

BEING EQUALLY WELL
IMPLEMENTATION ACTION PLAN
FOR
BETTER HEALTH CARE AND LONGER LIVES FOR
PEOPLE LIVING WITH SERIOUS MENTAL ILLNESS

OCTOBER 2022



ABOUT THE PROJECT

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

This Implementation Action Plan is the culmination of the Being Equally Well project and is intended to provide all stakeholders with responsibility for or commitment to this issue – government policy-makers, funders and administrators, health services and their administrators, health professionals and their practices and advocacy and consumer organisations – with a set of feasible, affordable and evidence-based action steps to achieve uptake and implementation of system and practice improvements that will both facilitate and encourage improved physical health care and better health outcomes for people with serious mental illness. These improvements are recommended in the Being Equally Well National Policy Roadmap, launched in August 2021, that provides a suite of interdependent evidence-informed policy recommendations for primary health care and services; mental health care and services and public health agencies that are designed to measurably improve the physical health of people with serious mental illness and close the life-expectancy gap between this group and the general Australia population.

ABOUT US

The Mitchell Institute for Education and Health Policy at Victoria University is an independent education and health policy think tank. Our focus is on improving health and education systems so more Australians can engage with and benefit from these services, supporting a healthier, fairer and more productive society.

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

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

ACKNOWLEDGEMENTS

More than 200 experts have contributed to this project and its reports. The Mitchell Institute acknowledges the work of all participants in this project, each of whom gave many hours of their time and committed their personal and professional knowledge to work collaboratively on the complex problems at the heart of this challenge. All participants are acknowledged as authors of the report of the working group or groups in which they participated.

Particular thanks to Professor James Dunbar who has been involved with the design and undertaking of this project from its inception and brought together the clinical expert working groups for the project. Also to members of the Project Steering Committee, who worked together to guide the project throughout 2021 and 2022. Committee members from Equally Well Australia are Professor Malcolm Hopwood, Dave Peters, Professor David Castle, Lee Cobb and Professor Russell Roberts; Professor Mark Morgan and Professor James Dunbar of the AHPC; Dr Chris Moy; and the National Mental Health Commission represented by Susan Hayward and subsequently Clare Sullivan. The Mitchell Institute team comprised Stella McNamara who coordinated all meetings and summary notes for the implementation working groups; Anouk Sherman who has organised and supported all public events and the final symposium, Adjunct Associate Professor Maria Duggan, Professor Maximilian de Courten and Professor Rosemary Calder.

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BEING EQUALLY WELL: IMPLEMENTATION ACTION PLAN FOR BETTER HEALTH CARE AND LONGER LIVES FOR PEOPLE LIVING WITH SERIOUS MENTAL ILLNESS

The *Being Equally Well* project aimed to create a strong, evidence and consensus-based suite of recommendations for improvements to health services and systems that will enable consistent and more effective physical health care for those who live with serious mental illness.

BEING EQUALLY WELL NATIONAL POLICY ROADMAP

Launched in August 2021, the *Being Equally Well National Policy Roadmap* (1) summarises the project's review of evidence and development of a suite of interdependent evidence-informed policy recommendations designed to measurably improve the physical health of people with serious mental illness and close the life-expectancy gap between this group and the general Australian population.

The *Being Equally Well* project was undertaken through 2021 by five expert working groups that considered how to improve the capacity of the frontline of health care, primary health care; the interaction of mental health services and primary health care services and supporting mechanisms; service structures, governance and funding for service provision and quality improvement throughout all levels of health care. These groups worked closely with a consumer and carer expert group that developed a suite of Measures of Success to inform the work of the clinical groups.

The *Roadmap* recommendations emphasise the necessity of a national, comprehensive and cohesive system approach to achieve

the aims of the Fifth National Mental Health and Suicide Prevention Plan (2), the National Preventive Health Strategy 2021 (3) and numerous initiatives by individual jurisdictions to reduce the mortality gap and improve the physical health of the more than 400,000 people who live with serious mental illness (4).

The *Being Equally Well Policy Roadmap* is a resource for GPs, for other primary health care and mental health professionals and services, for PHNs, and for local hospitals and health districts. It is also a map for governments and health system administrators, as frontline health professionals cannot achieve sustainable change without system improvements to support them.

Policy and system change recommendations are only the beginning. The two years of work leading to these recommended innovations and practical improvements will only have value if – and when - implemented.

BEING EQUALLY WELL IMPLEMENTATION

Following the launch of the *Roadmap*, the Mitchell Institute and Equally Well Australia worked with a wide range of individuals and organisations to engage and promote uptake and implementation of the recommendations in the *Roadmap*. A range of roundtable events and advisory groups of experts were convened to facilitate detailed determination of how to implement the various aspects of the *Roadmap* recommendations. These include:

Journey towards implementation

Implementation roundtables & advisory groups



What needs to be done next

MEASURES OF SUCCESS

- **Equally Well** resource portal/repository:
 - Bring available resources together in one accessible location and then promote to both consumers and health services with the **AMA** and **relevant colleges**
- Integrate the Measures of Success into Shared Care guidelines [parity of consumer and carer participation with **RANZCP** and **RACGP** Shared care guideline development]
 - Achieving accountability for informed consent to medications
- Multidisciplinary staffing profile in new services
- Create a tool/resource to articulate what consumers want out of the therapeutic relationship [**Equally Well Consumer resource**]
- The Measures of Success in time should be used as an audit tool
- **A national peak body for consumers** is needed:
 - National Mental Health Consumer Organisation

SHARED CARE

- Engagement of **RACGP** and **RANZCP** to lead the development of protocols with equal involvement and input from **consumers and carers** and **other health professional organisations**
- Funding proposal to be advanced to Commonwealth Government and NMHC

WORKFORCE REQUIREMENTS

- Facilitate an advisory group to define the roles and responsibilities of the clinical navigator role. [**Mitchell Institute**]
 - Undertake a scan of peer support roles and programs in physical health care. **MJA Supplement** systematic review and meta-analysis of the evidence for “Peer-facilitated interventions for improving the physical health of people with schizophrenia spectrum disorders” (10)
 - Education [**Equally Well** with support from **Colleges**]:
 - University Curricula
 - Continuing Professional development
- Develop papers on:
- Structural funding adjustments to enable the existing workforce to be better utilised
 - **MBS, Better Access, Chronic Disease Management Plans**
 - Data platforms/programs for:
 - Information sharing and physical health monitoring including Allied Health access
 - **MyHealth record**
 - Decision support and register and recall
 - **Strengthening Medicare taskforce** Voluntary Patient Registration

Journey towards implementation

QUALITY IMPROVEMENT

Quality Improvement leadership group to:

- Engage the **National Consumer Mental Health Peak Alliance** for support and collaboration
- Develop a set of principles that guide/shape conversations going forward
 - Data transparency, privacy and sharing
- Inform and engage **Federal/State ministers**
- Engage with the **Strengthening Medicare Taskforce**
- Scan for or develop digital systems for individual healthcare as per *Roadmap* recommendations including:
 - Register and recall systems to provide reminders, outreach capacity and inter-disciplinary health service communication to facilitate shared care
- Monitoring and reporting of interventions at a macro level to sustain improvement

DESCRIBING THE ROLE AND CAPABILITIES OF THE CLINICAL HEALTH CARE NAVIGATOR

- Care Navigator Role:
 - Health system navigation, connection with providers and services, care coordination, facilitate self-management & empowerment, support recovery pathways
- Advance funding proposal to support 20 clinical navigator positions within 5-8 PHNs with a national evaluation study to inform subsequent program development.
- Peer Support Worker Role:
 - Peer support, facilitate self-advocacy & management, health coaching
- **NMHC** has developed the *National Lived Experience (Peer) Workforce Development Guidelines*
- **MJA Supplement** systematic review and meta-analysis of the evidence for “Peer-facilitated interventions for improving the physical health of people with schizophrenia spectrum disorders” (10)

PHN ROLE & FUNCTION

- PHNs to collaborate nationally to develop guides/resources/tools together and implement and adapt to local circumstance as individual PHNs [**PHN Cooperative**]
- Engaging **Equally Well** CoP to share ideas and support learning between participants
- Develop funding proposals to Government

RESEARCH

Establish a research advocacy and network strategy through:

- *Strategic research leadership group/network* body- facilitated by **Equally Well**
- Expert group by/within **Equally Well** to develop *Standards for Research*
- **Strategic research leadership network** to create a business case to advocate for dedicated funding from MRFF

As a major contribution to the dissemination of the recommendations in the *Roadmap*, a *Being Equally Well supplement* of the Medical Journal of Australia (MJA) was launched on 3rd October 2022. The seven papers in the MJA Supplement provide health practitioners, administrators and policy makers with evidence that fills gaps in knowledge that contribute to premature morbidity and mortality among people with serious mental illness. This includes new evidence of what works to reduce cardiovascular and metabolic risk factors (5, 6) for this population group. The evidence of benefits to be achieved through shared care protocols (7, 8) for mental health and primary health care services and practitioners are presented. Workforce roles and funding are outlined to enable and support shared care between mental health and primary care services and multi-disciplinary care capability in primary care. These include expanded engagement of pharmacy and other allied health (9) and the establishment of peer support roles (10) in shared care system improvements to develop consistent quality care for all.

BEING EQUALLY WELL IMPLEMENTATION ACTION PLAN

This *Being Equally Well Implementation Action Plan* summarises the outcomes and next steps from the implementation roundtables and advisory groups. It provides the wider sector of stakeholders who can help make these improvements happen – policy-makers, services providers, practitioners, consumers – with clear guidance about what can be done now, by whom, and how.

The Mitchell Institute’s role in this project and work will conclude with this Implementation Action Plan and the publication of the Medical Journal of Australia *Being Equally Well Supplement*. Implementation relies on the engagement of all relevant stakeholders – organisations and individuals. What is needed are new initiatives, re-aligned funding, workforce investment and leadership – this is not business as usual because business as usual is failing to reduce the neglect of physical health care of people with serious mental illness.

Equally Well Australia (EWA) will continue to encourage implementation of the objectives and evidence established by the *Being Equally Well* project and reports. Without the support and drive of those stakeholder organisations central to these system and practice improvements, the long and exceptional work of all those who have contributed to the project will be lost. It is now up to you to take the intent of the recommendations in the *Roadmap* and the next steps from this *Implementation Action Plan* and make a difference to the physical health and potential for longer, healthier lives for people living with serious mental illness.

Roadmap Proposals

Purpose

Better physical health care and longer lives for people with serious mental illness

Consumer & Carer Measures of Success

Improved physical health

Management of medication impact

Relationships with health professionals

System navigation & support

Equity of access & care quality

Peer support

Working Groups to discuss the problems & needed system changes

Lived Experience

Clinical Microsystems

Mesosystem

Macrosystem

Quality Improvement

Roadmap of Recommendations



Shared care protocols and guidelines



Funding for tailored and shared care service provision



Removal of financial barriers for medication



Establish National Network of Quality Improvement Collaboratives



National Mental Health Clinical Quality Registry (NMHCQR) with public reporting



Workforce roles and development (clinical navigation and peer support)



Establishment of Medical Research Future Fund recurrent funding rounds



National advocacy campaign to address stigma



Education and training requirements for health professionals

Figure 2: Roadmap proposals

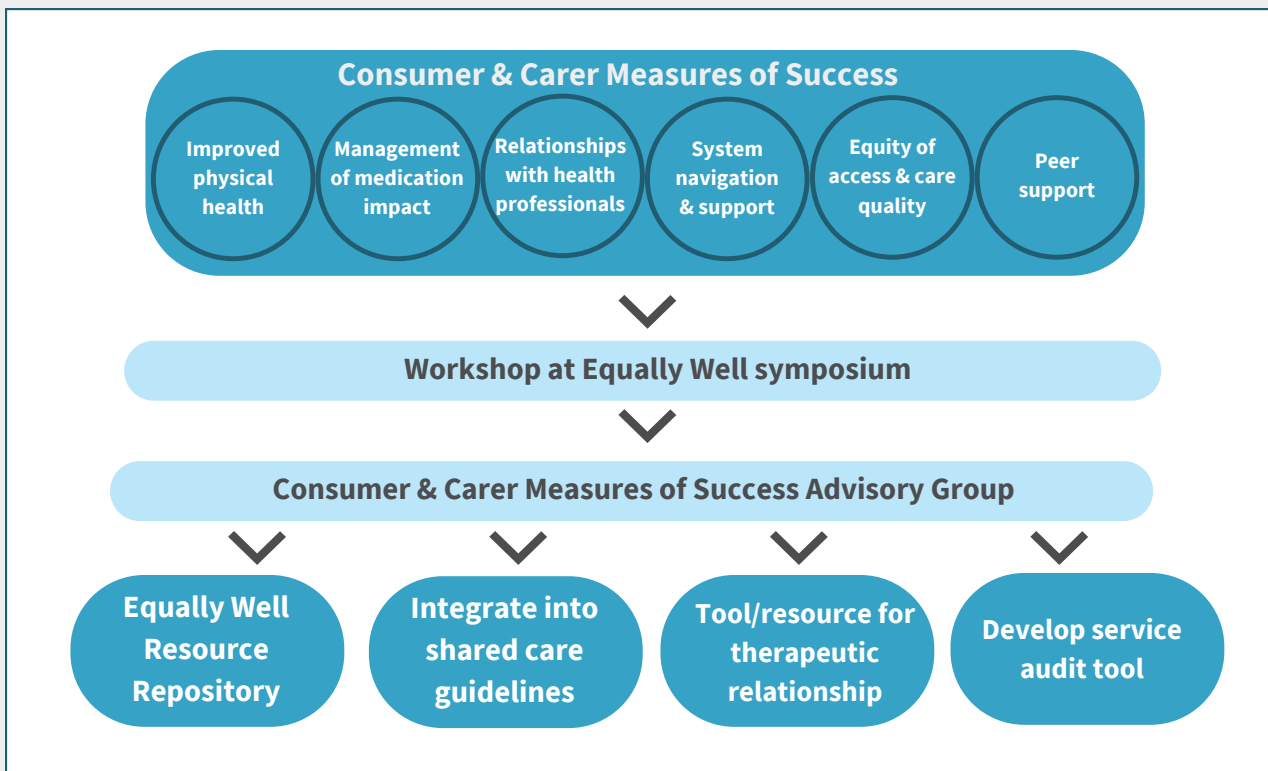
IMPLEMENTATION PROPOSALS

CONSUMER AND CARER Measures of Success

Whether and how to operationalise the ‘Consumer and Carer Measures of Success’ was the subject of a workshop at the Equally Well symposium on the Gold Coast in April 2022 and a subsequent Advisory group meeting.

