Workforce development for better management of physical comorbidities among people with serious mental illness

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Collaborative and holistic care that addresses multimorbidity could reduce excess disease burden and improve life expectancy

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The health burden in people with serious mental illness is considerably greater than that for the general population, with average life expectancy as much as 20 years lower for people with serious mental illness.[1] Co-existing chronic physical illnesses (predominantly cardiometabolic diseases), rather than mental health issues, contribute the majority of excess disease burden leading to this life expectancy gap.[1] Factors that adversely affect quality of care and health outcomes for established physical health conditions include: poor coordination of care; "diagnostic overshadowing" leading to physical health issues being overlooked; failure to refer patients to lifestyle modification programs; and lack of support for medication management.[2]

The Being Equally Well initiative established a roadmap to provide effective and improved care for patients with serious mental illness and co-existing physical health problems.[2] For the purposes of Being Equally Well, serious mental illness was defined as including "conditions requiring antipsychotic therapy, those requiring shared care provided between psychiatrists and GPs and thought disorder conditions rather than neuroses".[3] The roadmap documented significant potential roles for nurse navigators, pharmacists and allied health professionals to support a model of care shared between general practice and mental health services in Australia.[2] In this article, we describe the rationale for greater involvement by these health professional groups, to support improved physical health for people with serious mental illness in Australia.

Nurse navigators

A shared concern of consumers and carers engaged in Being Equally Well, which was endorsed by other stakeholders, was that people living with serious mental illness and their closest carers receive little or no support to navigate the complexities of services and systems that provide mental health care, physical health care and social support.[3] Current guidelines indicate that intensive external support is needed to optimise outcomes.[4] Social needs that contribute to better mental and physical health, and which could benefit from external assistance, include financial and housing security, meaningful employment, education, and other opportunities to engage in society.[2,5] The Being Equally Well roadmap and technical report provide details on why an expanded workforce of nurse navigators is considered the best evidence-based, clinically effective and currently feasible approach to addressing some of the multifaceted needs of people living with serious mental illness.[2,3] Potential roles of nurse navigators, depending on initial and ongoing shared understanding of individual patients' needs, are described in the Box.

Potential roles of nurse navigators for shared and improved care of patients with serious mental illness

Potential role	Purpose
Navigating care (primary role)	To help patients access primary care, specialist care and social services, including the National Disability Insurance Scheme
Managing cases	To ensure service episodes align with care goals, and to ensure follow-through of recommendations
Coordinating care	To ensure information flow and timeliness of appointments across multiple providers
Planning care	To assist the general practice team to create meaningful patient-held plans (that comply with Medicare rebate requirements)
Coaching patients	To support patients with making lifestyle changes
Prescribing social services	To connect patients with local non-health activities and services, including support groups and peer workers
Liaising with carers	To give carers and next of kin a voice, while maintaining patients' rights to privacy and autonomy
Assisting with panel management	To ensure medication monitoring and physical health checks are offered to all patients on the practice register in line with national shared care guidelines and local protocols
Educating and advocating	To increase the capacity of service providers to respond to the needs of individuals with serious mental illness

A nurse navigator workforce would require experience or training in caring for people with serious mental illness together with knowledge about prevention and management options for associated physical illness. Community psychiatric nurses are ideally placed to take on this work due to their extensive social interactions with patients. To expand such a service, practice nurses, occupational therapists, social workers and psychologists could be included in the workforce with appropriate expertise and/or training to take on this multifaceted and central role to improve clinical care and social support.

Nurse navigators would ideally work as part of the primary care team, embedded in general practice, where patients access most health care.[2] The value proposition for general practice clinics is to have a valuable resource to help manage patients with chronic and complex care needs. The Being Equally Well working groups identified that some patients do not have a primary care "home".[3] General practice clinics with an embedded nurse navigator, or access to one, would be expected to accept these additional patients.

The role of nurse navigators in health has been investigated in the contexts of specific diseases and specific high risk populations.[6-9] Many investigations fail to measure the quadruple outcomes of good health care (health outcomes, financial value, patient experience, and provider experience).[6,7] Reported outcomes are mixed; it appears that the more successful programs are those where the nurse navigator has contractual and in-person connections to service providers, and where the intervention is more comprehensive.[6,7,9,10]

Some existing roles and funding mechanisms could be adapted, expanded or used in conjunction to support the roll-out of nurse navigator roles and services (eg, community mental health nursing and team care arrangements). A clinical nurse consultant role based on a case management model, incorporating strong clinical and mental health knowledge, could be used in a nurse navigator workforce. The funding could be covered by existing Medicare arrangements, but this would need some expansion.

Pharmacists

The need for more effective medication management was an overarching priority of Being Equally Well consumers with serious mental illness, consistent with international literature.[4] Potential adverse effects of antipsychotics and other medications, including the impact of antipsychotic agents on weight gain and cardiometabolic risk, were a major concern of the Being Equally Well consumers and carers group. Related to this was a strong expectation and desire for shared decision making and informed consent, and clinician respect for patient concerns about medications. Pharmacists represent a highly accessible and trusted source of expertise in medication management that could be better utilised.[11] More effective medication reconciliation and management within a shared care model should, compared with current practice, reduce unnecessary polypharmacy, improve the accuracy of medication records, increase patient engagement with medication management, and increase patient uptake of medications that prevent and control chronic diseases.

