced service requires attention to the patient's goals as well as the effectiveness of the professionals' interventions and practice. Good measurement becomes a means to create new knowledge about service development.

The recommendations developed by working groups are intended to underpin the daily activities of the front line services in interaction with consumers and carers with mechanisms for driving sustainable, continuous improvement through the whole system. This will achieve the change of the whole system and not just some, probably uneven, changes within a system.

The proposals, summarised below, are discussed in detail in the accompanying technical report.

## National Mental Health Clinical Quality Registry (NMHCQR)

*Clinical quality registries* gather and analyse statistical information to monitor and enhance the quality of care received by patients. There is strong evidence that electronic clinical registries have the potential to achieve both more effective and more affordable health care. In the longer term, this has the potential to decrease the health discrepancies between different population groups.

Clinical quality registries have a long history of improving the quality of care and reducing the costs of healthcare. For instance, the Australia and New Zealand Dialysis and Transplantation Registry (ANZDATA) between 2004 and 2014 achieved the following improvements:

- 15% reduction in the dialysis mortality rate (1156 fewer deaths)
- 39% reduction in transplant graft loss rate (606 fewer transplant grafts lost)
- 40% reduction in peritonitis rates (2573 fewer infections).

The return on investment was \$7 for every dollar spent.

The main purpose of the proposed National Mental Health Clinical Quality Registry (NMHCQR) is to measure national progress towards parity in life expectancy for people with serious mental illness.

*Practice registers* should be used for recalling patients, prompting better care of physical health, and evaluating progress towards equitable physical health. This makes best use of measures already recorded as part of Practice Incentives Program Quality Improvement (PIP QI). Systems based on register and recall with risks managed according to guidelines and protocols have been demonstrated to be the greatest contributors to reductions in health inequities at the population level. It is the system which drives towards parity of outcomes for SES, ethnicity, gender and specific medical conditions. For instance, in the UK this approach has resulted in near parity of diabetes outcomes for people with serious mental illness. Nurse navigators will assist people to overcome barriers to care.

**System-level registries**, state or commonwealth (Clinical Quality Registries); based initially on models currently in use, will record morbidity and mortality to allow monitoring of progress towards equity of outcomes for people with serious mental illness. The registered data (individuals, measures, including patient-reported measures and social determinants) should be practice/service or system-specific.

The value of Clinical Quality Registries in improving health and reducing costs has been acknowledged in the national consultation on proposals to establish a national strategy to maximise the potential of Australian Clinical Quality Registries to improve the outcomes of health services (Commonwealth of Australia, 2019).

**The Australian Commission on Safety and Quality in Healthcare (ACSQHC)**, in line with the National Strategy referred to above, is recommended as the national agency that should establish an expert working group of clinicians and consumers to design the NMHCQR.

**A multi-level, continuous reviewing process** is also proposed and discussed below. Data at PHN level would be made available to the NMHCQR, and state or territory review groups so that progress with intermediate outcome measures is known relatively quickly e.g. blood pressure, smoking, cholesterol, HbA1c blood tests. The data from PHNs will provide an overall measure of how well the system is performing.

## Collaboratives for quality of care

### **Establishment of quality improvement**

**Collaboratives** is proposed to support rapid and comprehensive implementation of existing clinical guidelines which are based on systematic reviews of the evidence. A quality improvement Collaborative is an organised, multifaceted approach that includes teams from multiple healthcare sites coming together to learn, apply and share improvement methods, ideas, and data on service performance for a given healthcare topic (Wells et al., 2018). It is the fastest way to get evidence into practice. There have been thousands of Collaboratives conducted around the world. The Collaboratives follow the approach described by Batalden (2018) providing practical, comparative and applied learning which, evidence suggests, generates measurable results quickly.

The Australian Primary Care Collaboratives initiative was launched in 2004. Over the 10 years of its existence, Australian Primary Care Collaboratives (APCC) addressed diabetes, coronary heart disease, access, chronic obstructive pulmonary disease, patient self-management, Aboriginal health and diabetes prevention. The Collaborative accelerated the rollout of absolute cardiovascular risk assessment. Between 2005-2011 1,185 health services participated in Collaboratives, 83% of Australian divisions of general practice participated and 262 support staff received quality improvement training. Key measures showed improvement in all topics except access (Knight et al., 2012).