The sessions discussed how the measures could:

- inform, support and empower consumers and carers in their quest for better health;
- influence implementation of shared care and
- promote better physical and mental health care support, treatment and outcomes.



Box 1: From Roadmap recommendations to Action plan- Consumer and Carer Measures of Success

Context and goal

The ‘Measures of Success’ are a central component of *Being Equally Well*. They summarise the needs and aspirations for the mental and physical health care of people living with serious mental illness.

These measures were developed and agreed upon by the consumer and carer expert working group during the *Being Equally Well* project process. The clinical expert working groups used the Measures of Success to guide their consideration of recommendations for system level improvements.

Implementation Actions

Establish Equally Well Resources: bring available resources together in one accessible location and then promote to both consumers, carers and health services

A website, while not accessible to all, is considered to be a good initial step. This resource could be an easy to navigate portal that collates all other relevant resources and presents them as a 'one-stop shop'. It could provide links, resources and be an advocacy service. It would be advantageous to work with the AMA and relevant Colleges in its design to make this a resource for clinicians to engage with as well as a resource to inform and support consumers and carers as they navigate their health care.

Integrate the Measures of Success into Shared Care guidelines/protocols

The recommendation for development of shared care guidelines includes ensuring parity of consumer and carer participation. Integrating the Measures of Success into shared care guidelines could support this through the leadership of medical colleges and professional organisations. A core issue for consumers and carers is achieving accountability for informed consent to treatment and medications. Additionally, there should be an expectation that any program that offers antipsychotic medication as a primary treatment should have a staffing profile to provide for multidisciplinary health care including dieticians, peer support and exercise physiologists and others as appropriate.

Create a tool/resource to articulate what patients want from the therapeutic relationship

The Consumer and Carer Measures of Success could be developed into a tool or resource that allows the consumer and/or carer to understand what they can and should expect and to articulate what they want out of the therapeutic relationship. This will need to be balanced by support for consumers to change practitioners if a practitioner does not respect their preferences for the quality of their relationship.

The Measures of Success in time should be used as an audit tool

A long-term goal is to get the Measures of Success incorporated into national safety and quality measures for quality of care and into hospital accreditation standards and GP practice guidelines. This would require a working party to turn the Measures of Success into quantifiable targets.

Develop/support a national peak body for consumers

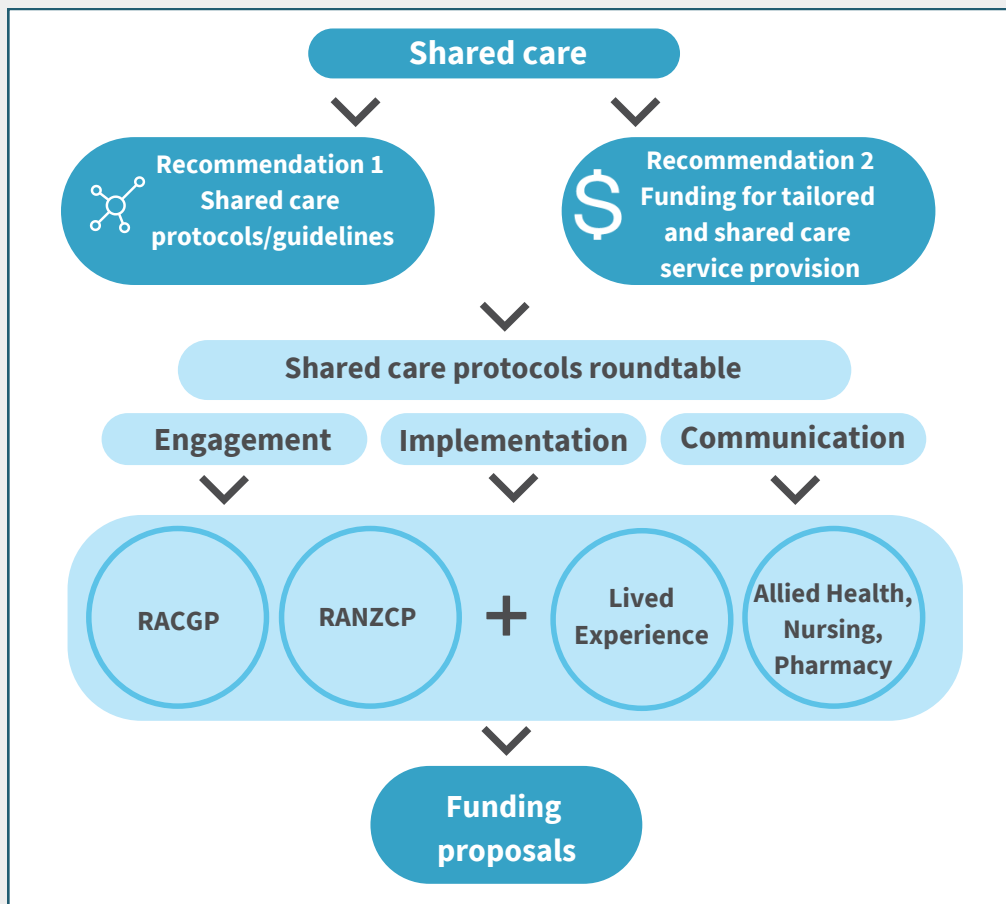
A national consumer peak body that has the support of consumers, carers and medical and other health professionals will provide a unified voice that has the potential to be more influential than individual advocates.

SHARED CARE

Participants were asked to consider three questions regarding establishment of shared care:

- How can national and widespread engagement in a shared care protocol be achieved?

- What do health providers, organisations and stakeholders need in order to implement shared care?
- What communication tools/systems and arrangements are necessary for effective implementation, quality control, accountability and system evaluation?



Box 2: From Roadmap recommendations to Action plan- Shared Care

Context and goal

Shared care, that is, the care of people with serious mental illness by general practitioners and psychiatrists working in collaboration and with the informed and supported engagement of individual consumers as well as other relevant allied health professionals, is a central recommendation of the *Being Equally Well Roadmap (1)*.

The development of intercollegiate shared care protocols would promote and support

effective shared care of those on medication for serious mental illness including antipsychotic medication and enhance monitoring of cardiometabolic risk factors. The Royal Australian College of General Practitioners (RACGP) and the Royal Australian & New Zealand College of Psychiatrists (RANZCP) are critical to such protocols, which should also include other relevant professional colleges and the health professionals they represent and must be informed by consumers and carers (1).

Implementation Actions

Establish collaboration between RACGP and RANZCP to lead development of shared care protocols with equal involvement and input from consumer and carers and other relevant health professional organisations

The Colleges of General Practitioners and Psychiatrists provide separate practice guidelines for physical health care of people who live with serious mental illness. The guidelines cover choice of medication for people with serious mental illness; cardiometabolic screening; interventions when risks are identified and engaging people with serious mental illness in cancer screening and in adult vaccination programs.

The establishment of shared care guidelines for both professional groups, through collaboration by the two Colleges, the RANZCP and RACGP, is a core recommendation of the *Being Equally Well* project and *Roadmap*. These need to be developed with consumers and carers and include other health professional organisations relevant to comprehensive shared care – such as pharmacists, nurses and allied health professionals

To achieve national and widespread engagement, there needs to be a unified approach and collective ‘buy-in’.

Funding proposal for shared care protocol development to Commonwealth and NMHC

Mitchell Institute, on behalf of members of the *Being Equally Well* project leadership group, submitted a formal proposal to the Australian Government Treasury for funding support through the 2022-23 Commonwealth budget for several initiatives outlined in the *Being Equally Well* Roadmap, including development of National Clinical Shared Care Guidelines for the physical health care of people with serious mental illness. The proposal was for \$400,000 to develop and disseminate guidelines, led by the Royal Australian College of General Practitioners and the Royal Australian and New Zealand College of Psychiatrists. The NSW HETI Positive Cardiometabolic Health Algorithm developed by Dr Jackie Curtis (11) would inform the guidelines.

Funding for this proposal would facilitate timely development and implementation of shared care protocols.

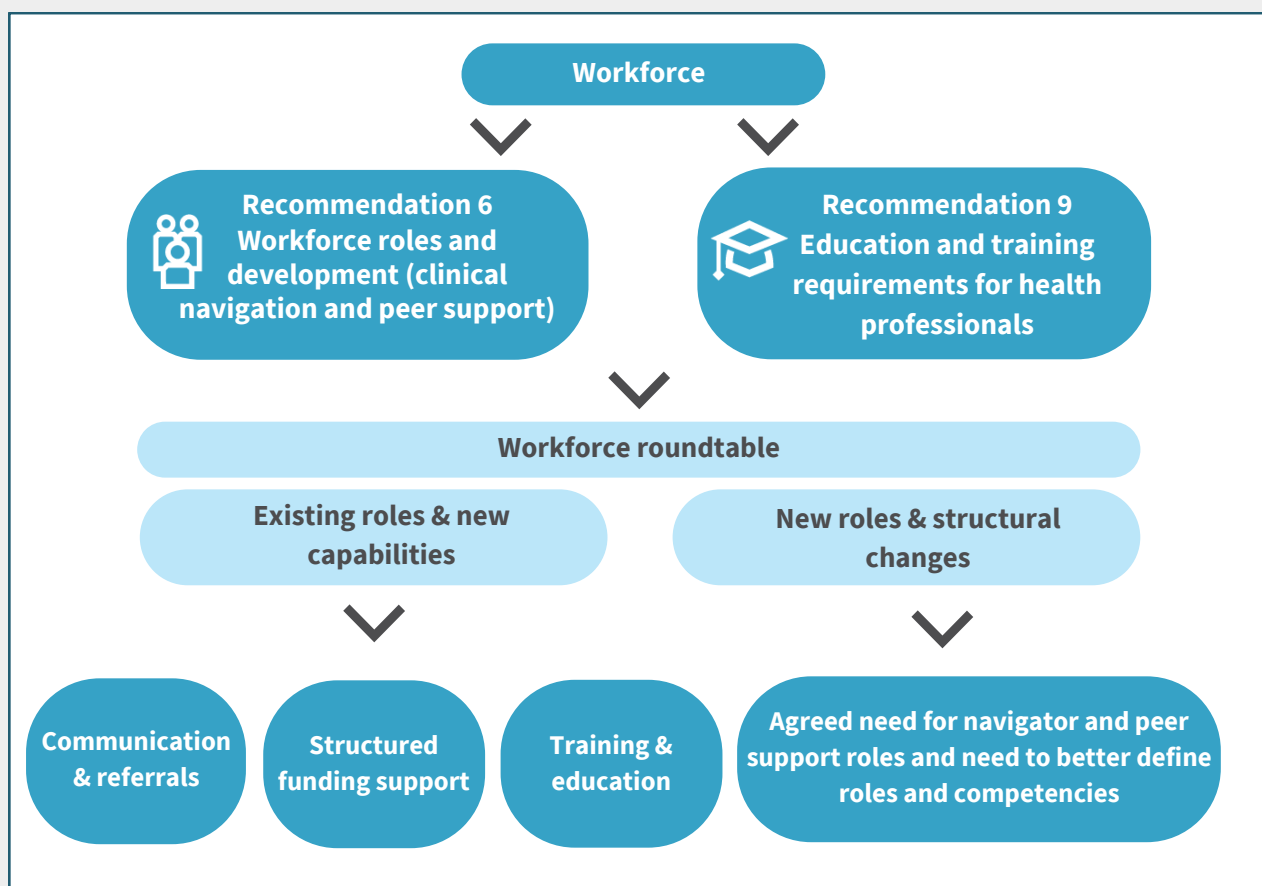
WORKFORCE

Roundtable participants were asked to consider two workforce capacity developments recommended in the *Roadmap*:

- new workforce roles: clinical care navigator and peer supporter

- expanded and resourced roles for relevant health professionals.

They were asked to consider what needs to be done to establish/expand the roles in terms of funding, training, integration, acceptance and support.



Box 3: From Roadmap recommendations to Action plan- Workforce

Context and goal

Development of a multidisciplinary workforce framework to fully apply the scope, skills and competencies that already exist within the health care workforce to improve the physical health of people living with serious mental illness was a key proposal in the *Roadmap*.

The *Roadmap* also proposed the development, funding and implementation of a specific clinical navigator position to support the physical health care of individuals and the implementation of shared care. The development of the role of peer support in primary care and shared care was also supported.

Implementation Actions

Facilitate an advisory group to define the roles and responsibilities of the clinical navigator role

The roundtable proposed that a core capabilities, role and responsibilities description be developed for a ‘clinical and health care navigator’ role, taking into account the recommendation for the development of a peer worker role, to inform and advance the work to achieve implementation of this recommended workforce and service enhancement.

The focus of the role is outlined in the *Roadmap* as: clinical care navigation, coordination and support, lifestyle coaching, and facilitation of engagement with carer, community and peer supports. The roundtable considered the evidence and identified needs for a role that provides for clinical and health care navigation based in primary care, to support individuals, and connect and enhance shared care, particularly between mental health services and primary care.

Undertake a scan of peer support roles and programs in physical health care

Work should be undertaken to identify what peer support roles are established and where and with what outcomes to promote awareness and foster development of this role in primary health care. A systematic review and meta-analysis of the evidence for “Peer-facilitated interventions for improving the physical health of people with schizophrenia spectrum disorders”, is included in the *Being Equally Well* Supplement to the Medical Journal of Australia (10).

Develop papers on:

- **structural funding adjustments to enable the existing workforce to be better utilised**

Many of the capabilities required to deliver the healthcare and support that are needed to fill the gaps in care for the physical healthcare of people who live with serious mental illness are available in the existing health workforce. Affordability remains a key structural barrier to people accessing these services. Current Medicare funding for access to services such as ‘Better Access’ or ‘Chronic Disease Management – GP Services’ are inadequate. A paper should explore the structural funding adjustments such as MBS items, block funding models or novel arrangements that could address this issue.

- **data platforms/programs for information sharing and physical health monitoring**

Many of the poor physical health outcomes of people who live with serious mental illness come about due to gaps between healthcare touchpoints. Information sharing and physical healthcare monitoring could allow better coordination and communication between healthcare providers. Register and recall systems for primary care providers are a core recommendation of the *Being Equally Well* Policy Roadmap.

Platforms such as ‘My Health Record’, ‘PrimarySense™’ and ‘Lumos’ are examples of data platforms that have potential to fill these gaps. Privacy and improper use of data is a considerable concern among many consumers and carers. A policy issues paper should be undertaken to provide options for policy and practice consideration.

Development of education resources

- **Incorporated into University curricula**

Integrated mental and physical health, shared care principles and practice and dispelling stigma should be incorporated into medical and other health professional education and training.

