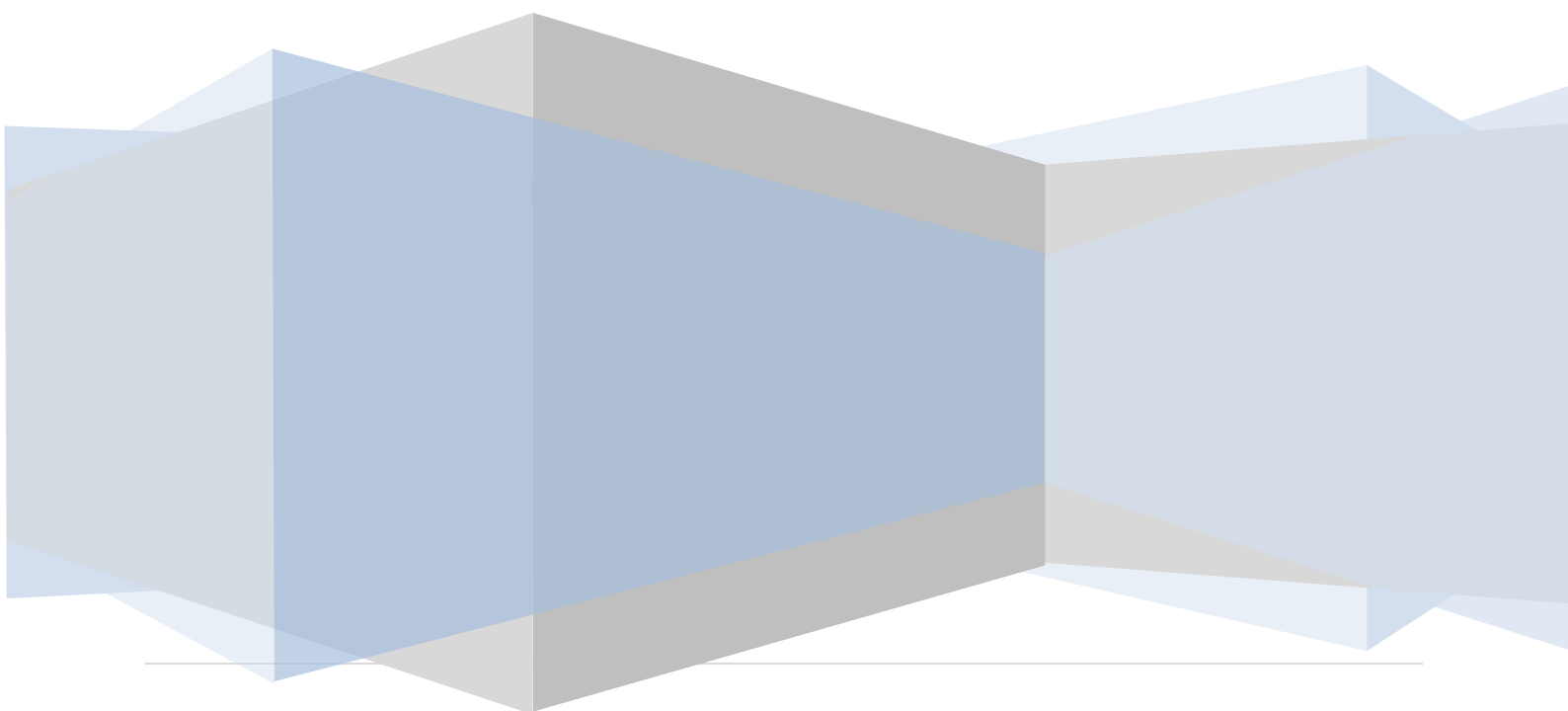


Improving the physical health of people with severe mental illness

No mental health without physical health

Report



Foreword

High premature mortality rates due to physical illness have been reported for people with severe and enduring mental illness for many years.

The life expectancy of people with a severe mental illness is estimated in some international studies to be as much as 25 years less than the general population. Such a reduction in life span is unacceptable by any standard. It implies a higher incidence of disease, a worse course of disease or both. This is a major social and public health issue that warrants urgent and sustained attention by all levels of government.

Many causes of death and illness which contribute to this reduction in life expectancy can be treated or prevented through timely access to targeted health promotion effort, preventative physical health care and effective chronic disease management care. The level of physical health inequality experienced by people with severe mental illness is also driven by complex, inter-related factors including poverty, homelessness and poor living conditions.

In response to this pressing issue, the Minister for Mental Health asked the Ministerial Advisory Committee on Mental Health to provide advice on the specific role specialist mental health services (clinical and Psychiatric Disability Rehabilitation and Support Services) should play, as part of the broader health care system, in reducing the prevalence of physical illness and premature mortality experienced by many people with a severe mental illness.

The evidence collected in the course of this project clearly identifies that significant barriers to physical health treatment persist for this population group. This raises serious questions of equity in health care provision for people who are mentally ill.

The literature challenges any view that people with a mental illness are not motivated to improve their physical health. This is not the case. Clients of specialist mental health services look to their case manager or key worker to play an active role in encouraging and supporting them.

It was also evident from the consultation process that specialist mental health services believe they have an important role to play in supporting people with severe mental illness and enduring psychiatric disability to improve their physical health as part of a holistic approach to their overall health care. However, this is clearly not the responsibility of the specialist mental health service system alone. General practitioners and other primary health and allied health services, including Community Health, have a central role in the provision of preventative health care and medical treatment.

A whole of system approach involving specialist mental health services, general practice and Community Health is needed to improve access to timely and effective physical health care for people with severe mental illness. Achieving this will require a stronger focus on accountability for outcomes by all stakeholders.

This report makes recommendations for consideration by both the Victorian and Australian Governments as the respective funders, policy and system managers of the specialist mental health and primary health care service systems. Bringing about the cultural, practice and system change envisaged by this report will require concerted, coordinated action and adequate resourcing across both service systems, supported and guided by strong committed leadership from government and service providers.

I commend this report to the Minister for Mental Health for her consideration.

Bill Brown
Chair, Physical Health MAC Sub-committee

Acknowledgements

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Executive Summary

Preamble

In the last decade, there has been growing recognition and understanding of the complex interrelationship between physical and mental health. The high level of physical ill health experienced by many people with a severe and enduring mental illness has a direct impact on their life expectancy and quality of life, notwithstanding the fact that mental illness itself does not have any inherent causative connection to physical illness.

The evidence on the level of health inequality and higher incidence of physical illness experienced by people with a severe mental illness, relative to the rest of the population, is extensive. What is clear is that much of the physical health co-morbidity associated with mental illness is potentially preventable through lifestyle modification and early recognition and treatment of common physical diseases such as cardiovascular disease and diabetes.

The evidence indicates that a significant amount of the health burden experienced by people with a severe mental illness is directly linked to the detrimental side effects of psychotropic and mood altering medication. However, poor living conditions, a product of the entrenched socio-economic disadvantage experienced by many people with severe mental illness, is a significant contributing factor to this burden.

This is further compounded by the way many mental health and medical professionals respond to physical health matters for this population group, resulting in missed opportunities for prevention and early detection and treatment of common physical health conditions.

The evidence strongly supports the need for the development of an integrated health response that supports prevention and the early diagnosis, treatment and management of physical health problems as part of the overall treatment and care provided to people with severe mental illness.

What do we want to achieve?

The MAC strongly advises concerted action and investment to address the physical health inequality experienced by many people with severe mental illness, targeting key diseases to achieve demonstrable improvement in physical health. The aim is to reduce the premature mortality rate and the prevalence of co-morbid physical health problems, particularly cardiovascular disease, diabetes and oral health problems. This will involve reducing the risks associated with poor health that are common to this population group including obesity, smoking, poor nutrition, low levels of physical activity and drug and alcohol misuse.

We want people with severe and enduring mental health problems to have access to the same standard of physical health care as the general community. This population group requires a higher, sustained and tailored level of support to achieve physical health outcomes that are at least equivalent to that in the general population. Affirmative action is both a principle and a responsibility.

The Australian Government has a critical role to play in closing the gap on health inequality by improving access to high quality responsive General Practice (GP) and primary health care funded through the Medical Benefits Scheme and the broader health budget. At the state level, the Victorian Government must support the specialist (clinical and Psychiatric Disability Rehabilitation and Support Services (PDRSS)) mental health service system to embed physical health into its core business.

The recommendations contained in this report seek to build a multi-system response to the physical health needs of people with severe mental illness. The MAC proposes that coordinated action be taken by the Australian and Victorian Governments to build a comprehensive system response that will result in:

- **Easy to navigate pathways** to affordable and responsive GP and primary health care and allied health services for people with a severe mental illness.
- **All people with a severe mental illness having a general practitioner** who will play a proactive role in the early detection and treatment of physical illness, the management of chronic physical disease, as well as the provision of preventative health support.
- Clients of specialist clinical mental health services **accessing comprehensive health assessment with supported referral** to appropriate assessment, treatment and support from the broader GP and primary health care system, including Community Health services.
- **Improved continuity of care** achieved through strengthened coordination and collaboration at the local level between specialist mental health, GP and Community Health services.
- Sustained action being undertaken to address the **social and economic determinants of good physical health**, with particular attention to improving access to affordable housing, employment and adequate and nutritious food.

Role of the specialist mental health service system

Community based specialist clinical mental health services

The MAC is of the view that specialist clinical mental health services should, as part of their core business, have a mandated role in improving the physical health of service users as part of a holistic approach to client care. This role should include early detection and intervention, through physical health assessment and supported referral, and a focus on prevention, through health promotion, education activities and targeted health interventions.

It is recommended that specialist clinical mental health services be adequately resourced and mandated to have the following core roles and responsibilities:

- **Comprehensive physical health assessment.** As standard practice, community based clinical mental health clinics will undertake a comprehensive health assessment for all case managed clients on their entry to, and exit from, the service and at regular intervals during the period of treatment and support. This assessment should provide a systematic appraisal of lifestyle, health and medication side effects. It should form part of an integrated physical and mental health plan and be subject to standard review, monitoring and follow-up processes.
- **Supported referral¹ and linkage to:**
 - General practitioners for assessment and appropriate investigation and the provision of medical treatment and health consultation as needed. With the permission of the client, the GP and the clinical case manager should share an integrated health care plan with both sectors fully understanding their roles and responsibilities to the patient/client in respect to the implementation, monitoring and review of this plan.
 - Allied health services such as dietitians, podiatrists, diabetes educators and oral health (dentistry) services in the private, Community Health and other relevant service sectors.
 - Local providers of healthy lifestyle services such as exercise groups, gyms and recreational activities.

¹ Supported referral means the case manager/lead worker actively assists the client to find and engage with the service provider they are referred to and provides follow up support to ensure ongoing engagement occurs.

- **Health promotion and targeted interventions.** As standard practice, clinical mental health services should provide health promotion education, advice and information with a particular focus on smoking cessation, reducing alcohol consumption, weight management and nutrition, sexual health and physical activity. They should also have the capacity to provide targeted interventions such as healthy lifestyle counselling and physical activity programs.
- **Supported decision making.** Support patients to be involved in decisions about their medical treatment and care within the compulsory treatment framework governed by the *Mental Health Act 1986*.

Psychiatric Disability Rehabilitation and Support Services

The MAC recommends that Psychiatric Disability Rehabilitation and Support Services have the following core roles and responsibilities:

- Ensure that initial assessments of all new clients identifies their known physical and oral health needs and embed physical health in the client's Individual Support Plans.
- Provide supported referral and linkage to general practice, allied health services, Community Health and oral health services where issues are identified.
- Deliver tailored healthy lifestyle programs in collaboration with Community Health (e.g. healthy diet and weight management) and local government and other providers (e.g. walking groups and physical activity programs).
- Provide health promotion education, advice and information and modelling of appropriate lifestyle and dietary choices.

What is needed to make this happen?

Integrating and embedding physical health into the policy, practice and service delivery of the specialist mental health service system will require a clear policy and authorising environment (from government and within Health Services and the PDRSS non government sector), coupled with strong leadership and careful, sustained investment in infrastructure and system capacity.