Collaboratives have also been shown to improve outreach to marginalised or 'hard to reach' groups. The working groups have agreed that there is a need to adapt primary care services to respond to the complex needs of people living with serious mental illness and physical health comorbidities and a collaborative approach has been agreed as the most effective approach. Collaborative topics for general practice, mental health services or both could include better management of medications, smoking cessation, operationalising the recommended shared care guidelines, optimising the role of practice-based nurse navigators or addressing local or regional access and outcome disparities for this group. The Queensland Mental Health Clinical Collaborative has supported a successful smoking cessation statewide program in mental health services (Pleaver et al., 2020).

The Collaboratives would provide regular feedback to the ASQHC as part of the NMHCQR reviewing process.

A detailed account of how Collaboratives will work is provided in the Technical Report.

## Supporting success – funding quality of care

**Current PIP QI data returned by general practice to PHNs** in aggregated, anonymised form is recommended as the measures of impact and outcomes. Whilst this is recommended as a means of making best use of existing data arrangements, there are disadvantages. Firstly, there is no subsequent quality improvement activity. Secondly, the PIP QI measures are inadequate for determining at the population level the contribution of improved risk factors to the predicted main causes of death in people with serious mental illness.

**Payment for a new SMI Health Check for people with serious mental illness, Item 705, is proposed.**

This will link remuneration with care tailored to improve the risk factors contributing to poor physical health. The necessary tool for recall and measurement of clinical outcomes is the **practice register of people with serious mental illness**.

The following measures are proposed and all would be necessary to obtain payment (with exception reporting for consumer decisions to opt out or other relevant circumstance).

- number of people with SMI on the register
- number of cardiovascular risk assessments (aCVR) completed
- number of diabetes risk scores completed
- absolute measures of cholesterol, blood pressure, HbA1c and smoking rates needed to calculate predicted changes in CVD and diabetes consequences – for national reporting, the Framingham and UK Prospective Diabetes Study (UKPDS) equations can be used to predict changes in CVD and diabetes events and costs

- number on the register prescribed statins
- number on the register prescribed antihypertensive medication
- number on the register prescribed metformin
- number on the register with smoking recorded and number of non-smokers
- number with BMI recorded and number with normal BMI
- number on antipsychotic medication.

**A second health check is proposed** to cover the shared care of people initiated on antipsychotic medication (with exception reporting as above).

The health checks proposed in Table 2 are for consideration in the development of the intercollegiate shared care guidelines.

**A Medicare Benefits Schedule (MBS) Item Number for asynchronous case conferencing** is the third recommendation to ensure that shared care is structurally enabled and promoted.

Health checks	Baseline	12 weeks	Annually
History/Family History	X		X
Lifestyle risk factors: diet, physical activity, smoking, alcohol and other drugs	X	X	X
Weight	X	X	X
HbA1c or fasting glucose	X	X	X
Lipids	X	X	X
Blood Pressure	X	X	X
Prolactin	X	X	X
ECG	X	X	X
Use of statins and antihypertensives where absolute cardiovascular risk is high (after adjusting for additional SMI risks).		X	X
Metformin use where metabolic risks and weight gain cannot be controlled by lifestyle interventions and adjustment of antipsychotics		X	X
Shared care protocol reviewed by psychiatrist		X	X

Table 2. Recommended potential health checks for people commenced on antipsychotic medication

## Research and evaluation

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Achieving parity of opportunity for better physical health and longer lives among people living with serious mental illness needs the best evidence for health care system improvements.

***Progress to parity should be considered as a priority area for research funded by the Medical Research Future Fund.***

Project expert working groups identified the following issues and questions for research and evaluation as gaps in the current evidence:

- Evidence of the most effective and cost effective prevention of anti-psychotic induced weight gain and metabolic syndrome in people with serious mental illness, including the use of Metformin.
- Evidence for metabolically safer psychiatric medications and mechanisms to reduce metabolic side effects.
- Optimal effectiveness of peer workers in supporting people with a serious mental illness to improve their physical health.
- The impact over time of the clinical registries, Collaboratives and the annual morbidity and mortality reporting.
- What interventions, and strategies such as social prescribing, work effectively and cost effectively to improve diet and physical activity in people with serious mental illness?
- What are the effective mechanisms to enhance co-operation and integration across state, federal and private systems, including the NGO sector?
- What is the cost-effectiveness of mechanisms to improve service coordination?