Recognising the University syllabus is already oversubscribed, adding on an adjunct program unit is difficult. Development of resources for students to access (e.g. medical, dietitian, pharmacist), potentially by Equally Well Australia, would facilitate this. A long-term goal will be to achieve complementarity of education and training resources across and between relevant disciplines (medical, pharmacy, nursing, allied health) and to complement and where appropriate, integrate, education and training relevant to other health and disability conditions requiring integrated mental and physical health care.

- **Continuing Professional Development (CPD)**

Develop CPD courses that address integrated mental and physical health, shared care principles and practice and tackling the stigma of people who live with serious mental illness. Most CPD is an opt-in arrangement and only reaches those who choose to do it. Professional bodies such as RACGP and RANZCP could be supported to incorporate these programs as part of mandatory topics.

Describing the role and capabilities of a clinical health care navigator

Following the workshop, an expert advisory group was established to consider and develop the role, capabilities and responsibilities of the clinical and health care navigator/coordinator that is a central recommendation of the *Being Equally Well* Roadmap and project.

The advisory group considered the alignment and complementarity of the navigator role with peer support in primary care services. The group also considered the importance of the role and capabilities proposed being able to adapt to diverse local and community contexts.

Outcomes

Facilitation of connection to health care and between physical and mental health care services is missing for people with serious mental illness. They need support through a role that can accompany them through their care pathways and connect them to both the clinical and non-clinical supports that they need to be physically and mentally well. There is currently not the right capability within existing health services to do better with the physical health needs of individuals.

The role of the navigator is to:

- support and address the rights of the person to health care
- define who is accountable for the physical health care needs of the person
- support individuals
- establish and support those connections

Table 1: Functions for the navigator role

<p>Establishment of good referral pathways within the clinical health care system to be able to support people, alongside and with a case manager such as a GP.</p> <ul style="list-style-type: none"> Referral pathways will include allied health professionals, nurses and medical specialists as needed. Flexible funding packages could support referral to required supports, including non-clinical supports relevant to health needs. The Partners in Recovery program prior to the establishment of the NDIS provided flexible funding for access to dental health care, gymnasium access, connections to employment, and was based on the establishment of a trusted relationship between the person and the navigator / coordinator.
<p>Care coordination between all care providers, to facilitate the provision of the right care at the right time in the right way.</p>
<p>Facilitation of access to services for essential basic needs such as housing, adequate nutrition and advocacy for the individual.</p>
<p>Facilitation of access to routine screening as clinically indicated.</p>
<p>Support for recovery pathways, facilitating development of self-management and empowerment of the individual as appropriate.</p>

The navigator role needs to help an individual prioritise what is going on with their health and then advocate within the system to get them support for their priority health needs. This will need to include delivering care differently – such as joint appointments – that is, thinking how to work within the system but to do it better, tailoring it for the individual consumer. Patient navigation is focussed on removing barriers to good physical and mental health care.

Importantly, the functions are not to take over the functions of other health professionals, but to ensure these are available and connected to the others that are required for each individual. There should be no artificial division between biomedical and biopsychosocial health care and support. Navigators should create a more seamless flow between providers. However, this needs to be balanced against the responsibilities of all health professionals to provide the navigator

function within their professional role, in conjunction with specific navigation capacity for those requiring this level of support. Otherwise, the risk is that all navigation support is left to that role.

Even with this role, the difficulty of getting access to health care for people outside of major cities is a major barrier to good health care. This is exacerbated by the now consistent difficulty for people outside major cities having access to a usual GP, getting an appointment to see a GP or being able to afford to see a GP.

Additionally, access to allied health services is restricted in eligibility and quantity to referral supported by ‘Chronic Disease Management – GP Services’ Medicare benefits. This can also present a financial barrier to individuals because of the common requirement for a co-payment.

Without flexible funding for referrals to allied health services and psychosocial supports, an individual has to be eligible for

the NDIS and then has to be able to get these services and supports into their care plan.

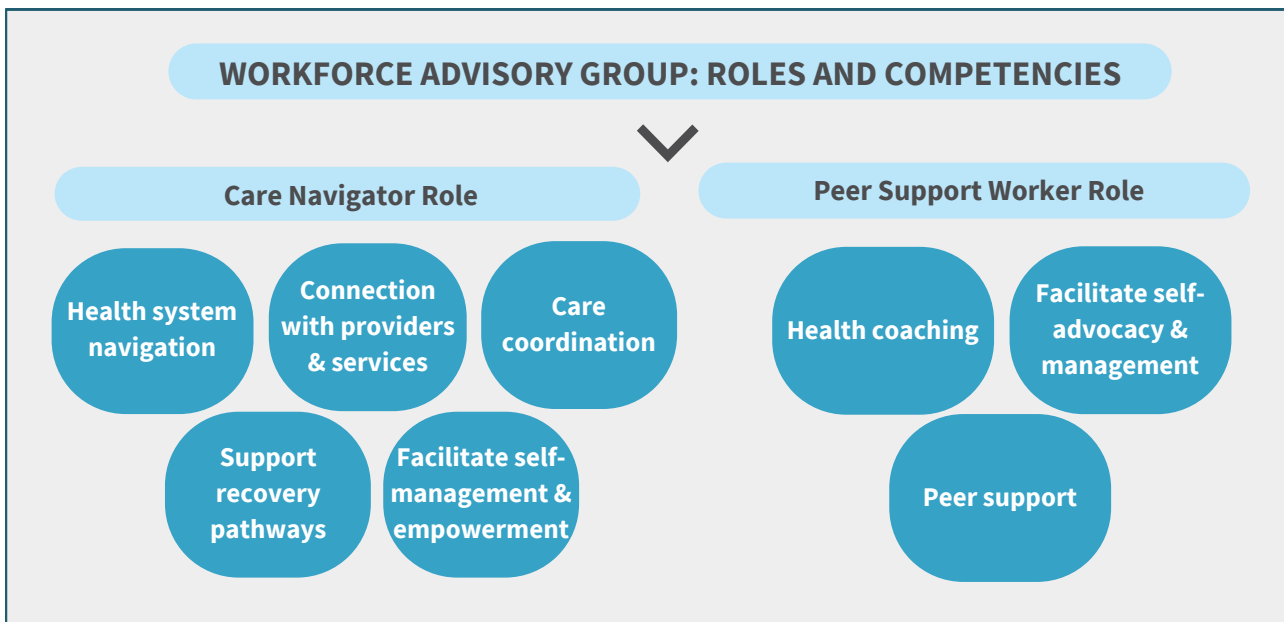
Peer Support

The additional capacity to provide psychosocial support and access to non-clinical services is also missing for many but is not within the scope of the role of a clinical navigator.

There are two sets of functions that may be two roles that are required to bridge the barriers to good physical health care for people with serious mental illness.

The role that is additional to clinical health care navigation is based around health coaching and developing self-advocacy and management. This is ideally within the potential role of peer support.

Functions that would be within the peer support role would include advocacy and support to empower the individual.

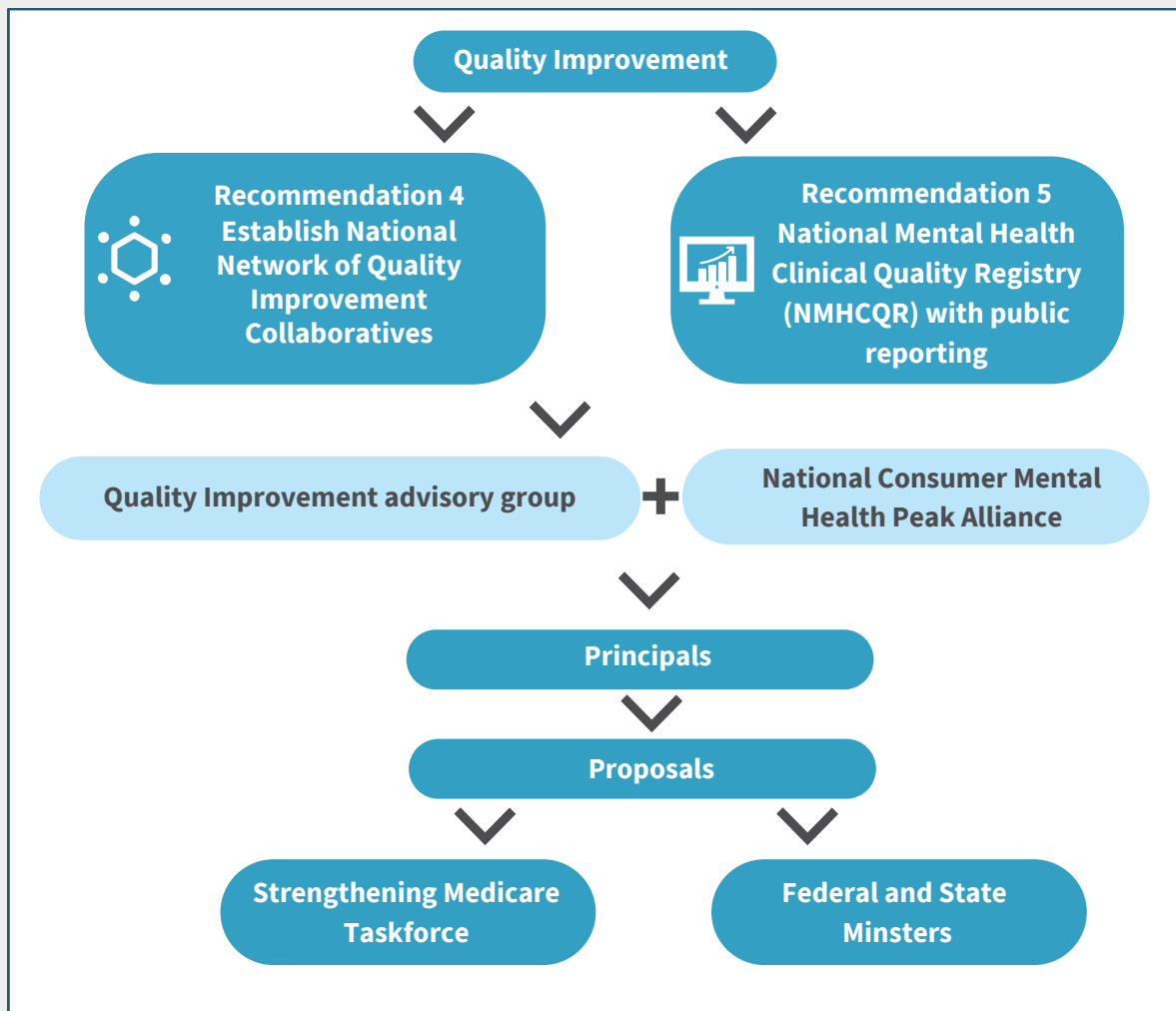


Box 4: From Roadmap recommendations to Action plan- clinical health care navigator role

QUALITY IMPROVEMENT

The *Being Equally Well* quality improvement advisory group proposed to continue to work together over time using the *Roadmap* and implementation roundtable

discussions, to engage key stakeholder organisations and influencers in developing a quality improvement data system and measures to support *Being Equally Well* aims.



Box 5: From Roadmap recommendations to Action plan- Quality Improvement

Context and goal

A quality improvement framework was developed as a key component of the *Roadmap*. The importance of measuring outcomes to gather data on impact of intervention and to continuously improve health services is central to success of the *Being Equally Well Roadmap*. The goal is to develop a quality improvement data system

and infrastructure in alignment with the recommendations of the *Roadmap* that allow:

- Digital systems for individual healthcare including register and recall systems to provide reminders, outreach capacity and inter-disciplinary health service communication to facilitate shared care
- Monitoring and reporting of interventions at a macro level to sustain improvement

Implementation Actions

Engage the National Consumer Mental Health Peak Alliance for support and collaboration

Ideally the advocacy for the suite of system changes recommended would be endorsed and led by consumers under the “nothing about us without us” principle. A collaborative approach with the National Consumer Mental Health Peak Alliance has the potential to ensure that recommendations and proposals continue to be co-designed and based on the consumer Measures of Success at their core.

Develop a set of principles that guide/shape conversations going forward

Development of a set of principles for the quality improvement framework is important – addressing key issues such as:

- privacy is important - why?
- data sharing is important – why?

From these principles develop a proposal for:

- the data required
- where that data is already available or if not already available where to collect/source
- how to integrate systems to allow adequate reporting and tracking of data

This could be used as a brief resource pack for people to use to advocate in their jurisdiction.

Inform and engage federal and state ministers

Health Ministers in federal, state and territory jurisdictions need to be informed of the benefits to the health system of getting this right and be engaged in the quality improvement of services and health care for people with serious mental illness.

Engage with the Strengthening Medicare taskforce

Primary care is essential to achieving better physical health care for people who live with serious mental illness and therefore it is essential that the Strengthening Medicare taskforce is informed and engaged with this project.