On this basis it is recommended that the Victorian Government, through the Department of Health:

1. **Develop a clear policy and authorising environment** that has high level engagement within Health Services and the PDRSS sector, to drive the structural, practice and cultural change required within the specialist mental health service system.
2. **Invest in the necessary infrastructure and capacity building** required to support the specialist mental health service system to embed physical health into core practice and work collaboratively with local GP and Community Health services.
3. **Establish a statewide physical health advisory body** to oversee the system reform and development needed to drive outcomes in this area, including research and the development of clinical guidelines, health promotion resources and targeted health promotion strategies and interventions.
4. Ensure **policy and operational frameworks and funding guidelines** for current and planned investment in public primary health and acute health services prioritise and optimise physical health outcomes for people with severe mental illness.
5. **Develop physical health outcome measures and performance indicators** for inclusion in existing reporting and accountability frameworks for specialist mental health services.

6. Invest in **research and evaluation** to ensure evidence based physical health best practice, assess impact of investment and support continued improvement in service provision.

The Victorian Government, consistent with the policy directions articulated in the *Victorian Mental Health Reform Strategy 2009-2019*, has a key role to play in supporting policies that address the social and economic determinants of good physical health, particularly access to affordable housing and employment. The MAC strongly supports continued and sustained effort in these areas on the basis that unless basic life needs are met, people with severe and enduring mental illness will remain compromised in their ability to self manage their mental and physical health.

Role of the general practice and primary health care service system

Any meaningful analysis of the role of the specialist mental health service system in improving the physical health of people with severe mental illness must take into account the role and performance of the broader primary health care system, including general practice and Community Health.

It is the view of the MAC that positive discrimination is needed to remove the barriers to adequate medical treatment and primary health care for people with severe mental illness. General practice has a central, critical responsibility for the provision of medical treatment, chronic disease management and preventative health care to all members of the community, including people with severe mental health problems.

As the funder, policy and system manager of general practice health care, the Australian Government must take proactive, sustained action to close the health inequality gap experienced by people with severe and enduring mental illness. This can only be achieved by improving access to affordable and responsive medical treatment and preventative health care, and linking providers of these services to state-funded allied health and primary health services to ensure these service sectors provide people with a severe mental illness, as a minimum, the same level of physical health care afforded the general community.

There are currently significant disincentives for GPs to treat people with severe and enduring mental illness, most notably the cost disincentive. This client group often requires more time for a consultation and can miss appointments making them a 'risk' in any for-profit business model. Coupled with the perceived 'difficulty' of treatment by the GP, many clients of the specialist mental health service system do not receive any or adequate medical treatment.

Improving access to general practice health care, however, will require more than simple market incentives. It will involve the provision of GP education and training; targeted capacity building (such as the expansion of Mental Health Nurse Incentive Program) and infrastructure support; and the development of stronger links between GP, specialist mental health and Community Health services.

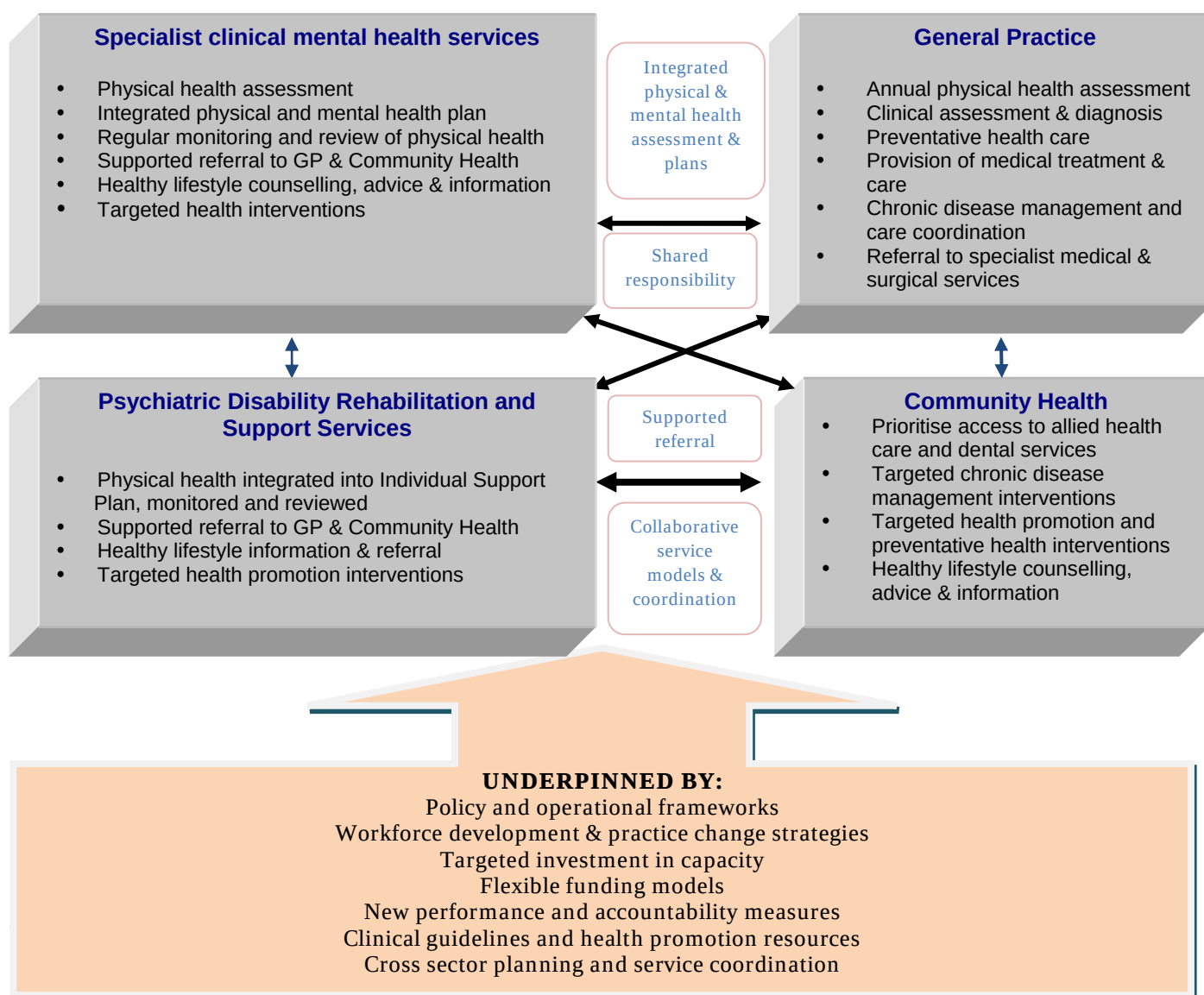
It is recommended that the Victorian Government advocate for and work proactively with the Australian Government to develop a GP and primary care policy that ensures:

- All people with a severe and enduring mental illness have a general practitioner and that barriers to access (geographical and financial) are addressed. Given the level of chronic physical health problems experienced by people with a severe mental illness, it is proposed that an adequately funded system of voluntary 'patient enrolment' (currently in place for people with diabetes) be extended to this population group.
- Cost disincentives for general practice to provide medical treatment, chronic disease management and preventative health care to people with severe and enduring mental health conditions are systematically addressed.

- Where GP health care services fail to adequately respond to the physical health needs of people with a severe mental illness, the Australian Government take action to address this issue in collaboration with the Victorian Government through, for example, block funding to selected GP practices and Community Health services and the use of credentialed nurses where GPs are unable or unwilling to provide treatment and care to this client group.
- The Primary Health Care Organisations (Medicare Locals) being proposed as part of the National Health and Hospital Reforms are required to prioritise the physical health of people with severe mental illness in all aspects of the work of these entities.
- The *Healthy Communities Reports* to be developed by the proposed Medicare Locals be required to include outcome measures and targets related to the physical health of people with a severe mental illness as well as population mental health outcomes more broadly.
- New or existing performance and accountability frameworks for general practice health care take account of the physical health of people with a severe and enduring mental illness. This is critical to strengthen accountability for outcomes and ensure clear and transparent reporting.

The proposed roles and responsibilities of the specialist mental health service system in relation to Community Health and General Practice are summarised in Diagram 1.

Diagram 1: Overview of proposed key roles and relationships



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References

1 Project Overview

1.1 Introduction

The Ministerial Advisory Committee on Mental Health (MAC) has prepared this report for the Minister for Mental Health to assist her to identify the concrete action needed to improve the physical health of people with a severe mental illness living in Victoria. This area was identified for early priority attention in the *Victorian Mental Health Reform Strategy 2009-2019*.

The report was produced by the Physical Health MAC subcommittee which was composed of members of the MAC and co-opted members with expertise in areas relevant to the project. The sub-committee was chaired by Bill Brown, a MAC member and Area Manager, Goulburn Valley Area Mental Health Service.

The terms of reference of the project were to provide the Minister for Mental Health with practical recommendations on how:

- The specialist public mental health services² can contribute to reducing the prevalence of common physical health problems and associated risks (e.g. obesity, substance misuse, poor nutrition, poor oral health and smoking) experienced by people with a severe and enduring mental illness.
- Specialist mental health and primary health care services can work more effectively together to proactively address common, preventable physical health problems and improve health outcomes for this cohort.
- Access to established chronic physical disease management programs for clients with severe mental illness can be improved.
- Targeted health intervention and health promotion could be used to encourage positive health behaviours, self management and reduce the common risk factors associated with poor general health and illness.

The report focuses on the role and functions of the specialist public clinical mental health services and Psychiatric Disability Rehabilitation and Support Services (PDRSS) in improving physical health outcomes for young people (16-25 years), adults and older people with severe mental illness, and the role of these service sectors as part of a broader system of health care.

1.2 Project methodology

The project methodology involved a review of literature, reports and relevant initiatives in Victoria and other jurisdictions. Best practice and exemplar service models and programs operating in Victoria and other jurisdictions were also examined.

A series of forums were conducted to identify the role and scope of function of the specialist mental health service system in improving the physical health of people with a severe mental illness. This included forums with general practice, Community Health, the PDRSS sector, and clinical mental health services with an interest in young people, adults and older people with severe mental illness. The analysis of the issues, barriers and solutions identified in these forums, coupled with the evidence provided by the literature review, provide the basis for the strategic actions recommended in this report.

² Specialist mental health services are defined as clinical mental health and psychiatric disability rehabilitation and support services.

2 Policy context

2.1 Mental health reform strategy

Improving the poor physical health status of people with severe mental illness has been identified as an area for early action in the *Victorian Mental Health Reform Strategy 2009-2019*. The strategy provides a broad ranging reform agenda to guide the development of mental health services over the next decade. It places emphasis on the role specialist mental health services can play in supporting clients to better manage their physical health as part of a broader system of health care. It highlights the importance of specialist mental health, general practice and primary health services working together to ensure timely access to preventative and chronic disease management care.

2.2 Development of the new mental health legislation in Victoria

People who experience a severe mental illness may be subject to compulsory treatment and care which is governed by the *Mental Health Act 1986*. The Review of the *Mental Health Act 1986*, which commenced in May 2008, will examine whether the safeguards in the Act appropriately protect human rights. A key Government reform proposed is the introduction of a supported decision making model of treatment and care. The new Act could provide mechanisms to give effect, wherever possible, to the person's wishes and place greater emphasis on respect for their autonomy¹.

Part of this reform includes improving patient access to physical health checks as well as facilitating coordinated care of both a patient's mental and physical health. This is in recognition of the need to improve the physical health of patients as part of their overall health care and promote recovery and wellbeing.

2.3 COAG National Health and Hospital Network agreement

On 20 April 2010, the Council of Australian Governments (COAG) agreed (with the exception of Western Australia) to establish the National Health and Hospital Network Agreement. This Agreement introduces changes to Commonwealth and State roles and responsibilities in respect to the funding and management of public hospitals and primary health care services.

As part of this agreement, the Australian Government will become the majority funder of Australian public hospitals, by funding 60 per cent of national efficient price for hospital services delivered to public patients. State governments will remain system managers and purchasers (through Service Agreements) for all public hospital services to be delivered by Local Hospital Networks (LHNs).