Australian and international evidence suggests that introducing structured pharmacist interventions in different settings can improve the effectiveness and cost-effectiveness of managing chronic diseases.[12-15] Common intervention components for patients with serious mental illness include medication reconciliation, patient education, adherence and self-monitoring interventions to support prescribing, medication reviews followed by medication-related recommendations to prescribers, therapeutic drug monitoring, dose titration, and screening and monitoring for cardiometabolic risk factors.[12] There is strong evidence that interventions by pharmacists are feasible and acceptable for people with serious mental illness in Australia and elsewhere.[16-18] Global evidence supports pharmacist interventions to reduce medication and documentation errors. In addition, international reviews show that pharmacists are already highly integrated into inpatient and outpatient care processes used by people with serious mental illness, and that they can support a range of improvements (eg, medication safety improvements).[16,17]

Existing schemes, such as the MedsCheck program in community pharmacy and the Home Medicines Review program, can be used to support people with serious mental illness. However, current remuneration might be inadequate given the complexity of medication management for many patients with serious mental illness. Pharmacists working in general practice, as well as hospital-based mental health pharmacists and outreach pharmacists who liaise with general practice and community pharmacy, are also well placed to provide leadership in these efforts where they exist, but availability and funding is inconsistent.

Allied health

In addition to the need for comprehensive lifestyle support for managing physical health needs, the roles of exercise, diet and nutrition as first line prophylactic treatments for severe mental illness are increasingly being recognised and recommended in Australian guidelines.[19] Allied health professionals are ideally placed to design and deliver lifestyle interventions that target modifiable risk factors, including suboptimal diet, physical inactivity and smoking in people with serious mental illness, hence the importance of ensuring access to relevant allied health professionals.

Evidence from meta-analyses has shown that lifestyle interventions delivered by tertiary qualified allied health professionals are associated with lower drop-out and greater efficacy compared with interventions delivered by those with less or non-specialised training.[20-22] For example, a meta-analysis of interventions aimed at reducing weight and cardiometabolic risk among people with serious mental illness determined that dietitian-led interventions had a larger effect size than interventions led by other

health professionals.[22] Similarly, recommendations made in a 2019 *Lancet Psychiatry* Commission report included integrating and embedding allied health professionals as routine members of the standard multidisciplinary mental health team.[23] Other recommendations in the report related to successful implementation of lifestyle interventions that are supported by Australian evidence. One such recommendation was to prioritise early lifestyle intervention to prevent deterioration of physical health; this was based on evidence such as study results showing that antipsychotic-induced weight gain in young people with early psychosis can be reduced or prevented during a 12-week program, with benefits maintained at 2-year follow-up.[24] Another such recommendation was to address staff and workplace culture to ensure that traditional mental health staff are aware of the roles, responsibilities and services provided by allied health staff as they increasingly integrate into multidisciplinary and shared care mental health teams.[25]

Australia provides funding for access to allied health interventions through the Medicare Benefits Schedule. People living with chronic disease are eligible for referral to allied health professionals under the arrangement known as Chronic Disease Management — GP services. Eligible patients, including people living with serious mental illness who might be eligible, have funding support for up to five sessions per calendar year which can be distributed between professions based on the unique needs of the individual. However, both the possibility that a gap fee is charged by the allied health service, and the limited number of visits funded, means that these arrangements can be insufficient to address the needs of people with multiple comorbidities.

Discussion

In summary, improved physical and mental health outcomes for people with serious mental illness depend on adequate and effective multidisciplinary and shared care that is resourced appropriately by relevant health professionals working within a shared care model. Reducing preventable deaths in people with serious mental illness requires mental and physical health services to incorporate treatment and care services that include the expertise and capacity of nursing, pharmacy and allied health professionals. To ensure that there is holistic and best practice care for people with serious mental illness, the health care team must have the capacity to:

- consider the needs of people with serious mental illness from the perspective of multimorbidity involving serious mental illness;
- provide multidisciplinary care and multifaceted lifestyle, psychological, medication and social support; and
- address the health and health care burden of serious mental illness through effective advocacy and care coordination.

International evidence and emerging Australian experience indicate that collaborative care for people with serious mental illness can improve physical and mental health care, can improve related health outcomes, and may reduce inequity related to socio-economic and ethnic background.[26]

Currently, a coherent national approach to multidisciplinary care appears challenging. Existing Medicare items and other funding sources might adequately fund appropriate services for some individuals, but they are limited in their relevance — in terms of financial and practical accessibility — to the complex needs of people with multiple and significant comorbidities. Similarly, inherent financial disincentives exist for allied health and pharmacy to engage comprehensively with the needs of patients with more complex needs, which entails increased workload, if funded by programs with standardised remuneration.[27] Moreover, many patients are from rural and regional areas and communities with low socio-economic status, where workforce capacity is already strained.[3] Equitable approaches to care will require policy and funding that supports relevant health professionals to engage adequately with vulnerable individuals and communities. This is needed to enable coordination of team-based and patient-centred care, and to overcome the many systemic barriers to effective care for people with serious mental illness and co-existing physical health issues.

In conclusion, there is sufficient and persuasive evidence on how to support coordinated multidisciplinary management of physical health for people with serious mental illness. Achieving this might not require substantial new investments but will require expanded and better targeted access to services for individuals and health professionals. Tailored policy settings and workforce programs would ensure equitable access to such care.

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