The Strengthening Medicare taskforce has been established to build on Australia’s Primary Health Care 10 Year Plan 2022-32 (12). A number of the Taskforce focus areas present opportunities to integrate the principles and proposals from the *Being Equally Well Roadmap*:

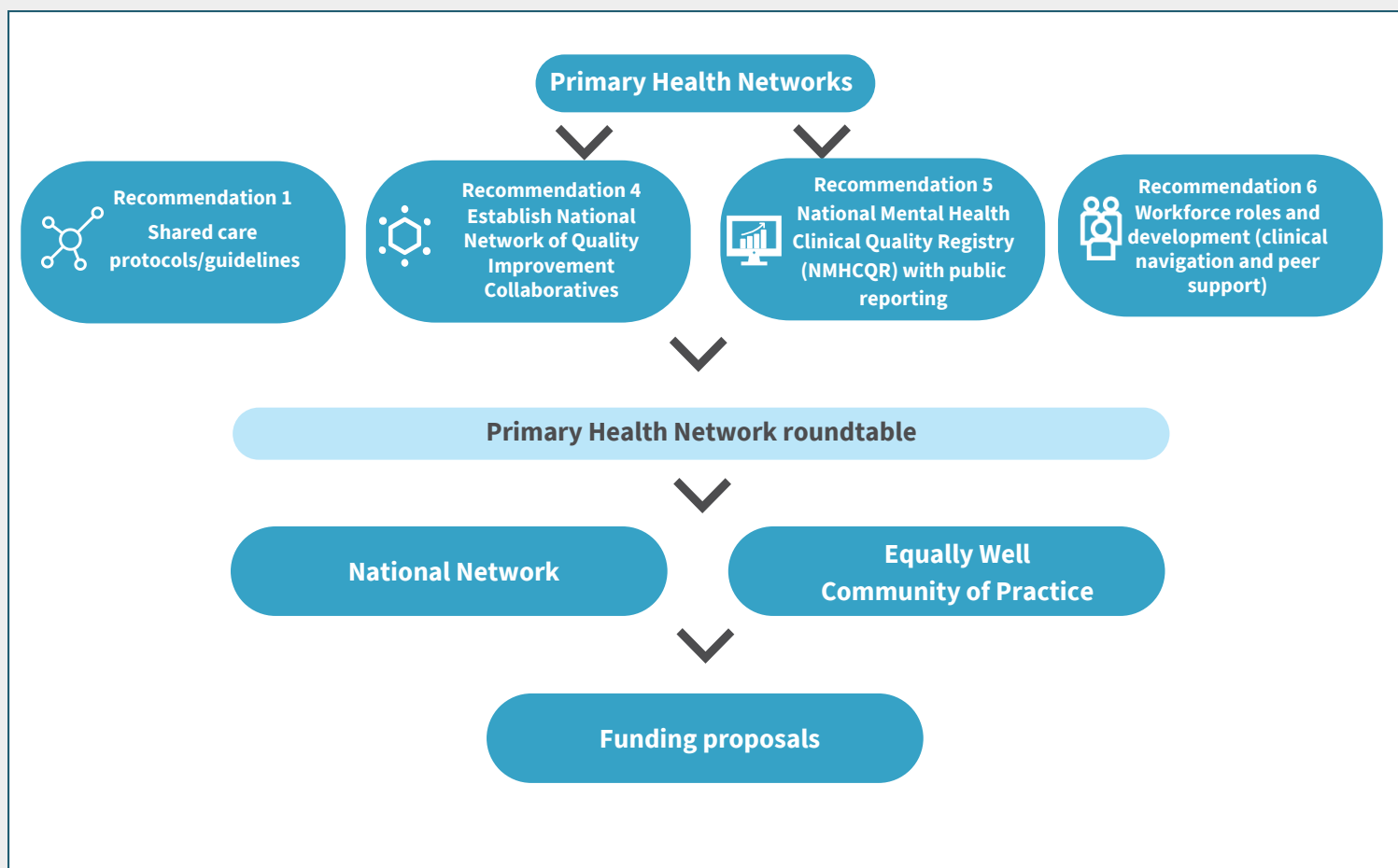
- improving patient access to general practice, including after hours
- improving patient access to GP-led multidisciplinary team care, including nursing and allied health
- making primary care more affordable for patients
- improving prevention and management of ongoing and chronic conditions
- reducing pressure on hospitals

PRIMARY HEALTH NETWORKS

Discussion at the roundtable considered:

- What can PHNs do to lift capacity of general practice including through fostering primary care engagement (eg pharmacy, GP, allied health, community support organisations)?

- What do PHNs need to foster and support shared care arrangements between specialist mental health services and primary care?



Box 6: From Roadmap recommendations to Action plan- PHNs

Context and goal

The *Roadmap* recommends establishment of a coordinated model of care for people with serious mental illness through a community-focused system supported by Primary Health Networks (PHNs) and local health and hospital networks and districts (LHN/Ds) (1).

To improve the physical health care of people with serious mental illness there needs to be structural support for PHNs including re-tooled funding and service

arrangements which will allow local and contextually appropriate arrangements to:

- support and engage general practices, mental health services and other allied health services in shared care
- provide non-clinical social supports to consumers and carers
- provide health professionals with resources and training

Implementation Actions

PHNs to collaborate nationally to develop guides/resources/tools together and implement and adapt to local circumstance as individual PHNs

PHNs should work together to develop tools and resources that can be distributed and adapted to local context. The PHN cooperative network may be the ideal place to nurture this community.

Engage Equally Well Community of Practice (CoP) to facilitate and engage the PHN network in progressive development

Equally Well's CoP works on a collaborative learning principle. Encouraging all PHNs to engage in the CoP would enable all PHNs to share with and learn from each other.

Develop funding proposals for resource and system development

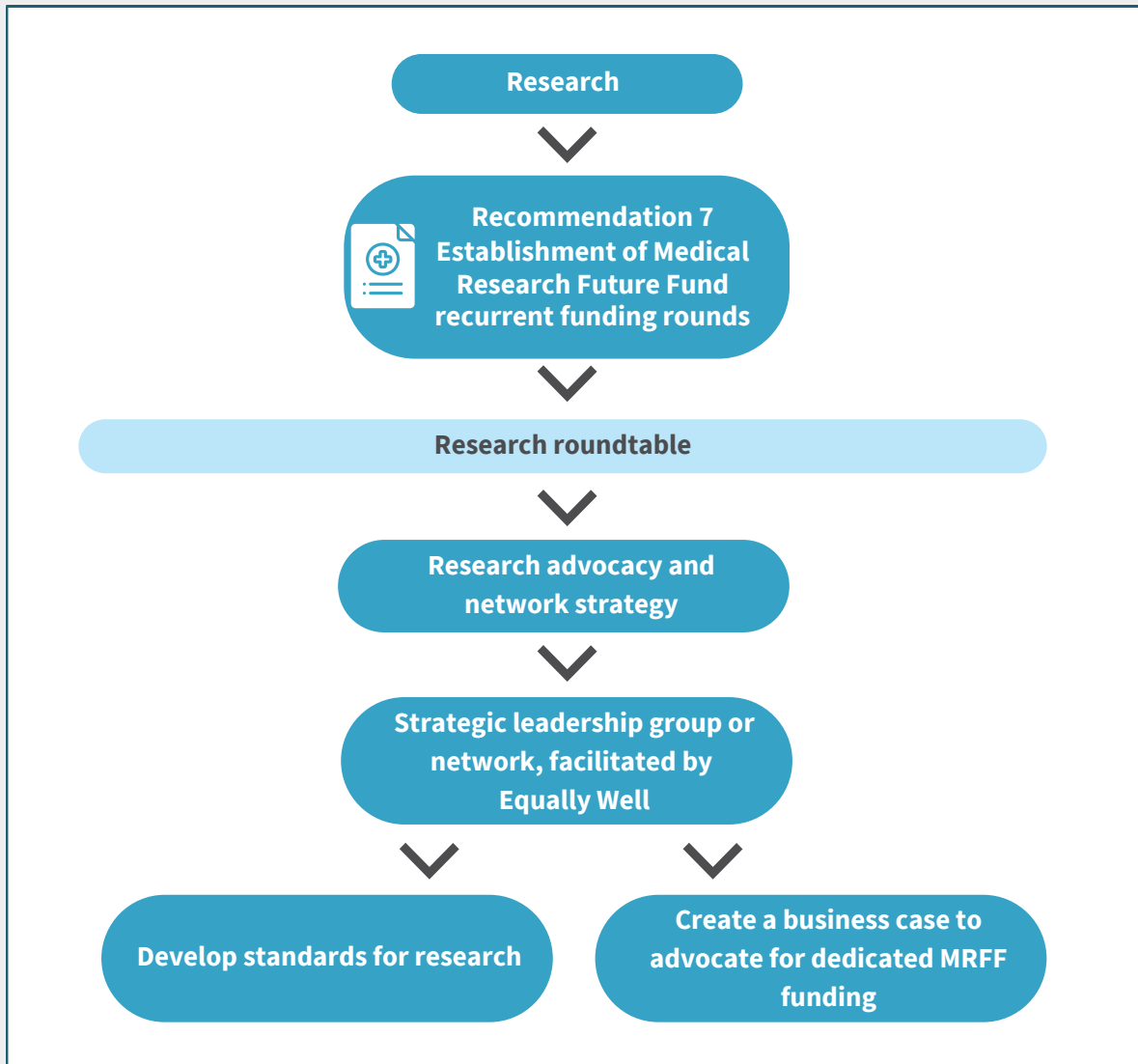
PHN funding is tied to current work streams. To be able to commission specific services or develop systems to address the physical health of people with serious mental illness, advocacy for additional funding and grants is required. Proposals to obtain this additional funding should be developed through the PHN cooperative network development and Equally Well PHN CoP.

Mitchell Institute, on behalf of members of the *Being Equally Well* project leadership, submitted a [funding proposal](#) to the 2022-23 Commonwealth budget for several initiatives outlined in the *Being Equally Well Roadmap*. These included funding of \$7.92 million over 3 years to support 20 clinical navigator positions within 5-8 PHNs with a national evaluation study to inform subsequent program development.

RESEARCH

The research group considered how to develop a national research strategy and advocacy network that could connect

individuals and research departments in collaborative and complementary research while respecting and accommodating the competitive context of research funding.



Box 7: From Roadmap recommendations to Action plan- Research

Context and goal

The *Roadmap* urged that the parity of opportunity for better physical health and longer lives among people who live with serious mental illness be established as a priority research area (1).

It recommended the establishment of Medical Research Future Fund (MRFF) recurrent funding rounds to support research towards better health outcomes for this population group.

Implementation Actions

Establish a research advocacy and network strategy through:

- **Strategic leadership group or network, facilitated by Equally Well**

Communication about what research is being undertaken is important. There needs to be a focus on how not to create or continue silos of information and activity while acknowledging confidentiality pressures in relation to funding applications. A strategic leadership group/network body can endeavour that research is innovative, gap filling, inclusive of consumers and carers at every step and implementable. It can also have a role in developing the standards for research and the MRFF business case discussed below.

- **Expert group by or within EW to develop standards for research**

The integrity of research is essential while pushing ahead with research momentum. A research agenda must be co-produced and this requires equity of inclusion of lived experience and relevant allied health perspectives. There is potential to establish SQUIRE (Standards for Quality Improvement Reporting Excellence) for research addressing the physical health and premature mortality of people with serious mental illness. A system like this could ensure quality and integrity of research.

- **Create a business case to advocate for dedicated funding from MRFF**

The *Roadmap* recommended establishing a Medical Research Future Fund (MRFF) recurrent funding rounds to support research in priority areas for the physical health of people who live with serious mental illness. A business case should be developed and put to MRFF to advocate for this. The proposal should encompass the standards for research discussed above. A successful proposal could be coordinated with a strategic leadership group/network body to ensure research undertaken is complimentary and avoids redundancy.

NHMRC recently announced an upcoming Targeted Call for Research (TCR) for *'Improving the physical health of people with a mental illness'* (13).

MEDICAL JOURNAL OF AUSTRALIA SUPPLEMENT

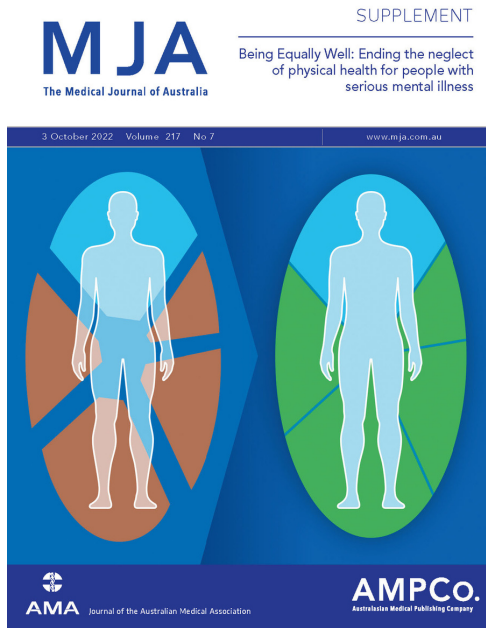


Figure 3: MJA supplement

Publication on 3 October 2022 of the Medical Journal of Australia (MJA) Supplement, *Being Equally Well: Ending the neglect of physical health for people with serious mental illness*, is a major contribution to the dissemination of the recommendations in the *Being Equally Well Roadmap*. The seven papers in the Supplement provide health practitioners, administrators and policy makers with evidence that fills gaps in knowledge that contribute to premature morbidity and mortality among people with serious mental illness.

Table 2: MJA Supplement articles

<u>The Being Equally Well national policy roadmap: providing better physical health care and supporting longer lives for people living with serious mental illness</u>	Rosemary V Calder, James A Dunbar and Maximilian P de Courten
<u>Effectiveness of nutrition and dietary interventions for people with serious mental illness: systematic review and meta-analysis (5)</u>	Tetyana Rocks, Scott B Teasdale, Caitlin Fehily, Claire Young, Gina Howland, Blair Kelly, Samantha Dawson, Felice Jacka, James A Dunbar and Adrienne O'Neil
<u>Peer-facilitated interventions for improving the physical health of people with schizophrenia spectrum disorders: systematic review and meta-analysis (10)</u>	Alexandria Coles, Kateryna Maksyutynska, Dunja Knezevic, Sri Mahavir Agarwal, Gillian Strudwick, James A Dunbar, Benjamin Druss, Peter Selby, Michelle Banfi eld, Margaret K Hahn and David Castle
<u>Should antidiabetic medicines be considered to reduce cardiometabolic risk in patients with serious mental illness? (6)</u>	Kevin P Mc Namara, Hamzah Alzubaidi, Margaret Murray, Catarina Samorinha, James A Dunbar, Vincent L Versace and David Castle
<u>Shared guidelines and protocols to achieve better health outcomes for people living with serious mental illness (7)</u>	Mark Morgan, Malcolm J Hopwood and James A Dunbar
<u>Clozapine shared care: mental health services and GPs working together for better outcomes for people with schizophrenia (8)</u>	Akanksha Sharma, Shoshana Buckhalter, Dan J Siskind and David Castle
<u>Workforce development for better management of physical comorbidities among people with serious mental illness (9)</u>	Kevin P Mc Namara, Simon Rosenbaum, Tetyana Rocks, Elizabeth Manias, Christopher R Freeman, Anna Wong Shee, Katherine G Schlicht, Rosemary V Calder, Johanna Moloney and Mark Morgan

PROJECT BACKGROUND

The problem

Existing health care services are clearly failing to provide adequate care for the physical health of people with serious mental illness. Currently, compared with the general population, more than 400,000 people in the Australian population are faced with a risk of premature mortality of up to 23 years (4, 14). Between 80% and 95% of the causes of early death relate to preventable physical illnesses such as cardiovascular disease, cancer, respiratory illnesses, and diabetes (14, 15).

Substantial work has been done in Australia to highlight this disparity. Both the 2017 Fifth National Mental Health and Suicide Prevention Plan (2) and the National Preventive Health Strategy 2021 (3) have identified this disparity as a priority issue. The establishment and funding support of Equally Well Australia is a major national commitment to leading change in health care and health outcomes for people with mental illness. However, the lack of structural connections and coordination between mental health services and physical health services, particularly primary care, has been and continues to be the major barrier to consistent and sustainable improvement.

Early work that contributed to this project was an analysis and report in 2016 on the costs and impacts of serious mental illness with concurrent chronic diseases, a joint project of the Australian Health Policy Collaboration and the Royal Australian and New Zealand College of Psychiatrists and undertaken by the Victoria Institute of Strategic Economic Studies at Victoria University (4).

Additionally, the Australian Health Policy Collaboration (AHPC) highlighted the extent of concurrent mental and physical ill-health in the Australian population in Australia's

Mental and Physical Health Tracker 2018 (16) and published a review of the evidence of the interaction between brain and body health (17).