The Australian Government will also assume full policy and funding responsibility for primary mental health services for people with mild to moderate disorders, as part of the Commonwealth assuming full responsibility for primary health care services².

The *National Primary Health Care Strategy*³ details key priority areas and initiatives to support the proposed reform of primary health care system across Australia. Addressing inequalities and gaps and improving access to health care, improved chronic disease management and an increased focus on prevention are identified priority areas. The MAC notes the proposed strategies include the establishment of Primary Health Care Organisations (Medicare Locals); a national eHealth records system; capacity building in the primary care health workforce; and investment in primary health care infrastructure including GP super clinics.

The MAC notes that e-health developments on the national level, including the recent passing of legislation to establish an Individual Health Identifier and plans to develop Personally Controlled Electronic Health Records, will significantly support more efficient and effective inclusion of a range of health providers, including GPs, in managing people with complex care needs.

3 The Case for Change

3.1 Prevalence of physical ill health

In comparison with the general population people with a severe mental illness have higher rates of mortality and physical morbidity. Recent research from the USA identified that clients of public mental health services die an average of 25 years earlier than the general public⁴ - many of the causes of death were found to be similar to the cause of death for all other persons and could be treated or prevented through timely access to effective health care and information.

The literature suggests that people experiencing poor social and economic circumstance have twice the risk of serious illness and premature death⁵. People with severe mental illness are more likely to experience poverty, unemployment, homelessness, social isolation and exclusion which are key determinants of poor health.

The *Duty to Care*⁶ report produced by the University of Western Australia highlighted some alarming statistics on the physical health of people with serious mental illness⁷. This report noted the number of excess deaths in the mentally ill due to ischaemic heart disease (IHD) has increased in women and remained roughly constant for men, despite a downward trend in IHD mortality in the general community. This report identified that hospitalisation rate ratios were often lower than corresponding mortality rate ratios suggesting that people with a mental illness may not have received the level of health care commensurate with their illness. It was also of note that despite very high rates of smoking, cancer incidence was no different in people with mental illness than in the general population. However, once a cancer was diagnosed there was a 30 per cent higher case fatality in users of mental health services.

There is now widespread acceptance of the direct relationship between physical and mental health, especially the poor physical health of people with severe mental illness. The physical health of people with schizophrenia, for example, is typically poorer compared to the general population (an estimated 50 per cent have a co-occurring physical illness⁸) with the prevalence rate for obesity up to three times greater for this group⁹.

New analysis of 1.7 million records of primary care patients in the UK found that people with a diagnosis of schizophrenia or bipolar disorder are more than twice as likely to have diabetes than other patients and also more likely to experience ischaemic heart disease, stroke, hypertension and epilepsy¹⁰. Obesity and hypertension are the most prevalent medical co-morbidities amongst this group in the UK¹¹.

People with a severe mental illness often have poor dental health and have a higher prevalence of smoking (70 per cent smoke compared to 20 per cent of the Australian public¹²). Gum disease is exacerbated by high levels of tobacco use. There is also a growing evidence base to support a close relationship between poor oral health and poor physical health. A significant number of people with severe mental illness also have co-occurring substance abuse problems¹³ – the long term health impact of harmful levels of alcohol consumption and other forms of substance abuse are significant.

3.2 Health impacts of psychiatric medication

The risk of obesity is compounded by the side effects of prescribed psychiatric drugs, particularly the newer atypical antipsychotics, which may lead to considerable weight gain¹⁴. Research suggests that between 40 and 80 per cent of patients taking antipsychotic medication experience weight gain that exceeds ideal body weight by 20 per cent or greater¹⁵. Weight gain is also found to reduce the likelihood of adherence to medication regimes, which is likely to have profound effects on the severity of the illness¹⁶.

In addition, antipsychotic medications (such as clozapine and olanzapine) used to treat psychiatric illness may result in other distressing physical side effects such as hyper-salivation and have been clearly associated with increased cholesterol and blood sugar level which can lead to diabetes.

The evidence base on the health impacts of new psychotic medications is still developing. Clinical observations in Victoria suggest that while the mental health of individuals has improved as a result of these medications and they have reduced the mortality rate associated with suicide and traumatic death, physical health is getting worse. In effect while mortality rates are decreasing in the short term, chronic physical disease can be expected to increase over the longer term.

The consequences of this dynamic are not fully known at this stage. This is an important reminder that not all patients need to be prescribed atypical rather than older antipsychotics. As both the older and newer drugs have a range of side effects, the drug used should be tailored taking into account the relative risks and benefits of each class of drugs to the person receiving the medication.

3.3 Social and economic determinants of good health

The health inequalities experienced by people with severe mental illness cannot be explained by physical health factors alone. The drivers for health inequality amongst people with severe mental illness are complex and interrelated and include poverty, homelessness, social isolation, lifestyle and living conditions, problems accessing health assessment and medical treatment in addition to the side effects of anti-psychotic and mood stabilising medication.

These socio-economic stressors directly affect the individual's capacity to care for their own health and pay for private medical services. The struggle to eat properly coupled with low levels of exercise can have long term health impacts and contributes to weight gain and obesity experienced by many people with severe and enduring mental illness. These issues are significantly compounded for those who are homeless or living in insecure housing¹⁷. The transient life experienced by this vulnerable population group dislocates them from health services which leads to inadequate or no treatment or no patient-practitioner relationship. This is supported by a recent study in Western Australia¹⁸ of over 200,000 users of mental health services which found that those with no fixed address (4 per cent of users surveyed) were unlikely to receive any medical care.

Improving physical health outcomes for people with a severe mental illness requires action that will improve their access to basic life needs, particularly affordable housing and nutritious and adequate food. Without this, the individual's capacity for self-management of reasonable good health is markedly reduced.

3.4 Access to responsive physical health care

There is a substantial body of evidence that some mental health and medical professionals interpret physical health symptoms and concerns as a mental health rather than a primary health issue - a phenomenon called 'diagnostic overshadowing'¹⁹. As a consequence, medical professionals often fail to identify and treat physical health problems.

Research also suggests that medical professionals may be challenged by people with a co-morbid physical health and mental health problem and as a result may fail to identify physical health problems or provide adequate treatment and care, routine preventative services (e.g. weight management and smoking cessation) or actively involve the person in decisions relating to their physical health treatment and care. Medical professionals may also experience frustration working with individuals who appear resistant to sound medical advice or fail to attend appointments, without understanding the reasons why people may find this difficult and that a different type of effort is needed to engage them.

There also appears to be differences in perception between people with a severe mental illness, professionals and carers regarding their desire to improve their physical health. More recent literature has found that medical and mental health staff and carers think people who experience severe mental illness are unmotivated and are not concerned with improving their physical health. The literature challenges this view.

People with a severe mental illness typically view their case manager/lead worker as their principal health care resource²⁰. Evidence suggests that the relationship between professionals and service users has the greatest influence on life changes.

This is a critical issue as many mental health clients often do not receive consistent medical care or have a designated general practitioner and may have difficulty accessing Community Health services. The 2010 census of PDRSS clients²¹ in receipt of home based outreach support (HBOS) identified that approximately 20 per cent accessed GP care and only 7 per cent accessed Community Health services. In contrast, it is estimated that 25 per cent of PDRSS HBOS clients have chronic physical health conditions.

While it is true that a person's motivation to do something about their physical health is often impaired by their mental health condition, this only highlights the critical importance of active encouragement, support and practical assistance. The evidence also suggests that any effort to improve the physical well being of people with a severe mental illness will need to improve their ability to self manage their physical health.

People with a severe mental illness have expressed frustration and difficulties navigating the complexity of mental health and broader health and social support service systems²² - a situation made even more problematic when these services do not work in a coordinated manner. These barriers impact directly on their ability to access timely medical treatment and care and the development of an ongoing, trusting relationship with a local GP or primary health care provider.

3.5 Access to health information

A study into the design of a self-management intervention for improving the physical health of adults with serious mental illnesses²³ found service users had limited knowledge and low self-efficacy regarding active self-management of their physical health. Despite their interest in learning more about health promotion, most participants expressed a sense of personal futility and powerlessness in improving their health.

Research suggests psychosocial rehabilitation programs and day programs can provide important settings for the delivery of health promotion efforts. Research has also found consumers especially liked getting health promotion information from other people, including health care professionals, friends and family. Print literature, the internet, and library services were found to have various limitations - consumers involved in the research were generally unfamiliar with community health fairs and related events. Trustworthiness, proximity and availability, and the specificity and depth of information provided by a communication source were considered by clients when getting health information²⁴.

The unacceptably high level of physical health problems experienced by people with severe and enduring mental health conditions and the resultant impacts on their quality of life and life expectancy, highlights the need for fundamental change.

HealthRight Project (Western Australia)

The HealthRight project is a funded initiative of Western Australian Health Department Mental Health Division, based at the University of Western Australia (UWA) ²⁵. The project aims to reduce the incidence of chronic physical disease for people with mental illness. It was inspired by the Duty to Care report produced in 2001 by the UWA.

In September 2002, the then Office of Mental Health established the HealthRight Advisory Group (HRAG) to respond to the Duty to Care report. A project worker was employed to implement recommendations of the HRAG which were published in the Who is Your GP? report in 2004. The project has developed strategies and resources to:

- *Raise awareness of the physical health needs of mental health consumers.*
- *Include physical health care in the routine care of mental health clients provided by mental health services (linked to standards and quality).*
- *Strengthen inter-sectoral linkages to facilitate better coordination and integration of relevant health services for physical and mental health care.*
- *Recognise the central role of General Practitioners in the management of the physical wellbeing of mental health consumers.*
- *Enhance the voice of consumers, their families and carers.*
- *Strengthen tertiary education and postgraduate training for health professionals, emphasising overall health care.*
- *Deliver targeted health promotion and illness prevention.*
- *Research, monitor and evaluate the impact of new services and programs developed as part of the project.*

4 Strategic action

This section of the report identifies concrete action to address the issues, barriers and opportunities identified in the consultation process. The recommendations and areas for action are summarised in Appendix 1 of this report.

4.1 Building the capacity of the specialist mental health service system

4.1.1 Role of community based clinical mental health services

There is broad consensus that specialist clinical mental health services should, as part of their core business, have a mandated role in improving the physical health of the estimated 60,000 Victorians who use these services every year.

Mental health clinicians and service managers involved in the consultation process felt that effort should focus on early detection and intervention (through physical health assessment, monitoring and supported referral) and prevention (through health counselling and promotion and education activities) to reduce the prevalence of common physical illness and the subsequent development of chronic physical disease. Services were of the view that this should form part of a holistic approach to client care.

This view is consistent with the literature which argues mental health nurses and allied health professionals should play an active role in health promotion, primary prevention and the early detection and management of physical health problems in all areas of clinical practice and that health information (such as nutritional advice, exercise counselling and healthy lifestyle education) and health monitoring should be delivered in tandem with the initiation of any psychotropic medication as part of routine practice.

Clinical mental health services, particularly those working with young people, identified a role in education and awareness raising for clients and their carers regarding medical conditions that are specific to certain mental health disorders, such as psychosis and anorexia.

The consultations noted that it is difficult to shift lifestyle behaviours related to ill health and effectively manage chronic disease in the general population and that this further emphasised the critical importance of prevention, early intervention and development of clear pathways to physical health care for young people, adults and older people with a severe mental illness.

Clinical mental health services were unanimous that the provision of preventative health, medical treatment and the clinical management of chronic physical disease was the central responsibility of the primary health care system, particularly general practice. While the specialist clinical mental health system felt they had an important role to play, they were part of a broader system of health care that had a **shared responsibility** to work together to achieve improved physical health outcomes for people with severe mental illness.

The MAC identified the following key roles and functions for community based clinical specialist mental health services:

- Provision of comprehensive physical health assessment for all case managed clients at point of entry into the service, at regular intervals after entry and at point of discharge from clinical mental health case management. On entry to a specialist clinical mental health service, if the client has a GP, they should be contacted to provide a summary of past and current medical problems and medication.
- Inclusion of the health assessment as a documented part of an integrated mental health and physical health treatment and care plan which would be subject to regular review, monitoring and follow-up in collaboration with the client and their carer/s.