## Workforce development

The clinical workforce is the critical lever in implementing the *Roadmap* and achieving its goals. There are issues of both supply and capability that need to be considered. The additional workforce role of nurse navigators within primary care practices and/or supported through PHNs is considered essential and engagement of the available primary level health workforce, including pharmacists and allied health professionals, is strongly recommended. Funding support for these positions and services is a national health funding responsibility. Measures are also required to ensure the current workforce has the capability to contribute to the development of shared care and to deliver the outcomes of better physical health care, improved physical health and longer lives for people with serious mental illness. Protected time for QI activities needs to be funded, particularly for self-employed medical and other practitioners, as occurred for the Australian Primary Care Collaboratives (APCC) program.

### ***Workforce Supply***

The current and projected nationwide skills shortage in the mental health sector is a significant impediment to the effective implementation of ***Being Equally Well***. The skills shortage includes:

- the long-standing undersupply of mental health professionals in all key disciplines, particularly in remote and rural locations
- a pressing need to update knowledge, culture, and practice in the mental health workforce to work within the new shared care system.

***The establishment of the role of nurse navigators*** was seen by the working groups as an essential role that is ‘vine binding and connecting together the otherwise siloed trees’ of health services and is a key component of the *Roadmap*. In a context of national nursing shortages, which is predicted to be 18,500 nurses short by 2030, these new nursing roles need to be defined, scoped, and made attractive to potential recruits and with care to avoid cannibalising other health care sectors.

***Peer worker support*** in primary care to provide consumers with support with their physical health needs and care and with their connections to health services and professionals are strongly recommended by consumers and carers. Research to support the optimal development of this role is recommended.

**The allied health workforce** already provides health care services to support people with serious mental illness, but those services are limited in availability and access and are not utilised to the full extent of their capability. Coordination between primary care and other health providers needs to include pharmacists, allied health professionals and non-government organisations.

**Pharmacists** are generally more accessible compared with other health services (Brewster et al., 2020; Zonneveld et al., 2021) and are trusted as experts in medicines management. There is increasing recognition of the potential to expand their role in the prevention and management of chronic diseases (Desse et al., 2021; Mc Namara et al., 2019). Pharmacists could support improved medicines adherence and cardiometabolic risk monitoring in appropriate circumstances. The Royal Australian College of General Practice (RACGP), the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Society of Hospital Pharmacists of Australia and the Pharmaceutical Society of Australia should work together to lead the development of a joint position statement defining such a role supporting people with SMI and how it should be implemented in practice. MedsChecks, Diabetes MedsChecks and Home Medicine Review programs could provide funding support for this component of shared care.

**Dieticians, physiotherapists, exercise physiologists, social workers and psychologists** have significant contributions to make to supporting physical and mental health. The allied health workforce is located in all parts of the microsystem, however is largely in the private sector and access is limited or not possible for people with limited financial resources. Access to most allied health services incurs out-of-pocket costs, except for some limited access through a GP Management Plan.

Dieticians have a major role in managing metabolic syndrome. Compared with the general population, people living with a serious mental health condition have a significantly increased risk of developing metabolic syndrome – a combination of obesity, high blood pressure, dyslipidaemia, (blood lipid levels that are too high or low, contributory factors for CVD) and hyperglycaemia (an excess of glucose in the bloodstream, often associated with diabetes mellitus). This cluster of risk factors has been associated with

the prevalence of cardiovascular disease (CVD) and premature mortality in people with serious mental health conditions. For people living with SMI, dietary modifications are an effective and safe approach to manage comorbid physical conditions, including the metabolic syndrome.

The Mediterranean diet has been shown to protect against cardiovascular disease, diabetes and Metabolic Syndrome. There is evidence that it can ameliorate depressed mood (Dinu et al., 2020; Jacka et al., 2017).

#### The Mediterranean diet is:

- High in vegetables, fruits, legumes, nuts, beans, cereals, grains, fish
- Unsaturated fats such as olive oil
- Low intake of meat and dairy foods

**Social prescribing** should be considered as a means to assist consumer access to local non-clinical and non-government organisation support services. Social prescribing has been supported by the RACGP and the Consumers Health Forum (The Royal Australian College of General Practitioners and Consumers Health Forum of Australia, 2020) as a means to provide adequate and appropriate access to local non-clinical services for people affected by socioeconomic disadvantage and particularly for people experiencing mental health issues and those with chronic physical health conditions and multimorbidity. In a joint report, the benefits of social prescribing are described as wide-ranging and include health, economic, social and productivity gains, with the ultimate benefit being improved health and wellbeing for individuals and communities. The role of a 'link' worker to support individuals with access to local supports is central to social prescribing. There are parallels between the link worker and the peer support role which could be considered when considering role defining and allocation.