The *Being Equally Well* project was informed by a joint symposium between members of the AHPC and Equally Well Australia, hosted by the Mitchell Institute in October 2019, that considered how to achieve systematic and structural change to address the barriers to equitable physical and mental health care for people with mental health conditions. The symposium was held at the Australian Parliament and addressed by the then Minister for Health, the Hon Greg Hunt MP.

The project

The project began in 2021, after being delayed by the onset of the Covid-19 pandemic. It was led by the Mitchell Institute at Victoria University as a collaborative project between the AHPC, a national network of chronic disease and population health experts and Equally Well Australia, a network of over 90 organisations working collectively to make the physical health of people living with mental illness a priority throughout the health system. The project brought together experts in primary care, chronic diseases, population health, mental health and consumers and carers to develop implementable clinical service and system improvements. Four clinical systems level expert working groups worked alongside and with a consumer and carer expert working group throughout the project. The *Being Equally Well National Policy Roadmap* proposals are the work of more than 60 individual professional and lived experience and experts.

The project was an intensive undertaking to map evidence-based interventions that are known to improve the physical health care and outcomes for people living with serious mental illness.

This includes establishing supporting structures that will facilitate the implementation and continuous improvement of these interventions throughout the health care system. The project was centred on the experience and expectations of consumers and carers who identified barriers and gaps in care that they experience, described the stigma and discrimination influencing their care and developed a consensus framework of consumer and carer Measures of Success – measures and indicators of health care and outcomes that consumers and carers seek.

The project method used the Clinical Microsystems Approach (18) because clinical microsystems, predominantly general practices and mental health teams, are the practitioners at the frontlines of physical health care for all. While it is at that frontline - and only at the frontline - that improvements in individual health outcomes are made, the meso- or macro-systems can facilitate outcomes produced by the clinical microsystems.

At the macro-system level are the federal and state governments and agencies. The meso-system level includes acute health services and primary health networks (PHNs). The project also considered quality across and within these system levels. The consumer & carer expert group developed ‘Measures of Success’ that were used by the clinical system groups in their consideration of clinical, practice and service improvements to improve health care and outcomes.

Being Equally Well **Implementation Action Plan**

This *Implementation Action Plan* brings together the outcomes of a number of roundtable events and meetings of expert advisory groups that were held during 2022 to extend engagement in the project aims and to facilitate detailed determination of how to implement the various aspects of the *Roadmap* recommendations. These events and meetings comprised:

Table 2: MJA Supplement articles

Consumer & Carer Measures of Success	Translating the agreed Measures of Success into self-advocacy tools and practitioner resources
Shared care protocols	Engagement of the relevant health professional Colleges with funding support for the development and implementation of shared care protocols and support development of an effective and sustainable shared care model of care between specialist mental health services and primary care / general practice.
Workforce	Promotion and establishment of recommended roles of clinical and health care ‘navigator’ and peer support worker
Navigator roles & competencies	Development of the roles, capabilities and responsibilities of the clinical and health care navigator roles.
Quality Improvement	Establishment of consistent national data to provide measurement and reporting of outcomes
PHNs	What is needed to facilitate implementation at a PHN level of support for shared care and engagement of practices in shared care and determine next steps
Research	Promotion of funding commitment to priority research in this area and areas of further research and development of a research advocacy and leadership strategy

The summary notes of these roundtables and Expert Advisory Group meetings are in Appendix A.

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Appendix A: Roundtable and advisory group summary notes

Consumer and Carer Measures of Success Advisory Group

Wednesday June 22, 2022 11:00am-12.30pm AEST
via Zoom

Barriers to adequate care and treatment for consumers and carers

- Addressing the physical health of a person with serious mental illness is still not a routine, standing agenda item in meetings about care and treatment being provided. There is still an above the neck / below the neck divide in psychiatry and mental health and physical health services.
 - Review of both mental and physical health conditions and concerns should be a key performance indicator for mental health services.
- Clinician practices and attitudes can be based on stigma and this needs to be addressed before a tool or resource will have any effect.
- Power imbalances exist within a therapeutic relationship. Vulnerable people often need support or an advocate to help them be able to speak up, but ultimately the power imbalances need to be addressed. There is little or no investment in and support for the value/importance of the therapeutic relationship.
- Clinicians are very time poor. Consumers and carers need support to help them get the important points across in what is often a brief consultation.
- Cost is such a big issue, and likely to become worse in the current environment. Poverty is a barrier to participating in health care.
- Choice of provider is really important but involuntary treatment orders, cost, geography, language etc can all be barriers to being able to access a provider of choice.

- Resources aren't coherent and visible to people who are newly diagnosed, or not in networks. How do they find those resources and choose which one helps them and get help with that?
Communication is a big issue.
- Medical providers, GPs and/or psychiatrists often don't explain or help mitigate potential side-effects of medications they are prescribing.
- Accountability of prescribers for the outcomes of medications prescribed by them is important:

"Something I found personally very frustrating within the first experience from seeking support, was it wasn't until a couple of years sort of into that process of you know, seeing a psychiatrist and getting medicated and things like that, that I found out about the potential impact on my physical health due to really major side effect issues and none of that was discussed prior to prescription."

"We don't expect doctors to be perfect or to have magic wands, but to understand, explain and help mitigate the risks of what they are prescribing"

- Consumers often feel the clinician does not favour some of the clinical tools for mental health assessment. However, for consumers, the tool itself isn't important, but each tool and answer is a means of starting and continuing a conversation between the consumer and clinician that would give consumers better opportunity to engage in their health care management.
- There are programs and projects to improve this happening within states and nationally but they are not connected and at the moment it feels very 'scatter gun'. Good projects are often localised to certain areas, which means the majority of people miss out.

Potential solutions

- There are some great resources that are available that could be brought together in one accessible location and then promoted to both consumers and health services.
 - While a website won't be accessible to all, it's a great place to start. It needs to be in a place where consumers and carers can understand and navigate and know about.
 - A resource for consumer and clinicians could be developed by Equally Well either as a:
 - personal medicine or wellness tool for consumers, patients, experts developed from the *Being Equally Well* Consumer and Carer Measures of Success;
 - as a resource that collates all other relevant resources and provides consumers 'a one-stop shop' to access them.
 - Head to Health is a gateway website for initial mental health resources. Could offer a similar gateway resource with guides, links, resource and advocacy service
 - Work with the AMA to engage clinicians in the design. Ensure it becomes something that clinicians engage with as well as consumers and carers
 - It also needs to be able to facilitate and adapt to localised solutions for local issues.
- Integrate the *Being Equally Well* Consumer Measures of Success into Shared Care guidelines.
 - To try and change behaviour from the top, by creating leadership across colleges, not just the RANZCP and RACGP but others that are relevant to:
 - what is good practice?
 - what is going to focus on physical health equally with mental health?
- The Measures of Success should become a tool that clinicians know they must use when they first see somebody:
 - Have I explained the harmful effects of medications?
 - How are you managing medication impacts?
- Achieving accountability for informed consent to medications
 - Formal accountability could be proposed as a standard for the prescription of antipsychotic medication and potential impacts on physical health. This could be a carrot-and-stick approach, providing:
 - education for people about their rights.
 - affirmative action and recognition for clinician/ health champions
 - a consumer voice portal, to enable consumers to recognise the clinicians that adopt the Measures of Success in their practice
 - avenues for consumers to report concerns about their healthcare
 - potential for litigation and link to professional indemnity insurance costs
- Accountability should be supported by an expectation that any program that offers antipsychotic medicine as a primary treatment should have a staffing profile that reflects multidisciplinary needs including, among others, dieticians, peer support and exercise physiologist. An example of this is the new service on the Gold Coast.
 - PHNs could promote and support the establishment of psychiatric liaison services that utilise multi-disciplinary health care for educational purposes for consumers and carers. Coordinaire, the South West Sydney PHN is an example of this.

- The Consumer and Carer Measures of Success could be developed into a tool or resource that allows the consumer and/or carer to understand what they can and should expect, and to articulate what they want out of the therapeutic relationship. This will need to be balanced by support for consumers to change practitioners if the practitioner does not respect their preferences for the quality of their relationship.
 - An Equally Well consumer resource could provide an independent, external source that may carry more weight with consumers rather than something developed by the services they are attending. Equally Well Australia is to undertake a consumer resource project commencing soon, led by Chris Maylea.
- The Measures of Success in time should be used as an audit tool.
 - Getting the Measures of Success incorporated into the national safety and quality measures for quality of care and getting them into hospital accreditation standards and into GP best practice standards would be the goal.
 - This could be proposed to the new Commonwealth Health Minister.
- A national peak body for consumers is needed: a National Mental Health Consumer Organisation.
 - Equally Well *National Initiative Scan* is to be undertaken and will provide an opportunity to find resources that are available and to ensure that they are at an appropriate standard and safe.

Existing resources

- Lived Experience Australia- creating positive experiences using NOCC Outcome Measures
 - One outcome was that they value these *Consumer rated measures* because it was a self-reflection tool that helped them with their own self-management and self-care
- St Vincent's (Melbourne) Medication Information Resource
 - often medications are prescribed with no understanding of the risks and how they need to be managed
- Pat Deegan – Personal Medicine
- Flourish- Back on Track Health (BOTH) program- Cue cards for improving health communication
 - Slides from 2019 EW symposium presentation
- Dr David Codyre- Wellness Support Team NZ
- Self-Efficacy for Personal Recovery Scale (SEPRS).
 - 14-item, self-report scale, self-efficacy own ability to enact specific behaviours relating to personal recovery from severe mental illness. (Provider resource)
- Neami – Neami Health Prompt
 - Tool for consumers to use either independently or with a support person to help guide GP appointments
- Consumer Integrated Mental Health and addiction (CIMHA) application
 - clinical information system designed to support clinicians in the provision of safer quality mental health

Shared Care Protocol roundtable

Thursday March 10, 2022 11:00am-12.45pm AEDT
via Zoom

Engagement

Getting shared agreement: the content is not controversial but the mechanism is the challenge. There needs to be agreement re roles - defining responsibilities of each essential and significant party to achieve the objective.

How do we achieve national and widespread engagement?

The consensus was that to achieve national and widespread engagement, there needs to be a unified approach and collective 'buy-in'. Examples from the UK context where success has been due to the unified approach of the GP and Psychiatrist colleges and organisational structures that includes other interest groups. The lived experience voice is necessary from the start. There is a need to get 'buy-in' from people in public mental health and allied health.

Who leads it?

Commitment is needed from the RACGP and RANZCP to agree on a proposal to complete the work. Lived experience and allied health need to be brought into the project early. Shared care must be inclusive of both the consumer and the multidisciplinary team. Support from Mental Health Commissions could add weight to the proposal. The *Being Equally Well* work needs to be presented to the boards of RANZCP and RACGP outlining what a shared care guideline and protocol will require and provide, and seeking their formal endorsement. When that commitment is established, the wider network of relevant stakeholder organisations should be brought in to build impetus. Two colleges are essential, but not sufficient.

Who funds it?

Funding for shared care development was proposed in the 2022-23 Commonwealth budget process. With a collective voice, led by the colleges, funding for shared care

protocol development should be sought from the Commonwealth and/or other funders to provide a national and collaborative approach.

What levers are needed to encourage the use of a shared care protocol?

Incentives:

- The commissioning role of PHNs needs to be considered
- Incentives for service providers: including incentives to communicate between providers
- MBS item numbers that adequately support shared care will be required
- MBS incentive payments for providing the recommended comprehensive physical health checks and risk reduction. And not paying when people are not effecting good practice.

Data and Quality Improvement:

- Data sharing with PHNs through to national aggregate data and reporting (as per BEW roadmap recommendations)
- PHN and NGO roles are essential to bridge gap between public MH services and primary care
- Ensure shared data set, clinical registers at state and territory levels as well as a national clinical register – particularly to enable reporting of what is being done and achieved in real time, e.g. re CV risk factors and outcomes.
- Visibility and awareness may encourage the best to teach the rest: a continuous QI loop.

Regional planning and commissioning

- The right structures are needed - achieved via regional planning and commissioning. All relevant players need to be involved, NO cherry-picking!
- An advantage is the accountability that regional commissioning offers.

Load Sharing

- Physical health providers are over-run and exhausted. There needs to be a strategy to engage them that doesn't feel like a burden. Innovative thinking to create healthy teams.
- Getting timing right when asking people to do more.
- Additional workforce: Navigator (e.g. peer worker) was proposed as the link:
 - achieving collective responsibility and providing support to GPs
 - to ensure clinical follow-up, working alongside the clinical team members with a view to strengthening consumer choice.

Digital solutions (my health record):

- An option to convey health alerts and connect online dispensing system with information sources
- Difficulty is My Health Record is still limited
 - less developed in MH care sector
 - inaccessible by allied health.
- GPs might prefer solutions via Health Pathways and prompts/alerts at point of care and data extraction
- Something is needed that enables systems to talk to each other.
- Input from consumers and carers:
 - What data is shared and with whom?
 - What outcome measures are supported?

Implementation

This work needs a broad, united front of all relevant stakeholders to present a powerful message to government. Engagement of all stakeholders and advocacy bodies in the development of shared care protocol will drive this.

Holistic, connected care – the whole of the person with mental illness; integrated.
“Nothing about me without me.”

Shared care needs to be built into education and training and understood as the responsibility of all. At present there are no clear pathways, so while everyone agrees on the importance of the issue, there is no locus or agreement about responsibilities.

Everyone in the health system is busy, so it is understandable that anything beyond remit is hard to integrate. Incentives can be used to help integrate this into routine care.

Availability of and access to resources needs to be concurrently improved to make sure shared care can have an impact. The fragmented system and financial and structural barriers to wellbeing and health care need to be removed or adapted for screening and shared care to become possible. People need to be able to be connected to the services, both within and outside of MBS funding, that can make a difference. Current financial cost and structural barriers make these inaccessible. Therefore, tweaks to the MBS system will not be adequate and new funding arrangements or access arrangements need to be developed.

Communication

Communication within the shared care model between health care providers and consumers and carers needs consistency within the fragmented context of service provision. Currently my Health record is not available to many allied health professionals who should be involved in shared care. These communication systems should involve decision support and recall registers.

Indicators need to be developed to enable shared information to be available to all those who need it.

The strategic intent is to identify shared care in practice, to inform the development of shared care and to measure achievements (at PHN level, state/territory levels, and nationally) towards the goals of

shared care against agreed KPIs for improved physical health outcomes resulting from shared care.