- Supported referral to GP and allied health services (such as podiatry services, oral health, dieticians, diabetes educators and sexual health services) for further testing and treatment and other key services such as school nurses and healthy lifestyle services provided by local government and other community providers.
- Active collaboration with general practice to support GP led chronic disease management plans.
- Regular assessment of the side-effects of medication and where an adverse impact on physical health is identified, consideration will be given to an alternative treatment regimen.
- Healthy lifestyle counselling, education and promotion to encourage healthy behaviours and support clients to improve their ability to self manage their physical health.
- Provision of targeted health interventions, which could be delivered in collaboration with Community Health and the PDRSS sector.
- Creation of health promoting environments in bed and community based mental health service settings including ensuring smoke free environments and modelling by staff of good health behaviours e.g. smoking and healthy food choices.
- The role of case managers as a motivator, using a health coaching approach, Cognitive Behavioural Therapy and other motivational techniques.
- Collecting information against agreed clinical performance indicators in order to monitor impacts and outcomes achieved and strengthen accountability.

The MAC notes that over the last decade Victoria has strategically invested in the provision of specialist clinical mental health expertise to support primary mental health services, particularly general practice, to improve their skill and expertise in the early identification, diagnosis and treatment of people with a range of both high and low prevalence mental health disorders³.

This specialist expertise, delivered through primary mental health early intervention teams located in adult clinical mental health services, provides a critical interface between tertiary and primary health services for the management of demand between these two sectors. The MAC proposes that any planned redevelopment or enhancement of this service model include consideration of its role in strengthening access to GP health care for people with severe and enduring mental illness.

In order to better support clients to adopt health lifestyle behaviours and provide the practical support needed to navigate access to medical, surgical and allied health services, the MAC recommends the use of trained Peer Mentors be investigated and closer links between public specialist mental health services and the Commonwealth funded Personal Helpers and Mentors Program be encouraged.

While out of scope of this report, the MAC recognises the important role of private psychiatrists and psychologists in identifying physical health issues in their client population and supporting their referral to appropriate medical treatment and primary health care.

Impact of psychiatric medication

A key issue identified in the consultation process was the role played by the new/second generation (atypical) antipsychotics in the increased prevalence of obesity, diabetes and metabolic syndrome amongst people with severe mental illness.

The MAC notes that large clinical trials have failed to show a difference between the older and new classes of antipsychotics in terms of clinical outcomes²⁶. This raises a significant question regarding the continued use

³ This service model provides assessment, secondary consultation and training to general practice and other primary health care providers. It also supports shared care arrangements and provides a pathway for people to enter/re-enter the specialist mental health system from primary care.

of an atypical antipsychotic for people at risk of developing long term life-threatening physical health problems and emphasises the important need to consider the likelihood of physical health side effects when deciding the most appropriate medication for an individual.

The MAC recommends that, given the relative risks and benefits of the older (typical) and new (atypical) antipsychotics in respect to physical health side effects, that their use be reviewed and clinical guidelines developed to inform practice.

Adult mental health services also reported the need to support clinicians to resolve the inherent tension between telling people about the potential impact of antipsychotic medication on their physical health and the resultant risk of non-adherence, particularly for those who are involuntary clients. This tension was significantly less prevalent in youth and aged specialist mental health services as physical health was regarded as a more integral part of client overall wellbeing.

St Vincent's metabolic screening program

St Vincent's has introduced metabolic screening in its community mental health clinics in response to the levels of physical health problems in clients and the impact of medication on their weight and consequent physical health and self-esteem. This service has been operating at St Vincent's for two years.

Implementation was initially met with a high level of resistance from mental health clinicians who did not understand the extent of the problem and did not feel they had the resources to deal with it. These issues were overcome by providing education on key physical health issues (such as diabetes) and providing equipment such as scales, blood pressure cuffs etc, for clinicians to use with clients. Keeping things simple, as well as putting physical health into policy documents (such as the strategic plan) and developing guidelines, helped embed change in organisational culture and practice.

Outcome of metabolic assessments are provided to GPs and also to clients if they wish. A booklet has been produced for clients and includes an example of the metabolic screening form. These forms are used by clinicians as part of the Individual Service Plan (ISP) review process. Clients are also screened for dental health, family history etc. New clients are assessed for baseline physical health information on admittance to the service and GP details are collected. Contact is made with the GP to discuss shared care arrangements.

Staff have been trained as QUIT educators. Physical health checks are done by St Vincent's staff and referrals are made to GPs if an issue is detected. Feedback from clients indicates that they want and expect their mental health clinician to work with them to improve their physical health.

4.1.2 Role of acute and sub-acute mental health services

The consultation process identified that the short length of stay in acute inpatient settings provides a small window of time to deal with physical health issues. There was also a view that the acute phase of illness may not be the most appropriate time to discuss healthy behaviours and lifestyle change. Notwithstanding this, optimising the quality of physical health assessments undertaken when people are admitted to hospital and the action taken in response to the assessment (including consistent monitoring and follow up on discharge) is critical. The inpatient unit also provides the opportunity to obtain specialist medical assessment by physicians and surgeons in the co-located medical and surgical units of the general hospital.

Improving access to acute medical and surgical treatment for people with a severe mental illness, including those under the care of a general practitioner, was identified in the consultation process as an area for development. Consideration could be given to expanding the existing consultation and liaison (CL) psychiatry function in hospitals to work with, and provide support to, medical and surgical staff providing care to people with a mental illness.

The MAC notes the uneven distribution of CL services was identified as a major barrier to such care. Even amongst the major metropolitan hospitals the type and level of CL service is variable; in regional and rural services these services are absent.

Sub-acute Prevention and Recovery Care (PARC) services provide an opportunity to follow up issues identified in the physical assessment undertaken while the client was in hospital. PARC services should also be mandated to undertake physical health assessments for new clients entering from the community (which

could also be delivered by a GP ‘in-reach’ response), ensure individual service plans include the clients physical health status and needs, actively link clients to appropriate primary health care services and provide healthy lifestyle counselling.

The Hospital Admission Risk Program (HARP) service model demonstrates the value of working with clients to link them to community-based health and broader social support services on discharge from hospital and the Emergency Department. Consideration could be given to expanding this model to support people with a severe mental illness (after admission to acute psychiatric inpatient ward as well as after admission to a medical/surgical ward), focusing on those with chronic physical disease conditions.

Crisis Assessment and Treatment (CAT) and Case Management teams, as part of their discharge planning role, can support patients to link to appropriate health services and ensure information regarding medical conditions identified while the person was in hospital is communicated to their treating clinician and GP.

As the joint funders and system managers of public hospitals, the MAC recommends that the Victorian Government in collaboration with the Commonwealth, take all necessary action to ensure the physical health of people with a severe mental illness are prioritised by the acute health care system. This includes ensuring the Local Hospital Networks (LHN) proposed as part of COAG National Health and Hospital Reforms are held directly accountable for their performance in this area and that this is reflected in LHN service agreements and related performance standards and measures.

Case Studies from the United Kingdom²⁷

A health screening pilot was conducted in a long term inpatient unit. 82% of patients sought a health screen delivered by a practice nurse or GP. 59% of patients had a BMI over 25; 59% smoked; 27% had ear problems; 17% had raised blood pressure and 11% had sight problems. 50 of the 66 patients had recommendations for action and only 66% of those were followed up. This pilot raised the need for nurses on wards to take a more proactive health promotion role with additional training and support, and for patients to be provided with follow-up support post discharge.

GP led weekly primary care service in an acute inpatient unit. 22% of all patients admitted to the acute unit attended the GP service over a 10 month period. Presenting complaints include a wide range of acute and chronic conditions. New medication was prescribed for 66 consultations, existing medication altered for 8 and watchful waiting was relevant for 49 consultations. As well as treating specific complaints, the GP undertook health promotion directly with 97% of cases. The doctor also provided information and advice to staff on wards about physical health assessments, care and maintenance. This program could also be delivered by nurse practitioners.

4.1.3 Role of Psychiatric Disability Rehabilitation and Support Services

The MAC has identified specific roles and functions for the PDRSS sector in improving physical health outcomes for clients with a severe mental illness and associated psychiatric disability.

A clear policy and authorising environment is required, as with the specialist clinical mental health service sector, to ensure physical health issues are addressed in organisational policy and practice. This needs to be linked to capacity building, workforce development and targeted investment in health promotion.

Identified roles for the PDRSS sector include:

- System advocacy to improve access to local GP and Community Health services.
- Embedding physical health in the client's Individual Support Plans and providing supported referral to GP, Community Health services and other allied health services.
- Provision of education, health promotion information and healthy living/lifestyle interventions delivered through psychosocial rehabilitation outreach programs and day programs. Healthy living interventions could be delivered in collaboration with Community Health and other local services.
- Delivery of a peer support model for health promotion (e.g. quit smoking, weight management and diet) and to provide practical support to clients to attend medical appointments.
- Support the introduction of health assessments in PARC services in collaboration with the client's mental health case manager and general practice.
- Implementation of smoke-free workplace policies with cessation support programs for both clients and staff.
- Practical support for clients to improve their oral health (for example by supplying toothbrushes, paste and dental floss linked to education and health promotion on basic dental hygiene) and the development of stronger links to Community Health and other providers of public dental services to facilitate referral and priority access to public dental services.
- Modelling lifestyle behaviours, such as teaching clients to cook their own food and thereby reduce their reliance on high fat/high sugar take away food.

4.1.4 Role of Emergency Department

Keeping people with a severe mental illness healthy and out of hospital should be a key aim. From an efficiency perspective it is worth ensuring that people with a mental illness do not use the Emergency Departments (ED) for a primary physical health care response.

This highlights the importance of the interface between hospitals and specialist mental health care services and the need to align hospital and primary health policy frameworks and accountability structures.

The MAC understands that Emergency Departments are not necessarily the best location to undertake a comprehensive physical health assessment or to commence health education for a person with a severe mental illness, but it may be the only health service people with a mental illness make contact with. On this basis this service setting provides an invaluable opportunity to assess for physical health issues.

The consultation process identified that when people with a mental illness present to an ED with co-existing physical health problem their psychiatric presentation tends to be prioritised. As a result the person is often given only a cursory health check unless admitted to a hospital ward. The consultation suggests this may be occurring for a number of reasons:

- Inadequate time being allowed to assess people with mental health conditions for underlying physical health issues when they present to the ED due to the assessment targets in the ED of four hours.
- Many staff may lack the confidence to enable them to appropriately interact with a person with a mental illness in order to conduct a more comprehensive physical health assessment in the ED.
- Tendency for 'diagnostic overshadowing' resulting in ED staff overlooking physical symptoms when an individual has a mental health condition.
- Skill and competency of ED staff in the diagnosis of physical conditions in mental health patients.

The MAC recommends that a strategy be developed to strengthen the role of ED in respect to the physical health of people with a mental illness. This may include consideration of: standardised physical health assessments; education and training for staff in the ED to improve skill, confidence and competency in the diagnosis of physical illness in this target group; performance measures to strengthen accountability for outcomes in this area; and a review of the four hour target for assessment in the ED to allow adequate time for a physical assessment to be undertaken.

What is needed to make this happen?

Supporting specialist mental health service system to play its part in achieving the client outcomes identified in this report will require:

- A policy driven authorising environment and strengthened accountability
- Workforce capacity development
- Targeted investment in system capacity
- Strengthened cross sector planning and coordination
- A robust evidence base
- Development of health promoting physical environments.

Creating the authorising environment

The MAC strongly advises the Victorian Government develop a policy framework to drive the structural, practice and cultural change required to embed physical health into clinical and PDRSS practice. The absence of this was identified in the consultation process as a key barrier. High level engagement within Health Services and at the clinical director and nurse/service manager level was identified as critical to ensure organisational policy and strategic frameworks include physical health.

The experience from other jurisdictions, such as the United Kingdom, indicates that while policy and accountability frameworks are critical to creating the authorising environment needed to drive action in this area, this by itself is not enough.

Bringing about change will require sustained effort and leadership within the mental health service system supported by targeted investment in capacity, workforce development and support for culture and practice change.