### **Workforce capabilities**

The development of new staff roles, such as nurse navigators and peer support workers are not sufficient to achieve the *Roadmap* goals by themselves. The drive to reorientate the system requires the development of capabilities for everyone who works in it.

#### **Continuing Professional Development programs**

of all relevant health professional bodies, commencing with the RACGP and the RANZCP, should be supported to incorporate education and training in shared care in accordance with the proposed shared care guidelines.

#### **The National Mental Health Workforce Strategy**

(Commonwealth of Australia, 2020) which is currently under development through a Strategy Taskforce should give consideration to implementation requirements for the Being Equally Well workforce roles and development priorities.

#### **Medical and other health professional education and training**

will need to provide a common foundation in integrated mental and physical health and in shared care principles and practice.

**The role of NGOs** was acknowledged by working groups. Individual clinicians and support workers employed by NGOs are actively engaged in health promotion and practically assist consumers in attending appointments and undergoing investigations needed for the screening, assessment, intervention and monitoring of physical health issues. Peer support and social prescribing link worker roles are also relevant for access to local community supports.

## **National advocacy campaign: equal mental and physical health**

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*Achieving the Roadmap goals requires a serious and sustained attempt to tackle stigma.*

Discriminatory and stigmatising attitudes amongst health care staff in a range of settings may inhibit help-seeking by people with mental illnesses and associated physical health needs (De Hert et al., 2011). Inequalities in access to and outcomes of health care are evident in relation to general medicine and cardiovascular care but may also be present in cancer and diabetes care (Mitchell et al., 2012). The Royal Australian College of Emergency Medicine (ACEM) has published the findings of recent research demonstrating that whilst mental health presentations account for only around 4% of presentations in hospital emergency departments, this cohort disproportionately experiences delayed or blocked access to necessary treatment compared with patients presenting with other emergency conditions (Australian College of Emergency Medicine, 2018).

**A national advocacy campaign** is recommended as a necessary step to increase awareness of the poor physical health of people with a mental illness and will challenge stigma. The campaign should target different population groups, including the general population, people with a serious mental illness and health professionals. Co-development is essential, seeking input from all key stakeholders including consumers, carers and health professionals to develop the content of the campaign with a focus on a broad approach to maximise reach. The content should be tailored appropriately for each audience, for instance, encouraging access to physical health care for people with SMI, promoting equal value of mental and physical health care for health professionals, and reduction of stigma for the public. The overarching message should be one of 'parity of esteem': equal value of mental and physical health.

## Measuring quality, monitoring progress to sustain improvement

Governance and support will be required to ensure that the components of the *Roadmap* at micro-, meso- and macro-levels are welded together into a coherent national mechanism for quality-driven health care and improvement.

**An annual national report to the Australian Health Council** (of Health Ministers) is recommended to provide essential central leadership and accountability for better health and longer lives for people with serious mental illness.

**A national Office for Quality in Physical and Mental Healthcare Outcomes** is recommended. This is considered best placed within the Australian Commission for Safety and Quality in Healthcare (ACSQHC). The office should comprise two sections: the first section would establish a National Mental Health Clinical Quality Registry (NMHCQR) and the

second section would establish and support Quality Improvement Collaboratives for mental health services and primary care.

These recommended arrangements are illustrated in the Chart below.

The Office would feedback benchmarked, anonymised reports showing performance in improving the risk factors. The purpose of these reports would be for practices to learn and improve. PHNs should be resourced to identify high performing practices and set up Communities of Practice in which GPs as a peer group could learn from each other and with mental health teams. This activity would parallel the Collaboratives. The working groups consider that this would, within a few years, translate into improved life expectancy.

**State and territory outcome review groups** should be established in conjunction with state and territory mental health services and should also have access to the measures from PHNs and from the Collaboratives to monitor and support the continuous improvement in shared health care by mental health services and general practices.