Data collection and reporting is essential for quality assurance and control. PHNs already collect data KPIs, but PHN data is collected through General Practice Primary Care, which assumes all people interact with GPs. PHN KPI data collection should be streamlined to eliminate inefficiencies and reduce unnecessary workload, but simultaneously needs to be expanded to collect data from other primary care providers, such as allied health and social services, to capture comprehensive shared care provision. Quality Improvement Collaboratives could be the means to developing this as a national framework with local tailoring to contexts

Next Steps

- Being Equally Well project team to engage RACGP and RANZCP with short presentations to boards. The colleges to be asked to agree to lead development of protocols with equal involvement and input from consumer and carers and other health professional organisations relevant to comprehensive shared care – such as pharmacists, nurses and allied health professionals.
- Presentations to other health professional organisations subsequently.
- National Mental Health Commission involvement will be important.
- Tasks:
 - Being Equally Well project team preparation of presentation to RANZCP, RACGP
 - Public statement of commitment and formal invitation to other professional organisations to be engaged
 - Proposal for funding to be advanced – to government and NMHC.

Workforce roundtable

Thursday March 25, 2022 11:00am-12.45pm AEDT
via Zoom

New roles and structural change

The clinical and health system navigator role and peer support role are agreed as necessary workforce developments. The complexities of the health system and barriers to care can be best addressed through navigator / support facilitator roles. There are examples of successful models of these roles both past and present. The former Partners in Recovery program provided support facilitator roles that were regarded as effective. The PACER-nurse role within the Victorian police response capacity, provides immediate assessment and referrals.

The Commonwealth Department of Health has a new psychosocial support program that sits within PHNs and will include a service navigator.

Peer work in navigation roles has a number of effective programs (such as the NSW Peer Supported Transfer of Care initiative).

To establish the case and advocacy for a clinical and health system navigator role that can be implemented on a national scale, the role needs to be defined in terms of its core capabilities, roles and responsibilities with scope for diversity determined by context. The location of these navigators is also important to consider. Some options include within GP practice or PHNs. They need to be accessible to all potential consumers, not just those that engage with general practice and need to have easy links to services that may be required by the consumer. The defined navigator position should be compared to currently funded PHN roles including the new service navigator role to see how they can be integrated.

There is support for peer support worker roles within the consumer and carer community.

There is limited evidence on peer workers helping to improve physical health, so research has been proposed as a priority. The National Mental Health Commission has developed National Lived Experience (Peer) workforce guidelines.

The recommended next steps include:

- The PHN implementation roundtable (for Being Equally Well) to discuss commissioning and implementation of the navigator role and the peer worker support role
- A group should be established to put together a funding proposal to the MRFF to advance the evidence for the peer support role in improving physical health outcomes
- A piece of work to scan what is being done in peer support in physical health care, to then be followed by a webinar to generate further awareness and development.

Existing roles and new capabilities

Many existing health professions are experiencing the same barriers and fighting the same battle. By combining efforts together with the input of lived experience, the united front may create more momentum for change. Three main themes emerged from the discussion:

Communication:

Identification of the need for physical health care intervention through metabolic screening must be complemented by the appropriate referral. The existing allied health workforce are already well placed to assist the physical health care needs of people living with serious mental illness. Clarity of roles and mutual responsibility of the existing workforce on how they can contribute to shared care will help identify where these referral networks can emerge. Interprofessional communication is an important enabler for chronic health screening, cross-referral, management and intervention.

Tools can be developed to help with decision making for the health provider and consumer, carer and navigator.

Structured funding supports:

Current MBS funding is inadequate to support the facilitation of allied health involvement in the physical health care of people with serious mental illness. The Chronic Disease Management plan item is the main MBS funding for subsidised access to allied health services and is both limited and not comprehensive enough to be effective for this client group. Payment mechanisms must consider the complexity of the issue. Restructure of MBS payments and allocation of aggregated funding to support complex chronic health conditions for people who live with serious mental illness (and others) is required to provide for the existing health workforce including pharmacy and allied health to be better utilised and engaged. The commissioning role of PHNs also needs to be considered.

Training and education:

Training and education for mental health competencies across various professions is recommended, although it is recognised that implementing extra curricula into already busy tertiary courses is difficult. Education and advisory groups working across different needs populations need to be connected. The Commonwealth is developing guidelines around the care of intellectual disabilities. Outcomes and measures from both areas should be connected.

Continuing professional development with the equal input of lived experience for upskilling of health professionals on trauma-informed care and referral pathways should be developed.

Work already underway

Commonwealth psychosocial support programs for people with severe mental illness

Lived experience workforce guidelines

Outcomes

- *Being Equally Well* project team to facilitate a working group to define the roles, responsibilities and core capabilities of the clinical and health care navigator role, to be co-designed with lived experience experts. The Commonwealth funding proposal to be further developed
- *Being Equally Well* project team to undertake a scan of what peer support roles and programs in physical health care are in place and to follow with a webinar to raise awareness, advocacy and development
- *Being Equally Well* project team to develop a paper on structural funding adjustments including payments/MBS to enable the existing workforce to be better utilised and engaged
- *Being Equally Well* project team to develop a paper on shared information such as use of my health record or other platform for information sharing and physical health monitoring.

Describing the role and capabilities of a clinical health care navigator advisory group

Wednesday July 20, 2022 11:00am-12.30pm AEST
via Zoom

The workforce capacity to support equity of physical and mental health care.

The *Being Equally Well* project identified the central importance of shared care between mental and physical health care, particularly between mental health services and primary care general practice; and the parallel and central importance of clinical care navigation support for people with serious mental illness to engage with and be equally supported by both. The project recommendations for this role included recommendations that the role be funded within primary care through the Medical Benefits Schedule (MBS) or through Primary Health Networks (PHNs).

Expert working groups for the project gave different weight to different aspects of the care navigation role that they considered and its role in enabling and supporting shared care. In particular, the clinical microsystem group, focussed on primary care, proposed the establishment of a community mental health nurse workforce embedded in GP practices to work directly with patients who have complex needs and complex care teams. The role could include: care navigation; case management; social prescribing; care coordination. The mesosystem group, focussed on the lack of coordination between mental health services and primary care services, proposed the establishment of a workforce of practice-based 'Nurse Navigators' to assist consumers in navigating a complex and fragmented health system across different levels of healthcare. The role would include the empowerment and upskilling of consumers and carers in managing their own health conditions. The navigator role would engage peer workers in providing support with whole-of-health

care, particularly at the primary care level, and provide people with serious mental illness access to peer and professional support to navigate health and social services, education and employment.

Discussion following the launch of the *Roadmap* emphasised that care navigation is emerging as a capacity requirement for people with complex and chronic health care needs, and that it is important to make this agnostic of an individual profession. The workforce implementation roundtable earlier in 2022 identified the need to determine a set of competencies and functions rather than defining it along professional lines, such as limiting it to nurses, and to consider how best to develop this capacity within existing services utilising, wherever possible, available funds.

Navigators, care coordinators and case managers: roles and differences

The advisory group was provided with a summary of contemporary literature and evidence by Mary Malakellis, Deakin University.

Care Coordination has been described as:

- Important to achieve high quality, high-value, patient-centred healthcare
- A key process of care at all levels throughout healthcare systems and across the care continuum
- Broad care coordination definition was developed by Evidence-based Practice Centre
- Many interventions fit within the broad definition of care coordination e.g., patient navigation, case management

Patient navigation has been described as:

- Reduce modifiable barriers (physical or psychological) to care
- Patient navigation performed by peer/lay people or professionally trained e.g. nursing, social work

- Variability of patient navigation programs, variations in organisational setting, clinical context and navigator background
- Range of tasks for patient navigation are dependent on the type of navigator

Case management has been described as:

- Integration of health care, social services and other sector services
- Case management performed by people from many different disciplines e.g. nursing, OT, psychology, social work
- Multiple components and variations depending on the context and client population
- Horizontal and vertical integration of care
- Range of tasks for case managers is described with considerable heterogeneity, complexity and inadequate descriptions

The differences between these are summarised as:

- Patient navigators do not provide clinical care, case managers may provide clinical care
- Patient navigators navigate existing services, case managers are able to fill the need by acting as care provider
- Patient navigators are not identified to play a role in discharge planning, case managers are involved in discharge planning
- Patient navigators are a staple in oncology care delivery, case managers are prevalent across many complex disease types
- Patient navigation and case management definitions depend on the nature of the governing health care system and the focus of the provider

The role and functions envisaged for improved physical health care and shared care of people with serious mental illness

The role of navigator is considered the most appropriate.

The group agreed:

- The role of the navigator is to:
 - support and address the rights of the person to health care
 - define who is accountable for the physical health care
 - support individuals
 - establish and support those connections
- What is missing for people with serious mental illness is the facilitation of connection, the role that can accompany them through their care pathways and to connect them to both the clinical and non-clinical supports that they need to be physically and mentally well. There is currently not the right capability within existing health services to do better with the physical health needs of individuals.
- The additional capacity to provide psychosocial support and access to non-clinical services is also missing for many but is not within the scope of the role of a clinical navigator.

However, this needs to be balanced against the responsibilities of all health professionals to provide the navigator function in conjunction with specific navigation capacity for those requiring this level of support. Otherwise, the risk is that all navigation support is left to that role.

Functions for the navigator role must include:

- establishment of good referral pathways within the clinical health care system to be able to support people, alongside and with a case manager such as a GP.
 - Referral pathways will include allied health professionals, nurses, and medical specialists as needed.
 - Flexible funding packages could support referral to required supports, including non-clinical supports relevant to health needs.

- The Partners in Recovery program prior to the establishment of the NDIS provided flexible funding for access to dental health care, gymnasium access, connections to employment, and was based on the establishment of a trusted relationship between the person and the navigator / coordinator.
- Care coordination between all care providers, to facilitate the provision of the right care at the right time in the right way.
- Facilitation of access to routine screening as clinically indicated
- Facilitation of access to services for essential basic needs such as housing, adequate nutrition and advocacy for the individual.
- Support for recovery pathways, facilitating development of self-management and empowerment of the individual as appropriate.

The navigator needs to help the person prioritise what is going on with their health and then advocate within the system to get them support for their priority health need, including delivering care differently – such as joint appointments – that is, thinking how to work within the system but to do it better, tailoring it for the client. Patient navigation is focussed on removing barriers to good physical and mental health care.

Even with this role, the difficulty of getting access to health care for people outside of major cities is a major barrier to good health care. This is exacerbated by the now consistent difficulty for people outside major cities in getting to see a GP or being able to afford to see a GP.

Additionally, without flexible funding for clinical referrals, an individual has to be eligible for the NDIS and then has to be able to get these services and supports into their care plan.

Importantly, the functions are not to take over the functions of other health professionals, but to ensure these are available and connected to the others that are required for each individual. There should be no artificial division between biomedical and biopsychosocial health care and support. Navigators should create a more seamless flow between providers.

Two roles: navigator and peer worker

The group agreed there are two sets of functions that may be two roles that are required to bridge the barriers to good physical health care for people with serious mental illness.

The role that is additional to clinical health care navigation is based around health coaching and developing self-advocacy and management. This is ideally a peer support worker.

Functions that would be within peer worker roles would include advocacy and support to empower the individual.

Quality Improvement Advisory Group

Tuesday July 12, 2022 2:00pm-3:30pm AEST via Zoom

Australia's Primary Health Care 10 Year Plan

- Australia's Primary Health Care 10 Year Plan, commissioned in 2019 by the then Government was published in March 2022.
- The national Labor government has given in principle support to the plan and have indicated an investment of \$750 million through a Strengthening Medicare Fund.
- The Strengthening Medicare taskforce, established July 2022, has been commissioned to advise on this development.
- A centrepiece of the 10 Year Plan is a proposal for voluntary patient registration (VPR) to support the development of new models of care, more flexible models with less reliance on fee for service care. VPR would:
 - formalise relationships for doctor/practice with patient in the system
 - enable longitudinal and continuous care (bundled, managed health care) where patients have taken up enrolment
 - channel funding in a well-targeted and directed way to service patient needs- depending on their morbidities and comorbidities
 - enable development of new service models, potentially with less reliance on fee for service care
 - enhance capability to identify and clean data
 - identify gaps in data to improve service outcomes
 - VPR would particularly support more flexible and convenient care, provide greater access, and greater support to patients. This could be a particularly important aspect for people with serious mental illness.
 - VPR would not be exclusive

The Strengthening Medicare taskforce- has been established to build on Australia's Primary Health Care 10 Year Plan 2022-32 and will focus on:

- improving patient access to general practice, including after hours
- improving patient access to GP-led multidisciplinary team care, including nursing and allied health
- making primary care more affordable for patients
- improving prevention and management of ongoing and chronic conditions
- reducing pressure on hospitals.

Data

- Outcome measures are essential. It will be important to work out what data is wanted/needed and where/how it fits with all other data sets. Primary care want data across all patients to accurately identify subgroups to be able to target interventions.
- Two types of data:
 - individual patient data: to outreach and support coherent, ongoing treatment and management
 - dataset to nationally track identified outcomes (minimum dataset)
- One of the issues for a dataset and quality measures to address is that the subgroup of people with serious mental illness are falling through the gaps and are not currently being adequately identified and offered outreach support for screening/treatment of physical health concerns.
- Data is particularly important for this patient group:
 - at the practice level through a practice register, to ensure that a person is supported to access care and to be connected proactively to care for support when they're going through acute health phases,

- to aggregate up to ensure that locally those people who are known to need the support are getting equivalent care through a PHN catchment area, for example, and then nationally so that we can actually report we are reducing mortality that is preventable through consistent practices and quality of care
- Need to clarify the current state of play in terms of data aspect at a national level
 - Don't reinvent the wheel, connect and build on data projects such as:
 - Lumos (NSW data linkage)
 - pretty good in public health services
 - blind spot in General Practice
 - (also Primary Sense™, the data and information program developed by Gold Coast PHN).
- The need is not just for data collection but also for change and adoption and getting people to collect and report data correctly
 - Data Security/transparency is essential. From the consumer perspective:
 - Lots of mistrust and lack of faith that monitoring is happening
 - What data is collected? How it is accessed? How is it used?
 - Qualitative data is important too
 - Consumers need a sense of control:
 - Consumers want to be able to see and correct data about them
 - They also don't want it used against them in anyway
 - How would it work across jurisdictions?

- National system
 - Should we be advocating for national support for national pilot-data system that allows use and aggregation of existing data, both around the individual between the public mental health service, primary care service, the commonwealth and state and also specialist, physical healthcare services?
- Annual national report
- Potential pilot or subgroup in this consumer cohort.