There was also a general sense from the consultation process that public mental health services needed to be more flexible and move to a new paradigm that places physical health as a critical, integral part of the client's health needs. This includes creating an expectation that all clients of the specialist mental health service system be in a shared care arrangement with a GP for their physical health needs.

It is recommended that the Victorian Government invest in the 'in house' capacity needed to embed physical health in organisational frameworks, drive cultural and practice change, and assist Area Mental Health Services and the PDRSS sector to build and sustain the partnerships needed to achieve coordinated action across specialist mental health and the broader primary health care service sectors.

The MAC also recommends that a state-wide physical health advisory body be established to oversee the system reform and development needed to drive outcomes in this area. Such a body could also assist with the development of best practice clinical guidelines and support resources for physical health assessment. This body could also provide expert advice on performance measures, the design of targeted physical health interventions and health promotion strategies and resources.

The MAC has identified the need for performance measures to be developed to assist all public specialist mental health services to monitor improvement in physical health outcomes and strengthen accountability.

The MAC notes consideration is being given to improving patient access to physical health checks as well as facilitating coordinated care of both the individual's mental and physical health in the development of the new Victorian mental health legislation. The MAC fully supports this action.

Consideration should also be given to including an assessment of system activity regarding physical care as part of the planned reintroduction of the Chief Psychiatrist Office reviews.

It is the view of the MAC that without this matrix of effort the shift to a new paradigm that places physical health as a critical, integral part of the client's overall health needs, will not be achieved.

Building workforce skill and competency

Mental health staff require ongoing training to update skills and knowledge in physical health care²⁸. Areas identified in the consultation process include skills development in physical health assessment and monitoring, lifestyle counselling tailored to the needs of particular age groups and mental health conditions (particularly advice on nutrition and exercise), health modelling and strategies for motivating people.

It is recommended that a professional development package be developed and implemented to train and support nurse clinicians and allied health workers in these areas. This professional development package should be supported by evidence based clinical guidelines and resource material.

In addition, the MAC recommends that the Victorian Government liaise with professional organisations (e.g. College of Psychiatrists, the National Health Practitioners Board and Australian College of Mental Health Nurses) and tertiary educational organisations, to ensure they support and drive this approach and that relevant curriculum reflects the importance of physical health.

Targeted investment in service system capacity

The capacity of existing clinical staff to undertake physical health assessments, health lifestyle counselling and targeted health promotion activities was identified as a key constraint. There was a strong view that consideration should be given to funding specialist physical health nurse positions/nurse practitioners to undertake this role. These positions could work across a number of service settings including PARC, bed based clinical rehabilitation services and community-based mental health clinics.

The MAC is of the view that this new capacity should be targeted to child and youth, adult and aged mental health teams that do not have nurse clinicians, and high volume mental health clinics. These positions could also provide secondary consultation to mental health clinicians to facilitate supported referral and a follow up response to general practice and Community Health.

The MAC also recommends that consideration be given to further investment in CL psychiatry to enable mental health teams to provide treatment and support to people with mental illness admitted to medical and surgical wards. Consideration should also be given to extending the HARP service model to people with severe and enduring mental illness and chronic physical health conditions.

UK based pilots using nurse practitioners²⁹

Pilot programs in the United Kingdom using mental health nurse practitioners to deliver health improvement programs have been proven successful. The UK pilots suggest most effective results occur when nurse practitioners see 20 patients per week for checks, assessments, consultations and reviews as well as running health improvement groups and playing a lead role in liaison with primary and secondary health care. Identified success factors include: program lead having the right skills; clear boundaries between nurse practitioner and clients community mental health nurse; and effective communication/shared information. The nurse practitioner role was regarded as a pioneering position so a high level of training and support including clinical supervision was required.

Building the evidence base and driving practice change

It is the strong view of the MAC that practice must be contemporary and evidence-based with validated approaches actively promoted for wider use. Areas identified for priority development include:

- Evidence based clinical guidelines for physical health assessments and healthy lifestyle counselling, including the use of motivational techniques.
- Review of the relative benefits and risks of older versus newer antipsychotic medication with respect to physical health and development of evidence based guidelines to inform clinician use of both classes of antipsychotics medication and other psychiatric medication.
- A model of good practice in nutrition linked to a training program to up-skill clinicians and other relevant staff in its use.
- A chronic physical disease management framework tailored to the specific needs of people with mental health problems. The Early Intervention in Chronic Disease (EliCD) initiative in Community Health, which aims to move from an episodic/reactive care model to a chronic (planned, managed, ongoing) care approach, is a good example of the type of approach that could be adopted for use for people with a severe mental illness.

Strengthened cross sector planning and co-ordination

Action is required at the system level to strengthen referral pathways and the co-ordination of care between specialist mental health services, general practice and Community Health. Area Mental Health Services and the PDRSS sector must be supported and encouraged to build and sustain the local partnerships needed to achieve coordinated action.

Areas identified by the MAC for priority action include:

- Facilitate sharing of patient/client health information by supporting and encouraging specialist mental health services to become early adopters of the Individual Health Identifier (IHI) and the Patient Controlled Electronic Health Records (PCEHR) currently being developed by NeHTA.
- Improving local area planning and service coordination and building stronger referral pathways between specialist mental health, general practice and Community Health through Primary Care Partnerships and the proposed Medicare Locals. This should include requiring the newly created mental health planning and service coordination positions located in Department of Health Regions to take a lead role in facilitating an integrated local area health response to people with severe mental illness and chronic disease conditions, drawing on existing service sector partnerships and networks, including Primary Care Partnerships.
- Any planned redevelopment or enhancement of specialist primary mental health early intervention teams to give consideration to the role of this service model in promoting access to GP health care for people with severe and enduring mental illness.
- Consider establishing a statewide General Practice Mental Health Liaison Officer program in Area Mental Health Services, modelled on the existing General Practice Liaison Officer hospital program, to support improved access to GP care and continuity of care.
- Report on outcomes achieved in this area as part of annual reporting for Area Mental Health Services and outcome reporting associated with the implementation of the *Victorian Mental Health Reform Strategy*.

Creating health promoting physical environments

Internationally, there is increasing pressure on psychiatric inpatient settings to adopt smoke-free policies.

The consultation process identified a strong consensus that all mental health service environments should be smoke-free with pressure put on health care networks to ensure this policy gets implemented.

Lawn et al³⁰ examined smoke-free policies across psychiatric inpatient settings in Australia and identified factors that may contribute to the success or failure of smoke-free initiatives in order to better inform best practice in this important area. The authors concluded that a smoke-free policy is possible within psychiatric inpatient settings but a number of core interlinking features are important for success and ongoing sustainability. They include clear, consistent, and visible leadership; cohesive teamwork; training opportunities for clinical staff and fewer staff smokers; effective use of nicotine replacement therapies; consistent enforcement of a smoke-free policy; and health modelling by workers.

Given it is highly problematic to expect involuntary patients to stop smoking when they are experiencing an acute episode, support including nicotine replacement therapy (NRT) and behavioural therapy is critical. This support should continue post discharge from inpatient settings. Refer to 4.3.1 for specific recommendations regarding smoking cessation.

4.2 Working with General Practice and Community Health services

The literature presents a strong argument for primary physical health and mental health services to work together to provide holistic care in order to reduce the significant physical health inequality experienced by people with a severe mental illness. It also argues that an integrated approach to the provision of primary health care services for this population group will yield economic benefits through appropriate use of, and improved access to, health services (including hospital services) and will increase the take up of preventative measures.

Achieving this outcome will require local area service coordination and shared accountability between specialist mental health, general practice and Community Health services.

4.2.1 Role of General Practice

The MAC strongly asserts, as a core principle, that all people with a severe and enduring mental illness, *irrespective of whether they are clients of the specialist mental health service system or the nature or acuity of their mental illness*, should have a general practitioner responsible for their physical health care.

There was unanimous consensus from all service sectors consulted in the development of this report that general practice has a central role - defined as 'birth to death', whole of patient care – in the provision of medical treatment and preventative health care to people with a severe mental illness.

While specialist mental health services must play an important role in physical health assessments, healthy lifestyle counselling and health promotion, it is not the role of this sector to provide medical treatment for physical health problems. Both service sectors have a responsibility to prioritise the physical health of people with a severe mental illness with the role of the specialist mental health services system focused primarily on initial assessment and referral to GP services for in-depth diagnosis, treatment, preventative health care and lifestyle modification support.

The MAC recognises that general practitioners can and do provide good, comprehensive health care for many people with a mental illness. General practitioners are able to establish and sustain ongoing trusting relationships with patients and, in many cases, their families.

A number of GPs have noted, however, that it is particularly difficult to ensure ongoing health care for this population group when the patient is in crisis, is isolated and/or unsupported, under financial stress, or experiencing symptoms of mental illness which mitigate against compliance with medical appointments, use of medication and health prevention advice. A clear message from the consultation was the need for additional support to general practice to help achieve and maintain engagement with this patient group.

The key patient and system issues regarding GP health care identified in the consultation process are summarised in Appendix 2 of this report.

Improving access to general practice health care

It is the view of the MAC that general practice must have the lead role in chronic physical disease management for people with a severe mental illness, including facilitating their access to coordinated health care. The MAC notes that the current Commonwealth MBS funding model, however, does not adequately 'incentivise' care for patients with co-morbid chronic physical disease problems and severe mental illness - improving physical health for this patient groups takes considerable time, needs to be introduced step by step in order to be accepted by the individual and requires sustained effort by the GP.

To better enable people with a severe and enduring mental illness to access basic medical services provided by GPs, the MAC advocates for an adequately costed Medical Benefits Scheme (MBS) item for '*complex needs*' to enable GPs to take the time needed to effectively assess and treat this patient group, particularly those with chronic physical disease. To address the business risk/loss of income issue presented by this client group, the Australian Government must also consider 'block funding' selected GP practices which will enable people living with severe mental illness to get their primary health care needs met. Consideration could also be given to funding credentialed nurses to 'fill the gap' where GPs are unable or unwilling to provide physical health care to this patient group.

In addition, the MAC recommends specific MBS items be created to enable people living with severe and enduring mental illness to access a comprehensive annual health assessment, as well as regular dental care.

Chronic Disease Management under Medicare Benefits Scheme

Currently, the MBS includes a number of chronic disease management items designed to support multidisciplinary care for patients with chronic conditions, such as diabetes or ischaemic heart disease. The General Practice Management Plan (GPMP) (Item 721) allows for an extended GP consultation and plan for the management of a chronic medical condition (defined as one that has been or is likely to be present for at least six months).

A corollary item, the Coordination of Team Care Arrangements (TCA) (Item 723) supports a multidisciplinary approach (a team of at least three health or care providers including the GP) for the treatment of diabetes, for example, where a diabetes educator, podiatrist and general practitioner may provide (MBS rebated) services to the patient under the TCA.

The MAC notes there are several limitations to the utility of these MBS items in respect to adequately supporting health care for people with enduring mental illness. The total number of allied health services (five) allowed per calendar year is too few to support good health for this client group; the rebate is insufficient as an incentive for providers and inadequate for patients if they cannot meet gap payments; and the organisation and paperwork for the GPMP and TCA must be undertaken by busy GPs who find this a disincentive to co-ordinating care. Consequently, and anecdotally, few GPs use these items to arrange care for their patients with a mental illness.

It is recommended that the Victoria Government advocate to the Australian Government to:

- Introduce an MBS item for an annual GP physical assessment of patients with a severe mental health illness as a minimum requirement.
- Implement an adequately funded 'voluntary enrolled' GP population approach for people with severe mental illness on the basis of the degree of health inequality experienced by this population group.
- Reduce or eliminate 'gap' fees for people with severe and enduring mental illness who are economically disadvantaged.

- Provide 'block funding' to selected GP clinics, including Community Health Services, to ensure the prioritisation of access for people with severe and enduring mental illness.
- Consideration funding block funding credentialed nurses to 'fill the gap' where GPs are unable or unwilling to provide physical health care to this patient group.
- Review, expand and tailor the existing MBS Chronic Disease Management items (particularly the under the Team Care Arrangement) to provide additional and more affordable allied health services to people with severe mental illness.
- Review and make the current diabetes Lifestyle Modification Program openly available to, and appropriate for, people with severe mental illness referred through general practice.
- Investigate the tailoring of existing health promotion and lifestyle programs, currently delivered through general practice to patients with chronic disease, to the needs of people with a severe mental illness.