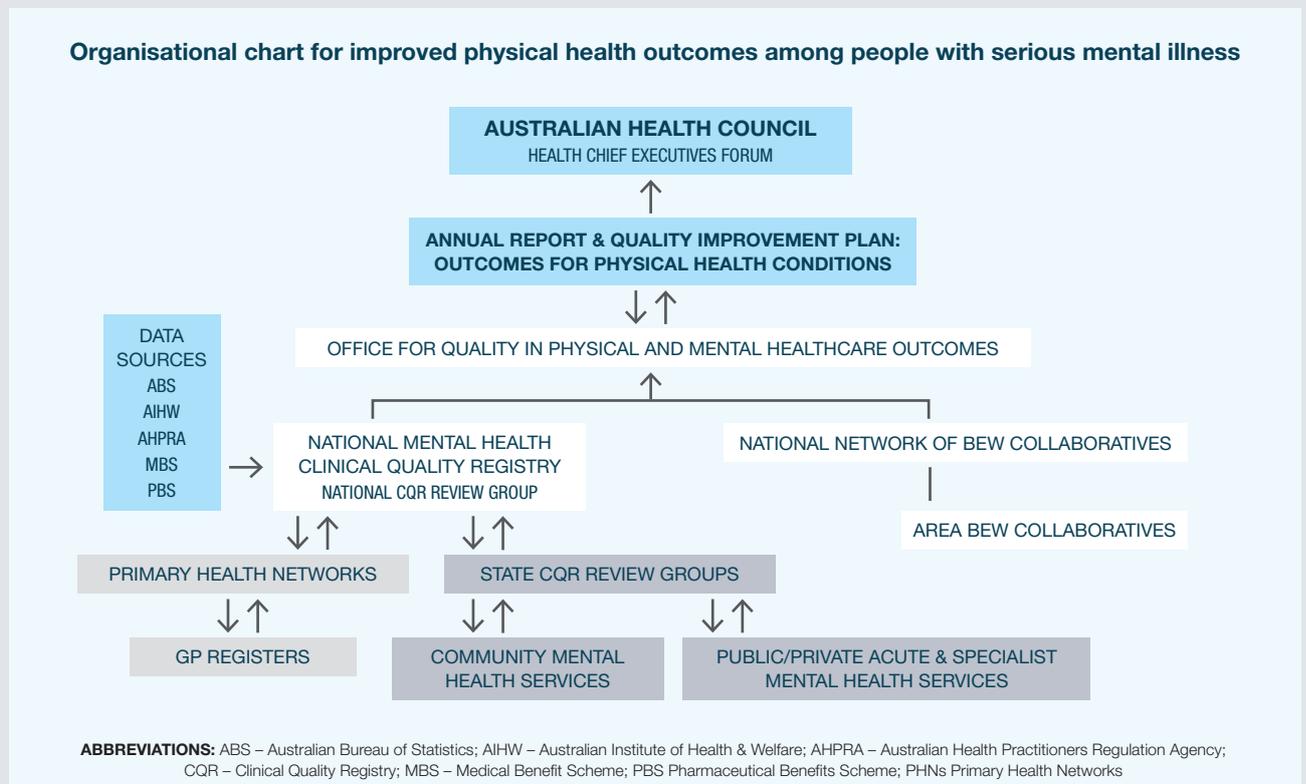


Figure 4. System supports to improve physical health outcomes for people living with serious mental illness

# NEXT STEPS

**This *Roadmap* represents the work of more than 60 individual professional and lived experience experts over a period of almost 12 months.**

It draws from their professional and personal experience, concerns and frustrations and has been designed to provide practical, feasible, affordable, evidence-based and person-centred strategies for easy and ready implementation by those with the power to do so. The recommended system improvements and health care improvements are evidence-based, feasible, affordable and practical.

The implementation strategies that have been identified as central to the successful implementation of better physical health care for people living with serious mental illness are:

- The RACGP and RANZCP to collaborate on a plan for the development of shared care guidelines for serious mental illness
- The RANZCP, RACGP, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia to collaborate on a plan for the development of the role of pharmacists in shared care and medication support for serious mental illness
- The RACGP, the RANZCP, the Royal Australian College of Nursing and the Australian College of Mental Health Nurses to collaborate on a plan for the development of the role of nurse navigators in shared care for serious mental illness

With recommended funding support for:

- Provision of MBS funding including modified PIP QI, shared care and asynchronous case conferences.
- PHN capacity to obtain performance data to improve clinical performance, to quantify the significant variation in performance between PHNs and to enable targeted support and funding to reduce these disparities.