Engagement

- Consumers and carers engagement through:
 - the National Consumer Mental Health Peak Alliance, which is made up of BEING New South Wales, LELAN South Australia, VMIAC in Victoria, CoMHWA in Western Australia, Flourish in Tasmania.
 - National Alliance might be interested in as something they could take up
 - Organise a meeting with the alliance- with CEs
 - Bring them up to speed with what has happened and what we hope to achieve
- Government:
 - Clarify the current state of play in terms of data aspect at a national level
 - Understand what is happening and where it is happening
 - Who to approach
 - Federal ministers
 - State Health Ministers
 - National Cabinet
- Colleges- RANZCP and RACGP

Outcomes

- Meet with the National Consumer Mental Health Peak Alliance for support and collaboration
- Develop a set of principles that guide/shape conversations going forward
 - In the form of a brief resource pack for people to use to advocate in their jurisdiction (e.g. a question and answer approach)
 - Privacy is important- why?
 - Data sharing is important – why?
 - etc
- Pitch sheet
 - Developed from the principles
 - mapping exercise around who you target and get maximum “bang for buck”
 - part of the pitch needs to be that much of this data we've already got access to through general practice
 - what we haven't got is the integrated systems part
- Multi-pronged approach to Federal, state ministers
 - Benefits to health system around getting this right
 - Can we leverage agreements that already exist
- Write to and seek a meeting with the Strengthening Medicare taskforce.

PHN roundtable

Tuesday August 16, 2022 2:00pm-3:45pm AEST via Zoom

Panel presentations

Embedding Lived Experience in PHN programs- Paula Arro, Brisbane North PHN

Paula has a lived experience with MH, Suicide and AOD both as a consumer and a carer. In 2016 Paula was employed by the PHN to develop the capacity and support opportunities for people with a lived experience to actively participate in MHAOD reforms. During this time PHNs were handed over responsibility for the commissioning of MH, SP and AOD primary mental health treatment services. In 2018 her role has expanded to Chair and provide secretariat support to the National PHN Mental Health Lived Experience Engagement Network (MHLEEN). In 2021 Paula is now the Chair of the QLD Lived Experience Workforce Network (QLEWN). Paula has been an active leader in the development of the Lived Experience Workforce both in Queensland and Australia and is now an Australian Faculty Member at the Let's LEAD Academy at Yale University who supports and mentors emerging leaders.

PrimarySense™ – Dr Alyson Ross, Gold Coast PHN

Dr Alyson Ross has over 25 years' experience in executive and board director roles across all three tiers of government and the NFP sector in Australia and the UK. This has included working in the highly dynamic English National Health Service as well as at the state and national health service level in Australia. Most recently she has led the development project for GCPHN to develop an Australian first, a practice population health management toolset for primary care called Primary Sense™. This is now being scaled for national adoption across the Primary Health Networks of Australia. She was an inaugural non-executive board member of Gold Coast Primary Care and now leads the commissioning systems portfolio for the organisation.

What can PHNs do to lift capacity of General Practice including through fostering broader primary care engagement (e.g. Pharmacy, GP, allied health, Community support organisations)?

- Solutions need to be practical, implementable and sustainable to engage general practice.
- Capacity of general practice is stretched and it is difficult to facilitate or get engagement
 - GPs are time poor
 - Needs facilitation of the team care approach in primary care (practice nurses, allied health)
- There needs to be a clear value proposition for GPs to engage in services or education pieces
- Education: needs to not be a 'tick-a-box' exercise. To achieve take-up of education by GPs education needs to:
 - recognise the limitations of short courses
 - be included within the CPD calendar
 - be built into contracts with providers or regional planning (e.g. KPIs)
 - recognise that GPs are small businesses - every time a GP engages in education it comes at a time and/or financial cost to their business
 - programs need to be scalable in capacity without exponential costs
 - tap into GP workflow
- Social Prescribing is one strategy being implemented to expand capacity of primary care.

What do PHNs need to foster and support shared care arrangements between specialist mental health services and primary care?

- Co-location of services will help collaboration such as:
 - System integration – shared care is often reliant on co-location
 - Ensuring access to allied health and/or specialist mental health services
 - Access to resourcing
 - Osmosis of shared care principles
 - E.g. Head to health hubs- multidisciplinary team - one stop shop model for shared care
 - Upskilling – need to upskill and expand the workforce to promote shared care
- Regional plans around LHDs and LHNs- could support better integration and relationships.
- Navigators:
 - This is a really important role as clinical navigator and/or peer support role
 - Not ‘one size fits all’: physical health challenges will change across the lifespan and support needs to reflect this - for example, a youth peer worker does not have shared experience with an older person
- PHN activities:
 - Work the physical health of people with serious mental illness into programs/services (e.g. Health Pathways, data interface, quality improvement/workforce development, mental health service procurement) already being supported by PHNs
 - Inefficient if each PHN tries to develop their own from scratch – aim for national network driven improvements such as:
 - Develop guides/resources/tools together at a national network and implement as individual PHNs

- Aim for scalability through progressive and incremental gains
- Map
 - Why does the problem exist?
 - What is within the PHN remit and what is beyond the scope?
 - What else is needed?

Summary

Major barriers to be addressed:

- Workforce capacity: e.g. GP capacity, nurse capacity
- Funding of primary care capacity development for this purpose.

Potential next steps:

- Foster the national network of PHNs to develop tool/resources together
- Engage Equally Well Community of Practice (CoP) to facilitate and engage the PHN network in progressive development
- Develop funding proposals for resource and system development

Research roundtable

Monday April 11, 2022 2:00pm-3:45pm AEST
Hybrid

Current and potential research activity to advance priorities

Connections with the NHMRC clinical trials network (MFRR “Million Minds Mission” funded) will be important. The two trials underway are:

- **MAGNET: Mental Health Australia General Clinical Trials Network** (led by Michael Berk (Deakin University))
- **Growing Minds Australia: A National Trials Strategy to Transform Child and Youth Mental Health Services** (Clinical Trials Network (GMA-CTN) led by Mark Dadds, University of Sydney)

Both trials include a physical health stream, core deliverable is to engage with clinicians and researchers to identify gaps.

The Growing Minds Website could provide information about like research issues and researchers. This could become a link on the Equally Well website to foster connections and further develop a research network.

An opinion piece – such as in the Australian Jnl of Psychology and ANZ Jnl of Psychiatry – could be considered as a means of fostering a network.

Need to focus on how not to create or continue silos of information and activity while acknowledging confidentiality pressures in relation to funding applications. Communication about what research is being undertaken is important. It is important that research is innovative, gap filling, inclusive of consumers and carers at every step and implementable. This needs to be conveyed to funders and particularly the MRFF.

Equally Well is planning to conduct a scan of the literature and programs to develop a consumer resource and will also undertake

an analytical project analysing patterns of mortality and comorbidities with socioeconomic status. Is also resourced to undertake a scan of engagement and activity – this could be a resource for a platform for engagement and information.

Implementation

Implementation science is essential – to translate research into routine service provision and practice. SW Sydney has achieved that and it is proposed to roll this out statewide.

Service providers want a ‘how to’ guide to take research into service provision and practice – an example was given of a Victorian health service actively seeking this.

Need to work on how to provide this for the spectrum from intervention to implementation and integration in service provision and models.

Integrity of research is essential while pushing ahead with research momentum. Agenda must be co-produced going forward and this requires equity of inclusion of lived experience and relevant allied health perspectives.

There needs to be an advocacy agenda for investment in research implementation. Need to facilitate and support partnerships – and not limited to the MRFF.

There are 31 mental health ‘systems’ in Australia. GPs are most likely to look for research information for physical health care of people with serious mental illness.

Need to work towards alignment of consumer and carer and clinician views to advocate together for change. Need to aim to change culture – to chip away at gradually changing the culture within services – with the aim of achieving expectations that people with serious mental illness will and must have the same physical health care and treatment as others. Also need to ensure there is equity of focus on rural, regional and remote.

New areas for research development include:

- Resource guide on relevant research and interventions for health services and clinicians
- Resource for clinicians to facilitate their engagement in research:

Note: Need to work on how to provide these for the spectrum from intervention to implementation and integration in service provision and models.

- Potential to establish SQUIRE (Standards for Quality Improvement Reporting Excellence) for research addressing the physical health and premature mortality of people with serious mental illness. A system like this could ensure quality and integrity of research.

Need to consider:

- Lessons from common mental illness (I.e. depression and anxiety) and the levers that GPs and other health professionals can use to get service provision for consumers.
- Funding packages. E.g. NDIS for some, psychosocial support programs etc.
- Community and place based interventions.

Next steps

Establish a research advocacy and network strategy through:

- Strategic leadership group/network body- facilitated by Equally Well
- Expert group by/within EW to develop standards for research in this space
- Create a business case based on these standards and advocate for dedicated funding from MRFF with case for funding to be administered at sector level by sector.

Appendix B: Measures of Success and Roadmap Recommendations

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

Table B1: Measures of Success

The Roadmap in detail

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

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

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

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

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

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

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

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

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

The Roadmap in detail

6. Workforce roles and development through:

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

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

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

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

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

PARTICIPANTS

Consumer and Carer Measures of Success advisory group:

Dave Peters, Co-Chair and Lived Experience Representative, Equally Well Australia (**Chair**); Stella McNamara, Policy and Research Analyst, Mitchell Institute, Victoria University (**Rapporteur**); Lee Cobb, Project Director, Equally Well Australia; Michelle Sanders, Team Leader - Lived Experience (Peer) Workforce, Mental Health and Specialist Services, Queensland Health; Judith Drake, Lived Experience Advocate; De Backman-Hoyle, Senior Collaboration Coordinator, Lived Experience Australia; Fay Jackson, General Manager of Inclusion, Flourish Australia, Inaugural Deputy Commissioner, NSW Mental Health Commission, Founder of Vision In Mind; Tim Heffernan, Deputy Commissioner, Mental Health Commission of NSW; Debbie Childs, Helping Minds CEO; Michael Burge AM, Mental Health Consumer Peer Advocate; Darren Jiggins, Deputy Chair, Lived Experience Australia; Harry Lovelock, Director, Policy and Research, Mental Health Australia; Prof Sharon Lawn, Chair and Executive Director, Lived Experience Australia; Professor, College of Medicine and Public Health, Flinders University; Prof Rosemary Calder AM, Professor Health Policy; Director, Australian Health Policy Collaboration, Mitchell Institute for Education and Health Policy, Victoria University; Anouk Sherman, Engagement and Program Manager, Mitchell Institute, Victoria University.

Shared care protocol roundtable:

Prof Russell Roberts, Professor in Management, Charles Sturt University; National Director, Equally Well Australia (**Co-facilitator**); Prof Rosemary Calder AM, Professor Health Policy; Director, Australian Health Policy Collaboration, Mitchell Institute for Education and Health Policy, Victoria University (**Co-facilitator**); Prof Mark Morgan, Professor of General Practice, Bond University; Chair, RACGP Expert Committee – Quality Care (**Presenter and breakout group co-facilitator**); Prof Malcolm Hopwood, Psychiatrist; Director, Professorial Psychiatry Unit | Albert Road Clinic; Honorary Professorial Fellow, Florey Institute of Neuroscience and Mental Health; President, Asian Federation of Psychiatric Associations, University of Melbourne (**Breakout group co-facilitator**); A/Prof Kevin Mc Namara, Deputy Director Associate Professor, School of Medicine, Faculty of Health, Deakin University (**Breakout group co-facilitator**); Andrew Watkins, Nurse Practitioner, Ambassador and Professional Reference Group Member, Equally Well Australia (**Breakout group co-facilitator**); Prof David Castle, Scientific Director, Centre for Complex Interventions, Department of Psychiatry, University of Toronto (**Breakout group co-facilitator**); Dr Caroline Johnson, Academic Specialist- Primary Care, General Practice, University of Melbourne (**Breakout group rapporteur**); Dr Scott Teasdale, Accredited Practising Dietitian; Senior Research Fellow, School of Clinical Medicine, UNSW; Mindgardens Neuroscience Network (**Breakout group rapporteur**); Dr Carolynne White, Occupational Therapist; Participation and Co-design Manager, Mind Australia (**Breakout group rapporteur**); Antony Nicholas, Chair, Allied Health Professions Australia; CEO, Osteopathy Australia; Claire Hewat, CEO, Allied Health Professions Australia; Ms Karen Booth, President, Australian Primary Health Care Nurses Association; Debbie Bragg, Commissioning Consultant, Darling Downs and West Moreton PHN; Prof James Dunbar, Deakin Rural Health, School of Medicine, Faculty of Health, Deakin University; Kate Schlicht, Senior Research Fellow, School of Medicine, Faculty of Health, Deakin University; Dr Tetyana Rocks, Accredited Practising Dietitian, Research Fellow and Head of the Translational and Educational stream, Food & Mood Centre, Deakin University; Mark Roddam, First Assistant Secretary, Mental Health Division, Australian Government Department of Health and Aged Care; Dave Peters, Co-Chair and Lived Experience Representative, Equally Well Australia; Lee Cobb, Project Director, Equally Well Australia; Ms Lyn English AM, Equally Well Australia Lived Experience (SA) Representative and OCP Lived Experience Advisory Group (SA) Co-Chair; Prof Sharon Lawn, Chair and Executive Director, Lived Experience Australia; Professor, College of Medicine and Public Health, Flinders University; Danica Browne, Manager Lived Experience Programs, Mental Health Australia; Harry Lovelock, Director, Policy and Research, Mental Health Australia; Catherine Lourey, Commissioner, Mental Health Commission of NSW; Lynette Matthews, Mental Health Commission of NSW;

A/Prof Jackie Curtis, Executive Director, Mindgardens Neuroscience Network; Prof Maximilian de Courten, Vice-Chancellor's Distinguished Research Fellow (VCDRF), Victoria University; Kerry Hawkins, Commissioner, National Mental Health Commission; Mrs Lucinda Brogden AM, Co-Chair, National Mental Health Commission; Susan Hayward, Director, National Mental Health Commission; Kevin de Vries, Pharmacist, Policy advisor, Pharmacy Guild of Australia; Rebecca Segrott, Program Manager, Pharmacy Guild of Australia; Adel El Eid, Policy and Program Officer, Queensland Mental Health Commission; Scott James, Manager, Queensland Health; Dr Cathy Andronis, Chair, RACGP Specific Interest Psychological Medicine; Dr Stephan Groombridge, Manager, eHealth & Quality Care, RACGP; Ms Rosie Forster, Executive Manager, Practice, Policy and Partnerships, RANZCP; Rhujul Patel, Policy Analyst, Society of Hospital Pharmacists; Eugene McGarrell, Service Development and Performance Manager | Mental Health, South Eastern NSW PHN; Kaitlyn Graham, Primary Health Consultant, Tasmania PHN; Anouk Sherman, Engagement and Program Manager, Mitchell Institute, Victoria University; Stella McNamara, Policy and Research Analyst, Mitchell Institute, Victoria University.