Mental Health Nurse Incentive Program

The Commonwealth funded Mental Health Nurse Initiative Program (MHNIP) currently operating in GP clinics was identified by GPs and the clinical mental health service system as highly successful. This service model offers significant potential to link clients of the specialist mental health service system to GP care. Under the program, Mental Health Nurses may deliver case-management, counselling and appropriate medication administration as required. Amongst many benefits, the capacity to follow up patients who do not attend medical appointments and encourage regular medical attendance was considered to be a noteworthy strength of this program.

The holistic approach to care delivered through this service model ensures that the patient can be managed systemically and in conjunction with the GP for any physical health concerns. Opportunistic intervention is facilitated by the co-location of the Mental Health Nurse with the GP. Patients have been enthusiastic about this program because it is fully funded (no cost to the patient) and there is less stigma associated with attending a mental health nurse in a GP clinic.

Mental Health Nurses in the Melbourne East GP Network

The mental health nurse in the Melbourne East GP Network routinely screens for physical health issues as part of a holistic approach to patient care. This provides a baseline for physical health monitoring and includes BMI and Vitamin D tests. The mental health nurses have a strong focus on physical activity not necessarily related to weight loss but as part of a strategy to improve overall general fitness, motivation and nutrition and reduce late onset diabetes.

Patients have been found to respond well to this holistic approach and feel less stigmatised in relation to their mental health issues.

It is noteworthy that not all general practitioners have Mental Health Nurses engaged by their practice. Currently, there are approximately 60 Mental Health Nurses statewide employed by Divisions of General Practice who work sessionally in local general practices.

The MAC notes practice guidelines for Commonwealth funded Mental Health Nurses working in GP clinics restricts them from seeing patients who are clients of specialist mental health services. However, at least two Victorian divisions of general practice (North East Valley and Geelong divisions) have arrangements with their local Area Mental Health Service to “lease” Mental Health Nurses to work for several sessions per week in local general practices whilst remaining employed by the Area Mental Health Service. This model provides excellent continuity of care to patients once they are engaged with general practice and supports the Area Mental Health service discharge planning. This model also ensures that the GPs patients have timely access to acute care when needed.

Significant opportunity exists to strengthen the interface between Mental Health Nurses in GP service settings and the specialist mental health clinicians. The MAC recommends the Victorian Government advocate to the Australian Government to:

- Expand the Mental Health Nurse Incentive Program and mandate this program to include the physical health of people with severe and enduring mental illness.
- Expand the sub-contractual model of employment of Mental Health Nurses in general practice through Divisions of General Practice and Area Mental Health Services. The MAC, however, notes such a strategy may have significant workforce planning implications.
- Develop of a team-based approach between both service sectors to support the patient to access timely GP care and improve the management of chronic physical disease. This would require expanding the health role for Mental Health Nurses to include support to the specialist mental health clinicians to undertake, review and monitor physical health assessments.

Building a stronger, more connected system of health care

The consultation process identified that many clients of the specialist mental health service system, particularly young people and adults, do not access or maintain sustained engagement with GP services. Navigating GP and specialist medical/surgical services was recognised as particularly difficult for people with severe mental health problems of all ages. The consultation process identified strong support for expanding and improving initiatives that provide coordinated care for clients with severe and enduring mental illness and health and other multiple needs.

It was also noted that unless a GP has a special interest in mental illness they may not see people with a severe mental illness with any frequency. Consequently, specialist mental health services find it difficult to identify and liaise with a GP for every client registered in their service.

The consultation process identified that a significant disconnect currently exists between these service sectors. Building local service relationships and effective communication between general practice and specialist mental health services was identified as critical. It was noted that relationship building takes considerable, sustained effort by both parties.

It was stressed that recent processes, such as Area Mental Health Service discharge planning protocols, put in place to improve two-way access between specialist mental health services and GP care, are not currently uniform or adequate across Victoria. Access to primary care and specialist services, from the clients’ perspective must be straightforward and based on a “no wrong door” approach. Given the intermittent contact clients may have with the specialist clinical mental health system (driven by the episodic nature of the mental illness itself and the throughput nature of the service model) a trusting ongoing relationship with a primary health provider is particularly critical.

Early health intervention can have a major influence on the lifelong health of a young person with a mental illness. An integrated, no wrong door approach is especially important for young people with severe mental illness. In response to this issue, the MAC recommends consideration be given to developing the capacity of the Commonwealth funded *headspace* program to delivery physical health promotion, preventative health care and healthy lifestyle interventions tailored to the health needs of young people with a range of mental health conditions.

In addition, consideration could be given to establishing a statewide General Practice Mental Health Liaison Officer program in Area Mental Health Services, modelled on the existing General Practice Liaison Officer Hospital Program, to support improved access to GP care for clients of the specialist mental health service system. The MAC also recommends that the Victorian Government advocate to the Australian Government to expand the brief of Personal Helpers and Mentors to support clients under shared care GPs/specialist mental health service arrangements to access health care services, including routine visits to GPs.

Specialist clinical mental health specialist services should be supported and encouraged to become early adopters of the Individual Health Identifier (IHI) and the Patient Controlled Electronic Health Records (PCEHR) currently being developed by NeHTA. These initiatives will support the sharing of health information, such as medication and physical status, and should improve continuity of care for shared clients.

4.2.2 Role of Community Health Services

The MAC has identified the following specific roles for the Community Health service sector:

- Work collaboratively with the specialist (clinical and PDRSS) mental health sector to build their capacity in the area of physical health screening, healthy lifestyle coaching, local service networks and referral pathways.
- Provide integrated allied health services, health promotion and chronic disease management programs/interventions to people with severe and enduring mental illness (e.g. smoking cessation, diabetes education, oral health, weight management programs and strength training) with a focus on prevention/early intervention. This could occur in a range of service settings and could be delivered in partnership with both specialist clinical mental health and the PDRSS sector.

The MAC notes that, given policy and funding responsibility for primary health funding of Community Health is flagged for potential transfer to the Australian Government by 2016 (as part of the COAG National Health and Hospital reforms) future action in this area would require joint planning by both tiers of government.

Improving access to health care in Community Health

Community Health services have fewer geographical and eligibility barriers and are well placed to provide a consistent, streamlined access point (a 'no wrong door approach') to the provision of primary health care for all vulnerable population groups, including people with a severe and enduring mental illness.

Further, Community Health services provide a flexible, broad, integrated primary healthcare service delivery platform and have strong and established partnerships with acute services, general practice and Primary Care Partnerships.

The MAC notes that Community Health services have a track record in providing targeted health and wellbeing programs and chronic disease management support in a de-stigmatised environment for marginalised groups, including those who are socio-economically disadvantaged and who experience cultural barriers to service access. Some Community Health services have considerable experience in working with people with severe mental health problems through programs such as complex care outreach, SAVVI (a Supported Residential Service initiative) and as a PDRSS provider.

Community Health services identified the need for a policy-driven, authorising environment, linked to concrete investment in infrastructure and service delivery capacity, to improve the sectors responsiveness to the physical health needs of people with a severe mental illness. While Community Health does and is required to prioritise access to services for a range of groups, including people with a mental illness from July 2010, a priority referral and service access policy would streamline access for people with mental illness to physical health services provided by this service sector.

Such an approach would, however, likely exacerbate demand pressures on this Community Health services. The consultation process identified that many Community Health services struggle to prioritise one group over many others (e.g. refugees, young people, Indigenous people, those with mental illness and the aged) and face significant funding challenges in meeting demand. The limited resource base reduces capacity to adopt stronger affirmative outreach strategies known to be effective for people with a severe mental illness.

Evidence demonstrates that where Community Health is allocated targeted funding to provide particular services, such as refugee health and chronic disease programs, significantly improved outcomes can be achieved for particular high need client groups. The MAC recommends that Community Health be funded to provide tailored health services to young people, adults and older people with severe and enduring mental illness, particularly for oral health, diabetes education, podiatry, PAP screening, sexual health and health self management coaching. The funding model needs to take into account the flexibility and time needed to effectively engage with, and deliver care to, people with a severe mental illness, particularly those who are homeless (as they tend to not seek out support) and cannot afford to pay for services.

Some Community Health services have GP clinics as part of their service platform. However, these clinics often struggle with financial viability due to recruitment issues and the MBS funding model which requires quick flow-through of patients. Community Health settings often provide services to those with the most complex presentations but must rely on bulk billing. While recent changes to the MBS has resulted in better remuneration for this work, there continues to be pressure on some Community Health services to close their GP practices due to viability issues.

The MAC recommends that the Victorian Government give consideration to:

- Providing Community Health with incentives to meet performance targets for people with a severe mental illness. The current funding model should be reviewed in acknowledgement of the additional time and resources required to achieve outcomes for this client group (using the refugee health funding as a potential model).
- Funding selected Community Health services to provide integrated health promotion programs tailored to the needs of people with a severe mental illness taking into account the needs of different age groups and mental health conditions.
- Identifying and evaluating good practice in health promotion in Community Health targeted to people with a severe mental illness and bring these initiatives to scale selectively across this service sector.
- Undertaking training and workforce capacity building in Community Health to increase staff competence and confidence to engage mental health clients and remove stigma often associated with this client group.
- Working with the Australian Government to co-locate block funded general practitioners in selected high volume Community Health services and specialist mental health clinics to improve access to preventative health, medical treatment and chronic physical health disease management.

Building a stronger, more connected system of health care

As part of the Victorian Department of Health Early Intervention in Chronic Disease initiative, a demonstration project was established to improve the early detection of chronic disease of people with a serious mental illness and facilitate timely access to primary health care services. Operating in two catchment areas, led by Eastern Access Community Health (EACH) and Inner South Community Health (ISCH), the demonstration project confirmed the critical importance of providing dedicated resources to build system capacity and connectedness.

The key findings of the demonstration project to date include:

- Physical health assessment of clients of the specialist mental health service system should be the responsibility of the Area Mental Health Services.
- Policies and procedures related to this function should be developed, adopted and embedded in the practice of mental health clinicians.
- Training and workforce development - for the mental health and health/allied health workforce - is critical to support practice and attitude change in this area.
- Referral pathways between specialist mental health, Community Health and general practice need to be defined and agreed and communication between these service sectors strengthened.
- The use of peer mentors should be explored to assist with attending appointments and following a health plan.

The MAC notes that the demonstration project builds on the foundations of service coordination being supported by Primary Care Partnerships (PCP)⁴. Since their inception in 2000, the work of PCPs in Victoria has supported system and organisational planning and practice change to ensure better consumer access to services (particularly those with chronic disease) and improved continuity of care.

The MAC recommends that protocols and policies be put in place and capacity building be undertaken, to improve information sharing, strengthen referral pathways and shared care arrangements between Community Health, GPs and specialist mental health services, using the service coordination platform provided by PCPs and drawing on the learnings of the demonstration project.

Improving access to oral health services

Poor gingival (gum) health and multiple tooth decay is very common in people with mental illness, particularly those who are homeless and have substance misuse and physical health problems. Gum disease is exacerbated by high levels of tobacco use. Dry mouth, a side effect of psychiatric medication, can increase the effects of plaque acids. Other contributing factors include sugary drinks, neglect of personal oral care, other medical conditions and poor nutrition (due to low income, lack of nutritional knowledge and poor cooking skills or facilities).

⁴ Primary Care Partnerships provide a platform for joint planning to support the implementation of integrated health promotion, integrated chronic disease management and better service coordination across a range of member agencies, including mental health, primary health and community and aged care services. Divisions of General Practice and Community Health Services are part of the core membership of PCPs.