- Resourcing of nurse navigator positions for general practice
- Retooling of MedsChecks, Diabetes MedsChecks and Home Medicine Review programs to fund the role of pharmacists in providing support for improved medicines adherence and cardiometabolic risk monitoring in appropriate circumstances.
- Establishment and ongoing funding of a National Mental Health Clinical Quality Registry and of the provision of an annual report to the Australian Health Council
- Establishment and ongoing funding of a national Office for Quality in Physical and Mental Healthcare Outcomes within the Australian Commission for Safety and Quality in Healthcare. (ACSQHC).

The first step to success will be the acceptance of this suite of recommendations by relevant stakeholders, governments and government agencies, medical and health professional organisations. This work has been undertaken with deep commitment to achieving feasible, practical implementable improvement – that can only come with commitment to these recommendations and systematic implementation of them.

To support the first steps, the Mitchell Institute and Equally Well Australia will work with stakeholder organisations and leaders to plan and host a roundtable on an implementation strategy for this *Roadmap*.

## The Roadmap in detail

### 1. Development of national clinical guidelines for shared care should be:

- a. endorsed by the Australian Health Council and resourced by government
- b. developed and disseminated jointly by the Royal Australian College of General Practitioners and the Royal Australian & New Zealand College of Psychiatrists with parity of consumer and carer participation and in collaboration with state and territory mental health services and the development of the NSW Physical Health Clinician Resource package by Mindgardens Neuroscience Network, NSW
- c. maintained with funding support through regular evidence review and updating, consistent with the Living Guidelines model
- d. disseminated through state and territory mental health services and through private mental health services, PHNs and professional organisations and non-government organisations
- e. standards for physical health care of people with serious mental illness would be developed based on the evidence underpinning the national clinical guidelines.

### 2. Funding for tailored and shared care service provision to be provided through:

- a. expanded Health Assessment item number and eligibility criteria for SMI populations to be developed by the Medical Services Advisory Committee (MSAC) to the Australian Government Department of Health
- b. case conferencing item numbers to recognise asynchronous care coordination for people with serious mental illness to be further developed by MSAC.

### 3. Removal of financial barriers for medication such as gap payments for cardiovascular risk reduction medication including metformin, and for nicotine replacement therapy, similar to provisions under the Closing the Gap strategy.

### 4. Establishment of a National Network of Quality Improvement Collaboratives through funding support for:

- a. an expert working group to define outcome indicators
- b. establishment and ongoing operation of a National Collaboratives Network entity to support development and activity of local Being Equally Well collaboratives aligned with PHNs
- c. Being Equally Well Collaborative activity cycles (waves) to support learning between participating practices, address quality improvement priorities and support implementation of protocols by early adopters.

### 5. Quality improvement monitoring and reporting to be achieved by:

- a. establishment of a National Mental Health Clinical Quality Registry:
  - i. endorsed and supported by the Australian Health Council and funded by government
  - ii. with support of the Australian Commission on Safety and Quality in Health Care.
- b. the Australian Commission on Safety and Quality in Health Care and the Australian Institute of Health and Welfare working with an expert working group to design and implement the National Mental Health Clinical Quality Registry to enable accurate and timely reporting on the gap in physical risk factor management, hospitalisation and mortality for people with serious mental illness compared to population norms.
- c. public reporting to the Australian Health Council annually.
- d. the Australian Commission on Safety and Quality in Health Care and the Australian Institute of Health and Welfare to work with the Practice Incentive Program Advisory Group to design and collect regional and national primary care data on physical risk factors and preventative health processes for SMI populations.

## The Roadmap in detail

### **6. Workforce roles and development through:**

- a. establishment of and funding support for working group to develop role descriptor and core competencies for nurse navigators
- b. government funding for first 20 nurse navigators by end 2022 with commitment for staged increase to a minimum national benchmark capacity (such as one full time position per 20 GPs)
- c. investment in research to inform optimal use of peer support workers in primary health care.

### **7. Establishment of Medical Research Future Fund recurrent funding rounds supporting research into health system design and delivery for people living with serious mental illness. Priority areas for research include:**

- a. optimal use of peer support workers
- b. evidence of the most effective and cost effective prevention and treatment of anti-psychotic induced weight gain and metabolic syndrome in people with serious mental illness, including the use of Metformin
- c. evidence for metabolically safer psychiatric medications and mechanisms to reduce metabolic side effects
- d. interventions, and strategies such as social prescribing, that work effectively and cost effectively to improve diet and physical activity in people with serious mental illness
- e. further research should include:
  - i. The impact over time of the clinical registries, Collaboratives and the annual morbidity and mortality reporting
  - ii. What are effective mechanisms to enhance co-operation and integration across state, federal and private systems, including the NGO sector
  - iii. What is the cost-effectiveness of mechanisms to improve service integration.

**8. Funding for development and implementation of a national advocacy campaign, for a sustained period of time, to promote awareness of the poor physical health for people with a serious mental illness and address stigma.**

**9. Education and training requirements for health professionals to be addressed through funding support for the development and dissemination of targeted education materials informed by the National Shared Care Guidelines, through the relevant professional colleges such as the RACGP, RANZCP, Pharmaceutical Society of Australia, the Royal College of Nursing, and others.**

# GLOSSARY OF TERMS

**aCVR:** absolute Cardio Vascular Risk assessment.

**APCC:** Australian Primary Care Collaboratives run by Improvement Foundation Australia 2004-2014.

**HbA1c:** a blood test used to help diagnose and monitor people with diabetes.

**CVD:** cardiovascular disease.

**Chronic physical diseases:** Chronic physical diseases (also referred to as non-communicable diseases or long-term conditions) include a range of conditions that are non-infectious, long-lasting, and diminish health status due to disease symptoms, functional impairment and disability, and can reduce healthy life expectancy and cause premature deaths.

**Clinical Quality Registry (CQR):** are datasets that draw from existing health care data sources and platforms and are designed to report timely, actionable and risk-adjusted benchmarked data back to clinicians, health providers and other stakeholders for the purposes of quality improvement.

## **Clinical microsystems:**

Clinical Microsystems are the small, functional front line units that provide most healthcare to most people. For this project they are described as follows:

- Micro-system: the teams at the front lines of care where patients and their families meet the health system. These teams include General Practice, acute and community mental health services
- Meso-system: Primary Health Networks (PHNs), Local Health Networks/Districts (LHN/Ds), professional and industrial bodies
- Macro-system: federal, state and territory governments; NMHC, AHMAC, private health insurance

**General Practice Registers:** are a dedicated register and recall system for people with specific health conditions needing ongoing monitoring and support.

**Local Health Networks/Districts (LHN/Ds):** are independent organisations that directly manage groups of public hospital services and their budgets and are directly responsible for hospital performance (Australian Institute of Health Welfare, 2021).

**Medicare Benefits Schedule (MBS):** MBS is a listing of the Medicare services (subsidised treatment) by health professionals, such as doctors, specialists, optometrists and, in specific circumstances, dentists and other allied health professionals).

**Mental and physical comorbidity:** Is defined by the presence of at least one diagnosed mental health condition and one or more physical health conditions.

**Multimorbidity/comorbidity:** Multimorbidities are a growing concern worldwide, driven by population ageing and improvement of public health leading to lower mortality rates (United Nations, 2017). Multimorbidity is commonly defined as the presence of two or more chronic medical conditions in an individual (Fortin et al., 2007). However, multimorbidity has no single definition and is often given other names, including comorbidity and multiple morbidity. For the purpose of this paper, multimorbidity and comorbidity are used interchangeably.

**Pharmaceutical Benefits Schedule (PBS):** PBS is a list of medicines subsidised by the Australian Government.

**Primary Health Networks (PHNs):** 31 PHNs are independent primary health care organisations throughout Australia that commission services and support to primary health care and general practice (Commonwealth of Australia, 2018).

**Primary Care Practices:** principally general practices that are the entry point into the health care system that include care by general practitioners and can include nursing care, allied health care, midwifery, pharmacy, dental and Aboriginal health care (Commonwealth of Australia, 2018).

**Serious/severe mental illness (SMI):** the term serious mental illness and serious mental health conditions are predominantly used in this paper. Severe mental illness is the term used in some working group reports and whenever the reported discussion is drawn from a referenced report or publication. The project working definition of serious mental illness has included conditions requiring antipsychotic therapy, those requiring shared care provided between psychiatrists and GPs and thought disorder conditions rather than neuroses.

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