What works well in Community Health

The consultation process identified the following good practice models, approaches and opportunities:

- *The Early Intervention in Chronic Disease (EICD) management models used by Community Health and the learning's accrued with groups experiencing significant health inequality, such as Aboriginal people and refugees, could be applied/adapted for people with severe mental illness. Intervention approaches that could be extended to people with a severe mental illness include health coaching, adoption of the Active Service Model principles and motivational interviewing techniques.*
- *Self management support approaches promoted by Community Health could be used to support and empower people with a mental illness to develop the skills and confidence needed to better manage their health and engage with health services.*
- *Existing health literacy and health promotion programs could be tailored to this group.*
- *Primary healthcare could be provided on an assertive outreach basis. The mobile dental program targeted to people who are homeless in the inner south and outer east, are examples of such as service.*
- *Ability to refer internally to GPs working in Community Health.*
- *Using general practice to write 'lifestyle' scripts which the client is then supported to implement has proven successful.*
- *Open Health Day sessions to familiarise clients with Community Health service settings and services. This has worked well clients with mental illness as well as refugees and Aboriginal people.*
- *Some Community Health services have developed 'health interest' working parties with local GP and mental health services to further local area planning and cross sector collaboration.*

People with severe mental illness may also display extreme dental phobia, anxiety and paranoia, with high do not attend and treatment refusal rates. They may also fear judgement regarding the personal neglect of their teeth. The combined impact of these issues makes dental treatment for this group more time-intensive and expensive. Clearly, affordability is a key barrier to accessing dental care.

The MAC strongly recommends that:

- Dedicated block funding be allocated to public dental clinics in Community Health, Multi Purpose Services and Rural Health Services to provide free dental services for people with severe mental health problems (targeting those experiencing socio-economic disadvantage). These services should be delivered both onsite and through outreach venues.
- That service models like the *Dental as Anything* program be enhanced and expanded in selected sites in recognition of the particular barriers to accessing dental health care faced by people with a severe mental illness who are homeless.

'Dental as Anything' program³¹

This program is a collaborative partnership between mental health, dental and administrative teams in Inner South Community Health Services (ISCHS) using a cross-team approach delivered through assertive outreach. A dentist, dental assistant and mental health outreach worker take dentistry and mental health to a variety of settings, targeting hard to reach people living rough, in rooming houses and Supported Residential Services (SRS). It provides a flexible program incorporating engagement, clinical care, education and support in response to client needs.

The program rotates through these venues providing weekly sessions to create familiarity. Education sessions are also provided to staff at SRS and mental health clinics. The combination of assertive outreach and health promotion appears to be critical in delivering effective programs to this group. This program has been operating for six years and is part of ISCHS wider dental program. Success factors include: assertive outreach; health promotion; use of a peer model for engagement; cross-team collaboration; efficient, flexible and sensitive care; and block funding, which guarantees a fee free service.

4.3 Targeted health intervention and health promotion

The literature recognises that if supported to lead healthier lifestyle, people with a severe mental illness will improve their physical health as well as their psychological wellbeing. It also provides a strong evidence base for the health benefit of smoking cessation, physical activity and diet management for this population group.

4.3.1 Smoking cessation

Smoking is the largest cause of preventable illness in the United States, the United Kingdom, Canada, Australia, and many other countries. Smokers with mental illness smoke significantly more than the general community and therefore experience even greater smoking-related harm.

Smoking may be the most modifiable risk factor for decreasing the excess mortality and morbidity people with a mental illness face³². While research demonstrates that tobacco interventions can be effective for this population group, they are not commonly utilised in clinical practice. In addition to a high risk for metabolic syndrome, smokers with mental illnesses have more psychiatric symptoms, increased hospitalisations and require higher dosages of medications³³.

Smoking also increases the metabolism rate of many psychotropic medications used to treat mental illnesses such as schizophrenia, reducing both medication effectiveness and side effects³⁴. Persons with mental illnesses may, in part, smoke to reduce medication side effects such as akathisia³⁵.

Research conducted by Access Economics for SANE Australia³⁶ estimates the total financial cost to Australia from smoking by people with a mental illness was \$3.52 billion dollars in 2005. The report makes recommendations for cost effective interventions in smoking cessation for people with mental illness which include proactive telephone counselling coupled with Bupropion or Nicotine Replacement Therapy (NRT).

The VicHealth Centre for Tobacco Control advocates the use of NRT over Bupropion in a paper prepared for the Australian Pharmaceutical Benefits Advisory Committee. Bupropion is cited as a risk factor for serious neuropsychiatric symptoms³⁷. The MAC notes the nicotine patches have been approved by the Pharmaceutical Benefits Scheme (PBS) and are awaiting government approval.

Quit Victoria

Quit Victoria's Quitline callback service offers an additional tailored service for smokers with a history of depression. The service model involves Quitline and GP co-management of smoking cessation and depression, and tailored counselling that promotes strategies that assist with both smoking cessation and mood control. Analysis of this service model³⁸, demonstrated that quitting smoking was associated with improved mood and was not reliably associated with precipitation or exacerbation of major depressive disorder. The findings allayed concerns about the safety of quitting for smokers with a history of depression and have resulted in Quitline policy and practice changes.

Research suggests few mental health providers currently ask patients about smoking or advise them to quit. Research by Morris et al³⁹ has found that people with a severe mental illness often want to quit smoking, but struggle to find assistance and encounter barriers to accessing effective tobacco cessation services within the public mental health system. Insufficient resources are exacerbated by lack of knowledge and the negative expectations of both patients and providers. It does not help that many mental health workers also smoke, often at higher rates than health providers in other fields.

The Mac notes that current treatment options for smoking cessation in general populations are not tailored to the unique characteristics of people with mental illness and quit rates are still substantially lower than the general population.

Another paper by the VicHealth Centre for Tobacco Control⁴⁰ proposes that people living with extreme social disadvantage warrant special support with assistance to quit smoking, arguing that costs could be minimised by incorporating smoking cessation treatment into standard treatment and service protocols, mandated by governments in funding agreements.

The MAC recommends the following action areas be considered to reduce high prevalence of smoking by people with a severe mental illness:

- Address the misconception that smoking cessation is unrealistic in people with a mental illness and recognise that smoking is a coping strategy for anxiety and boredom.
- Acknowledge that people with a mental illness have the same desire to stop smoking as the general population and they find it difficult to cease this behaviour due to the addictive nature of nicotine.
- Recognise that smoking is an addiction and that targeted specialist strategies are required and should be developed by relevant agencies to assist this client group.
- Actively promote and police smoke-free clinical environments, supported by replacement therapy and behavioural change, in all specialist mental health service settings including inpatient services.
- Provide mental health staff with information on the benefits of smoking cessation for themselves and their clients.
- Develop and implement a training program for mental health staff on smoking cessation (to be delivered as a standard part of clinical treatment) and fund a targeted smoking cessation program tailored to the needs of this client group (could be delivered through Community Health).
- Consider providing peer to peer support services to promote smoking cessation and other healthy lifestyle behaviours.

4.3.2 Nutrition

Evidence suggests that the excess of mortality and morbidity seen in people with a severe mental illness is, to a significant degree, the consequence of diet or weight-related chronic disease. In fact poor diet has been found to be a higher risk for premature mortality than risk of suicide, accidental and violent death for people with a severe mental illness.

The cost of buying nutritious food was identified as a significant issue for people with a severe mental illness, particularly those living alone. Cooking skills and access to cooking facilities are also identified barriers.

Nutrition was identified as a significant issue in the consultation process. Specialist clinical mental health services identified the need for training, evidence based guidelines and information on nutritional advice, including strategies for motivating clients to improve their diet.

The MAC recommends the following action areas be considered:

- Provide specialist clinical mental health services and the PDRSS sector with training and information on the provision of nutritional advice including the use of motivational techniques.
- Provide clients of the specialist mental health service system with information on the benefits of a good diet.
- Take action to improve access to dietitians in Community Health, including increasing capacity of this service sector to prioritise access to people with severe mental illness.

4.3.3 Improving physical activity

Individuals with severe mental illness are at high risk of chronic diseases associated with sedentary behavior, including diabetes and cardiovascular disease.

There is a strong link between regular exercise, improved health and wellbeing and lifestyle modification on chronic disease outcomes. Evidence for the psychological benefits of exercise for clinical populations comes from two meta-analyses of outcomes of depressed patients that showed that effects of exercise were similar to those of psychotherapeutic interventions. Exercise can also alleviate secondary mental health symptoms such as low self-esteem and social withdrawal⁴¹.

Structured exercise program in Community Care Unit⁴²

A structured exercise program was developed and implemented for residents of a Community Care Unit in metropolitan Melbourne. Six residents participated in the program over a period of three months. The findings of this study suggest that involvement in the program produced very positive outcomes, most notably in the physical fitness of residents. The individual nature of the program which enabled gradual participation and the cohesive approach of the group as a whole were considered very important factors contributing to the overall success. Positive outcomes observed included improved mood, positive attitude change and a reduction in depression, anxiety, anger and rebelliousness.

People who exercise regularly frequently report a feel-good effect. Regular exercise also assists people to see themselves more positively as a result of changes in body image, improved fitness, strength and skill and resultant sense of self control and self efficacy. Furthermore, exercise is a key factor in effective weight control.

Exercise also offers a simple and relatively cheap alternative or adjunct to drug therapy. However, the evidence for the mental health benefits of exercise is not widely recognised outside the exercise fraternity. Some researchers have claimed that this is a result of reluctance in accepting exercise as a simple solution to 'highly clinicalised' problems⁴³.

Research also suggests that exercise is well accepted by people with severe mental illness and is often considered one of the most valued components of treatment. Adherence to physical activity interventions appears comparable to that in the general population⁴⁴.

The potential value of regular exercise for people experiencing a mental illness has significant implications and warrants further exploration.

ReLink – a sport and recreation service model⁴⁵

ReLink provides sport and recreation activities for highly marginalised people, many of whom have a mental illness. A summary of social impacts from interviews conducted with 61 ReLink participants found:

- 84% reported new friendships with other participants
- 83% reported their relationship with their support worker or agency improved
- 64% reported their relationships with family and friends improved
- 87% reported their physical wellbeing had improved
- 87% reported their confidence had improved.

Some comments from participants on their view of the benefits: "Killing Boredom"; "Relaxes me."; "Occupy mind"; "Getting off my meds"; "Getting better, not aggressive anymore"; "Being part of a group, team. Working together and supporting others. Challenge of each activity. Stepping out of your comfort zones and feeling supported by each other"; "It's like an extended family"; "It helps me with my recovery from depression and drugs and alcohol." "Better relationships with team and staff members"; "Less depressed and less isolated".

The MAC recommends the following action areas be considered in respect to physical activity:

- Provide specialist mental health services with information on the benefits of physical activity and motivational techniques.
- Provide clients of the specialist mental health service system with health promotion information on the benefits of regular exercise.
- Develop and deliver evidence-based physical activity interventions for individuals with severe mental illness, including those in bed-based clinical rehabilitation services.
- Support people with severe mental illness to access local physical activity services and programs provided by local government and non government organisations, while building the capacity of these services to respond to the needs of this group. Consideration could be given to the role of PDRSS Day Programs in delivering this support.
- Work with Sport and Recreation Victoria, Department of Victorian Communities, to expand service models such as Reconnect to people with a severe mental illness.

Appendix 1 Summary of recommendations and areas for action

	Specialist (clinical and PDRSS) mental health service system	General Practice	Community Health
Principles	The physical health of people with a severe mental illness should form an integral part of their overall treatment and care.	All people with a severe mental illness, <i>irrespective of whether they are clients of the specialist mental health service system or the nature or acuity of their mental illness</i> , should have a general practitioner responsible for their physical health care.	People with a severe mental illness who are socio-economically disadvantaged should have priority access to Community Health for their physical health care.
Recommendation	That the Victorian Department of Health require physical health to be integrated into the policy, practice and service delivery of the specialist clinical mental health and PDRSS service system. This will require an unambiguous authorising policy environment, coupled to strong leadership and careful, sustained investment in infrastructure, workforce development, system capacity and evidence base.	That the Victorian Government strongly advocate to the Australian Government to take proactive, sustained action to improve access to affordable and responsive general practice health care and primary health services to close the health inequality gap experienced by people with severe and enduring mental illness. Areas for action are identified below.	That the Victorian Government in collaboration with the Australian Government recognise the highly valuable role Community Health can play in improving the physical health of people with severe mental illness and take steps to strengthen the capacity of this service sector to achieve demonstrable outcomes in this area.
Areas for action			
<i>Strengthen system infrastructure capacity & accountability</i>	Establish a statewide physical health advisory body to oversee the system reform and development needed to drive outcomes in this area, including research and the development of clinical guidelines, health promotion resources and targeted health promotion strategies and interventions. Develop a clear policy and authorising environment that has high level engagement within Health Services and at the Clinical Director and nurse manager level of specialist clinical mental health services, to drive the structural, practice and cultural change required. Provide an equivalent policy framework mandating PDRSS to incorporate physical health into its core business. Establish time limited positions in Area Mental Health Services to support the change management needed to embed physical health in organisational policy, practice and culture. Create an expectation that all clients of the specialist mental health service system be in a shared care arrangement with a GP for their physical health needs.	Mandate that local General Practitioners are represented on the decision-making committees for Area Mental Health Services. Advocate to the Australian Government to: - Implement an adequately funded 'voluntary enrolled' GP population approach for people with severe mental illness on the basis of the degree of health inequality experienced by this population group. - Improve reporting and accountability of GP care for people with severe and enduring mental illness.	Provide Community Health Services with incentives to meet performance targets for people with a severe mental illness, including a review of current funding model in acknowledgement of the additional time and resources required to achieve outcomes for this client group (using the refugee health funding as a potential model).

	Specialist (clinical and PDRSS) mental health service system	General Practice	Community Health
	Develop physical health outcome measures and performance indicators for inclusion in existing reporting and accountability frameworks for all specialist clinical mental health and PDRSS sector. Regularly disseminate progress against accountability measures to all sectors involved in the physical health care of this client group.		
<i>Drive practice change & improved access</i>	Review use of newer antipsychotics in people with significant weight gain, metabolic abnormalities or diabetes and provide medical staff with the skill, confidence and competency to explore the full range of alternative medications. Develop a chronic physical disease management framework tailored to the specific needs of people with mental health problems. Include physical health care in the planned reintroduction of the Chief Psychiatrist's Office reviews. Develop practical health promotion resources for use by specialist clinical mental health and PDRSS staff.	Advocate to the Australian Government to: • Introduce an MBS item for an annual GP physical assessment of patients with a severe mental health illness as a minimum requirement. • Review and tailor the existing MBS Chronic Disease Management items to provide more and affordable allied health services under the Team Care Arrangement to people with severe mental illness. • Investigate the tailoring of existing health promotion and lifestyle programs, currently delivered through general practice to patients with chronic disease, to the needs of this client group. • Review the Life! Taking Action on Diabetes and RESET your Life diabetes programs to be appropriate and accessible for people with severe mental illness. • Review and make the current diabetes Lifestyle Modification Program (LMP) open and appropriate for people with severe mental illness referred through general practice.	Identify and evaluate good practice in health promotion in Community Health targeted to people with a severe mental illness and bring these initiatives to scale selectively across this service sector.
<i>Workforce capacity development</i>	Provide the specialist mental health service system with training in the area of physical health, including physical assessments, healthy lifestyle counselling, nutritional and exercise advice and how to deliver health promotion education and advice. Provide mental health staff and clients with training and information about causes of dental decay and strategies for promoting oral health care.	Advocate to the Australian Government to strengthen training (tertiary and post graduate) for GPs in the provision of preventative health care and medical treatment for people with a severe mental illness.	Undertake training and workforce capacity building in Community Health to increase staff competence and confidence to engage mental health clients and remove stigma often associated with this client group.

	Specialist mental health service system	General Practice	Community Health
Areas for action			
<i>Targeted investment in new capacity/expand existing capacity and resources</i>	Consider funding mental health nurses/nurse practitioners in specialist mental health clinics to undertake physical health assessments (targeted to high volume clinics), healthy lifestyle counselling and targeted health promotion interventions. Resource and require PARC services to undertake physical health assessments and lifestyle counselling or deliver this through a nurse practitioner/GP 'in reaching' into this service setting. Establish and standardise Consultation Liaison psychiatry services in all regional and metropolitan hospitals to enable mental health teams to provide treatment and support to people with mental illness admitted to medical and surgical wards. Establish arrangements for medical and surgical staff to provide assessment and treatment for people with physical health problems who are inpatients of acute psychiatric units. Provide child and adolescent, adult and aged mental health services with funding to purchase resources needed to do physical health assessments (e.g. weighing devices and blood pressure monitors) and brokerage funding to purchase disposable items for use by clients (e.g. NRT patches, dental hygiene kits). Investigate the efficacy of using the peer support model to deliver health promotion messages to clients, for example, smoking cessation, weight management advice and healthy eating. Provide access to free dental hygiene kits in mental health clinics, PDRSS and Community Health services. Develop and deliver evidence-based physical activity interventions for individuals with severe mental illness, including those in bed-based clinical rehabilitation services. Support people with severe mental illness to access local physical activity services and programs provided by local government and non government organisations, while building the capacity of these services to respond to the needs of this group.	Explore co-locating general practitioners in high volume specialist mental health clinics/joint clinics/Community Health services to improve access to both preventative health and chronic physical health disease management. Expand the Mental Health Nurse Incentive Program and mandate this program to include the physical health of people with severe mental illness. Consider expanding the brief of Personal Helpers and Mentors to support patients of Shared Care GPs/Specialist Mental Health services to access health care services, including routine visits to GPs.	Fund Community Health to provide integrated health and wellbeing and health promotion programs tailored to the needs of people with a severe mental illness taking into account the needs of different age groups and mental health conditions. Provide dedicated block funding to public dental clinics in Community Health to provide free dental services for people with severe mental health problems, targeting those experiencing socio-economic disadvantage. Expand and enhance models like the <i>Dental as Anything</i> program in selected sites in recognition of the particular barriers to accessing dental health care faced by people with a severe mental illness who are homeless.

	Specialist mental health service system	General Practice	Community Health
Areas for action			
<i>Strengthen cross sector planning, coordination and collaboration</i>	Drive improved local area planning, service coordination and the development of stronger referral pathways between specialist mental health, general practice and Community Health through Primary Care Partnerships and the proposed Medicare Locals. Mandate the newly created mental health local area planning and service coordination positions located in Department of Health Regions to take a lead role in facilitating this outcome. Report on outcomes achieved in this area as part of annual reporting for Area Mental Health Services and implementation of the <i>Victorian Mental Health Reform Strategy</i>. Advocate to the Australian Government to further develop the capacity of the <i>headspace</i> program to delivery physical health promotion, preventative health care and healthy lifestyle interventions tailored to the health needs of young people with a range of mental health conditions. Consider the establishment of a statewide General Practice Mental Health Liaison Officer program in Area Mental Health Services, modelled on the existing General Practice Liaison Officer hospital program, to support improved access to GP care and continuity of care. Support and encourage mental health specialist services to become early adopters of the Individual Health Identifier (IHI) and the Patient Controlled Electronic Health Records (PCEHR) currently being developed by NeHTA. Mandate the use of existing Electronic Service Coordination tools such as S2S or the ESC system to facilitate referrals, service pathways and continuity of care between specialist mental health services, the acute health system, GPs and Community Health.	Strengthen opportunity for integrated physical health and mental health assessments and care planning between general practice and specialist clinical mental health services. Explore the role of the proposed Medicare Locals in supporting this outcome. Promote the use of existing Electronic Service Coordination tools such as S2S or the ESC system to facilitate referrals, service pathways and continuity of care between specialist mental health services, the acute health system, GPs and Community Health.	Develop the role of PDRSS and Community Health in promoting access to, or delivering, health lifestyle programs, in collaboration with general practice. Implement protocols, policies and practice change need to improve information sharing between Community Health, GPs and specialist mental health services, using the PCP platform. This includes exploring the use of care planning software such as shared electronic client files. Mandate the use of existing Electronic Service Coordination tools such as S2S or the ESC system to facilitate referrals, service pathways and continuity of care between specialist mental health services, the acute health system, GPs and Community Health.

	Specialist mental health service system	General Practice	Community Health
Areas for action			
<i>Research and information</i>	Invest in research and evaluation to build the evidence based needed to support good clinical practice and continued improvement in physical health service delivery. This includes research to assess the impact of different forms of psychiatric medication on physical health of people with severe mental illness.	Provide general practice with up to date information about resources that are available locally using Divisions of General Practice. Consider the use of information technology to make this information easy to access. In time, the proposed Medicare Locals should play a key role in service mapping and social network mapping to support general practitioners to provide care for this patient group.	Invest in research and evaluation in Community Health. Use of Action Research and narrative evaluation strategies which engage clients in formative evaluation processes not only add to the evidence but reinforce change.
<i>Acute health, discharge from hospital and Emergency Departments</i>	The Victorian Government, in collaboration with the Australian Government, should take all necessary action to ensure the physical health of people with a severe mental illness are prioritised by the acute health care system. This includes ensuring the Local Hospital Networks (LHN) proposed as part of COAG National Health and Hospital Reforms are held directly accountable for their performance in this area and that this is reflected in LHN service agreements and related performance standards and measures. Develop and implement a strategy to strengthen the role of ED in respect to the physical health of people with a mental illness. This may include consideration of: standardised physical health assessments; education and training for staff in the ED to improve skill, confidence and competency in the diagnosis of physical illness in this target group; performance measures to strengthen accountability for outcomes in this area; and a review the four hour target for assessment in the ED to allow adequate time for a physical assessment to be undertaken. Expand the HARP service model to clients with severe mental health and chronic physical health conditions. Encourage Crisis Assessment and Treatment and Case Management teams to actively support clients with physical health conditions identified while in hospital to link to their GP and/or specialist medical/surgical care on discharge and follow up with case managers regarding issues related to the physical health assessment.		

Appendix 2 Summary of Key Issues – General Practice Health Care

Key patient related barriers to GP care identified in the consultation process included:

- Affordability in situations where bulk-billing is not available.
- Geographical access, particularly in rural and outer urban areas.
- Transport to attend appointments, particularly frail older people.
- Limited knowledge about how to access GP services, especially young people.
- Lower level of health seeking behaviour by people with a severe mental illness.
- Family or social support to this client group for the care of their physical health is not uniformly reliable.
- Responsiveness of some GP services and reception staff – the consultation noted attitude, interest, experience and skill in working with people with severe mental health problems is variable.
- Tendency by some GPs to neglect physical health problems, focusing only on the person's psychiatric condition.
- Problems with inflexible appointment systems and inaccessible information.

Experience of illness and noisy or crowded waiting areas are also barriers to accessing general practice health care⁴⁶. Research has also identified stigma and discrimination on the part of health care professionals as an additional barrier⁴⁷. Further, studies have shown that people with a mental illness who do use health services are much less likely to be offered blood pressure, cholesterol, urine or weight checks, or to receive opportunistic advice on smoking cessation, alcohol, exercise or diet⁴⁸.

The consultation process identified the following key issues and system barriers from the perspective of general practice:

- Insufficient supply of GPs, particularly in rural areas, to address the physical care of the community generally.
- Referral pathways between general practice and the specialist mental health service system need strengthening, including exchange of information and feedback.
- Time pressures and need for long appointments make this work difficult for GPs. The relatively high 'failure to attend' rate of this client group is a significant issue both in terms of continuity of care and cost to practitioners who are running small businesses.
- The lack of mental health case managers is a significant barrier to achieving coordinated and better integrated physical health care. The limited capacity for case managers to provide long term support to mental health clients was seen by GPs as a barrier to improving physical health outcomes. The skill and competency of case managers and how they view their role was also seen as a critical issue.
- Constraints on the use of Commonwealth funded Mental Health Nurses operating in selected GP clinics.
- General practitioners need specific training and support to provide medical treatment and preventative health care for people with severe and enduring mental illness.
- Maintaining ongoing engagement with this patient group can be highly problematic, particularly with those that are transient.
- Lack of availability of, and information about suitable community services in the local area limits the capacity of GPs to support people with severe mental illness to achieve better self-management of their physical health.

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