Workforce roundtable:

Prof Russell Roberts, Professor in Management, Charles Sturt University; National Director, Equally Well Australia (**Co-facilitator**); Prof Rosemary Calder AM, Professor Health Policy; Director, Australian Health Policy Collaboration, Mitchell Institute for Education and Health Policy, Victoria University (**Co-facilitator**); Prof Mark Morgan, Professor of General Practice, Bond University; Chair, RACGP Expert Committee – Quality Care (**Presenter and Breakout group co-facilitator**); Ms Karen Booth, President, Australian Primary Health Care Nurses Association (**Breakout group co-facilitator**); Dr Carolynne White, Occupational Therapist; Participation and Co-design Manager, Mind Australia (**Breakout group co-facilitator**); A/Prof Kevin Mc Namara, Deputy Director Associate Professor, School of Medicine, Faculty of Health, Deakin University (**Breakout group co-facilitator**); Dr Tetyana Rocks, Accredited Practising Dietitian, Research Fellow and Head of the Translational and Educational stream, Food & Mood Centre, Deakin University (**Breakout group rapporteur**); Tim Heffernan, Deputy Commissioner, Mental Health Commission of NSW (**Breakout group rapporteur**); Claire Hewat, CEO, Allied Health Professions Australia; Antony Nicholas, Chair, Allied Health Professions Australia; CEO, Osteopathy Australia; Linda Davidson, National Director, Professional Practice, Australia College of Nursing; Julianne Bryce, Senior Federal Professional Officer, Australian Nursing and Midwifery Federation; Anthea Raven, Assistant Secretary, Mental Health Access, Australian Government Department of Health and Aged Care; Dr Anne-marie Boxall, Assistant Secretary, Chief Allied Health Officer, Allied Health and Service Integration, Australian Government Department of Health and Aged Care; Prof James Dunbar, Deakin Rural Health, School of Medicine, Faculty of Health, Deakin University; Kate Schlicht, Senior Research Fellow, School of Medicine, Faculty of Health, Deakin University; Dave Peters, Co-Chair and Lived Experience Representative, Equally Well Australia; Jade Ryall, Manager, Back on Track Health Program, Flourish Australia; Judy Bentley, Lived Experience Australia ACT representative; Prof Sharon Lawn, Chair and Executive Director, Lived Experience Australia; Professor, College of Medicine and Public Health, Flinders University; Harry Lovelock, Director, Policy and Research, Mental Health Australia; Lynette Matthews, Mental Health Commission of NSW; Ella Bellamy, Peer Workforce Coordinator, Mental Health Council of Tasmania; Catherine O'Donnell, Lived Experience Project Manager, Mindgardens Neuroscience Network; Dr Scott Teasdale, Accredited Practising Dietitian; Senior Research Fellow, School of Clinical Medicine, UNSW; Mindgardens Neuroscience Network; Prof Maximilian de Courten, Vice-Chancellor's Distinguished Research Fellow (VCDRF), Victoria University; Susan Hayward, Director, National Mental Health Commission; Andrew Davison, Chief Allied Health Officer, NSW Health; Geoff Radford, Executive Officer, Northern Territory Mental Health Coalition.; Kevin de Vries, Pharmacist, Policy advisor, Pharmacy Guild of Australia; Adel El Eid, Policy and Program Officer, Queensland Mental Health Commission; Scott James, Manager, Queensland Health;

Workforce roundtable continued:

Dr Stephan Groombridge, Manager, eHealth & Quality Care, RACGP; Rosie Forster, Executive Manager, Practice, Policy and Partnerships, RANZCP; Rhujul Patel, Policy Analyst, Society of Hospital Pharmacists; A/Prof Simon Rosenbaum, Scientia Associate Professor, School of Psychiatry, UNSW; Anouk Sherman, Engagement and Program Manager, Mitchell Institute, Victoria University; Stella McNamara, Policy and Research Analyst, Mitchell Institute, Victoria University.

Describing the role and capabilities of a clinical health care navigator advisory group:

A/Prof Kevin Mc Namara, Deputy Director Associate Professor, School of Medicine, Faculty of Health, Deakin University (**Chair**); Mary Malakellis, Research Fellow, School of Medicine, Faculty of Health, Deakin University (**Presenter**); Stella McNamara, Policy and Research Analyst, Mitchell Institute, Victoria University (**Rapporteur**); Dr Caroline Johnson, Academic Specialist- Primary Care, General Practice, University of Melbourne; Nadia Marsh, Executive Director, Eastern PHN Victoria; Dr Kevin McNamara, Consultant Psychiatrist, Gold Coast HHS; Honorary Adjunct Professor and Discipline Lead in Mental Health, Bond University; Kate Schlicht, Senior Research Fellow, School of Medicine, Faculty of Health, Deakin University; Andrew Davison, Chief Allied Health Officer, NSW Health; Jade Ryall, Manager, Back on Track Health Program, Flourish Australia; Judy Bentley, Lived Experience Australia ACT representative; Ms Lyn English AM, Equally Well Australia Lived Experience (SA) Representative and OCP Lived Experience Advisory Group (SA) Co-Chair; Carolyn Der Vartanian, Director, National Cancer Control; Dr Carolynne White, Occupational Therapist; Participation and Co-design Manager, Mind Australia; Prof Rosemary Calder AM, Professor Health Policy; Director, Australian Health Policy Collaboration, Mitchell Institute for Education and Health Policy, Victoria University; Prof Russell Roberts, Professor in Management, Charles Sturt University; National Director, Equally Well Australia; Lee Cobb, Project Director, Equally Well Australia; Andrew Watkins, Nurse Practitioner, Ambassador and Professional Reference Group Member, Equally Well Australia; Darren Jiggins, Deputy Chair, Lived Experience Australia; Prof Rosemary Calder AM, Professor Health Policy; Director, Australian Health Policy Collaboration, Mitchell Institute for Education and Health Policy, Victoria University; Anouk Sherman, Engagement and Program Manager, Mitchell Institute, Victoria University.

Quality Improvement Advisory group:

Dr Chris Moy, former Vice President AMA; President AMA South Australia; Chair Federal AMA Ethics and Medico-legal Committee (**Chair**); Stella McNamara, Policy and Research Analyst, Mitchell Institute, Victoria University (**Rapporteur**); Prof Rosemary Calder AM, Professor Health Policy; Director, Australian Health Policy Collaboration, Mitchell Institute for Education and Health Policy, Victoria University; Clare Sullivan, A/g Director, Service Systems, National Mental Health Commission; Prof James Dunbar, Deakin Rural Health, School of Medicine, Faculty of Health, Deakin University; Prof Russell Roberts, Professor in Management, Charles Sturt University; National Director, Equally Well Australia; Lee Cobb, Project Director, Equally Well Australia; A/Prof John Allan, Faculty of Medicine, the University of Queensland; Co-Chair, Equally Well Australia; Prof Paresch Dawda, GP, Principal; Director Prestantia Health; Adjunct Prof, Faculty of Health, University of Canberra; Dr Tetyana Rocks, Accredited Practising Dietitian, Research Fellow and Head of the Translational and Educational stream, Food & Mood Centre, Deakin University; Dave Peters, Co-Chair and Lived Experience Representative, Equally Well Australia; Tim Heffernan, Deputy Commissioner, Mental Health Commission of NSW; Dr Murray Wright, Chief Psychiatrist, NSW Health; Kimberly Fitzpatrick, Senior Manager, Mental Health Patient Safety Program, NSW Clinical Excellence Commission; Dr Nick O'Connor, Clinical Lead Mental Health Patient Safety Program, NSW Clinical Excellence Commission; Dr Dale Ford, Western District Health Service and Principal Clinical Adviser; Dr Walid Jammal, GP, Hills Family General Practice; Dr Steve Hambleton AM, Director, Australian Digital Health Agency; Nadia Marsh, Executive Director, Eastern PHN Victoria; Anouk Sherman, Engagement and Program Manager, Mitchell Institute, Victoria University.

Primary Health Network roundtable:

Prof Russell Roberts, Professor in Management, Charles Sturt University; National Director, Equally Well Australia (**Co-facilitator**); Prof Rosemary Calder AM, Professor Health Policy; Director, Australian Health Policy Collaboration, Mitchell Institute for Education and Health Policy, Victoria University (Co-facilitator); Paula Arro, Lived Experience Engagement Coordinator, Brisbane North PHN (**Presenter**); Dr Alyson Ross, Director of Commissioning Systems, Gold Coast PHN (**Presenter**); Stella McNamara, Policy and Research Analyst, Mitchell Institute, Victoria University; Anita McRae, Senior Manager, Mental Health, Drug & Alcohol, Murrumbidgee PHN; Madeline Cairns, Project Officer, Mental Health Services, North West Melbourne PHN; Alecia Brown, Regional Services Coordinator, Gippsland PHN; Belinda Spagnoletti, Health Care Design & Evaluation Practitioner, Adelaide PHN; Paige Enright, Commissioning Lead Mental Health Services, North West Melbourne PHN; Catherine Goodwin, Drug and Mental Health Manager, South East Sydney PHN; Thea Prasad, Program Development Officer | Mental Health Alcohol and Other Drugs, Brisbane North PHN; Daniel Reynolds, Senior Project Office, Mental Health & Suicide Prevention Strategy and Partnerships, Hunter New England and Central Coast PHN; Catherine O'Donnell, Lived Experience Project Manager, Mindgardens Neuroscience Network; Lee Cobb, Project Director, Equally Well Australia; Daniel Rock, Principle Advisor & Research Director, WA Primary Health Alliance; Elizabeth Giles, Central Queensland, Wide Bay, Sunshine Coast PHN; Paul Martin, Executive Manager, Brisbane North PHN; Cassandra Morrell, Manager Regional Services, Gippsland PHN; Stewart Gordon, General Manager, Service Delivery, Darling Downs West Moreton PHN; Maja Asmus, Mental Health Alcohol and Other Drugs Manager, Murrumbidgee PHN; Alex Bickford, Primary Care, WA Primary Health Alliance; Janelle Dufty, Senior Manager, Commissioning, Murrumbidgee PHN; Trudy Johnston, Senior Development Program Coordinator, Service Navigation, Brisbane South PHN; Eugene McGarrell, Service Development and Performance Manager | Mental Health, South Eastern NSW PHN; Natalie Haugh, Program Lead, Western Victoria PHN; Philippa Fetterplace, Health Coordination Consultant, South Eastern NSW PHN; Kelly Wells, Operations Manager, Adelaide PHN;

Research roundtable:

Prof Rosemary Calder AM, Professor Health Policy; Director, Australian Health Policy Collaboration, Mitchell Institute for Education and Health Policy, Victoria University (**Facilitator**); Stella McNamara, Policy and Research Analyst, Mitchell Institute, Victoria University; Prof Russell Roberts, Professor in Management, Charles Sturt University; National Director, Equally Well Australia; Patrick Livermore, Senior Project Officer, Equally Well Australia; Andrew Watkins, Nurse Practitioner, Ambassador and Professional Reference Group Member, Equally Well Australia; Prof Amanda Wheeler, Professor of Mental Health, School of Pharmacy and Medical Science, Griffith University; Dr Chris Maylea, Associate Professor, Law, La Trobe University; Equally Well Australia; Darren Jiggins, Deputy Chair, Lived Experience Australia; Patrick Gould, Project officer, Mindgardens Neuroscience Network; Dr Scott Teasdale, Accredited Practising Dietician; Senior Research Fellow, School of Clinical Medicine, UNSW; Mindgardens Neuroscience Network; Prof Rosemary Calder AM, Professor Health Policy; Director, Australian Health Policy Collaboration, Mitchell Institute for Education and Health Policy, Victoria University; Dr Justin Chapman, Postdoctoral Research Fellow, QIMR Berghofer Medical Research Institute; Michelle Sanders, Team Leader - Lived Experience (Peer) Workforce, Mental Health and Specialist Services, Queensland Health; Sally Plever, Manager, Queensland Health; Dr Caroline Johnson, Academic Specialist- Primary Care, General Practice, University of Melbourne; Prof Jenny Bowman, Professor, Newcastle University; Prof Phil Ward, Professor, UNSW; Anouk Sherman, Engagement and Program Manager, Mitchell Institute, Victoria University.

Implementation roundtable:

Prof Rosemary Calder AM, Professor Health Policy; Director, Australian Health Policy Collaboration, Mitchell Institute for Education and Health Policy, Victoria University (**Co-facilitator**); Prof Russell Roberts, Professor in Management, Charles Sturt University; National Director, Equally Well Australia (**Co-facilitator**); Prof David Castle, Scientific Director, Centre for Complex Interventions, Department of Psychiatry, University of Toronto (**Presenter**); Prof Malcolm Hopwood, Psychiatrist; Director, Professorial Psychiatry Unit | Albert Road Clinic; Honorary Professorial Fellow, Florey Institute of Neuroscience and Mental Health; President, Asian Federation of Psychiatric Associations, University of Melbourne (**Presenter**); Prof Mark Morgan, Professor of General Practice, Bond University; Chair, RACGP Expert Committee – Quality Care (**Presenter**); Dr Tetyana Rocks, Accredited Practising Dietitian, Research Fellow and Head of the Translational and Educational stream, Food & Mood Centre, Deakin University (**Presenter**); Dave Peters, Co-Chair and Lived Experience Representative, Equally Well Australia (**Presenter**); Dr Ruth Vine, Deputy Chief Medical Officer for Mental Health, Australian Government Department of Health and Aged Care; Emily Carter, Administration & Campaign Support, Mental Health Council of Tasmania; Naomi Thomson, Policy and Projects Officer, Mental Health Council of Tasmania; Prof James Dunbar, Deakin Rural Health, School of Medicine, Faculty of Health, Deakin University; Jared Holt, Australian Government Department of Health and Aged Care; Kevin de Vries, Pharmacist, Policy advisor, Pharmacy Guild of Australia; Renae Hodgson, Assistant Director Strategic Management, Western Australia Mental Health Commission; Liz Everard, Primary Health Consultant, Primary Health Tasmania; Ms Lyn English AM, Equally Well Australia Lived Experience (SA) Representative and OCP Lived Experience Advisory Group (SA) Co-Chair; Mrs Lucinda Brogden AM, Co-Chair, National Mental Health Commission; A/Prof Jackie Curtis, Executive Director, Mingardens Neuroscience Network; Susan Hayward, Director, National Mental Health Commission; Lee Cobb, Project Director, Equally Well Australia; Dr Stephan Groombridge, Manager, eHealth & Quality Care, RACGP; Prof Sharon Lawn, Chair and Executive Director, Lived Experience Australia; Professor, College of Medicine and Public Health, Flinders University; Prof Michael Hazelton, President, Australian College of Mental Health Nurses; Carolyn McKay, Mental Health & Alcohol and Other Drug Integration Coordinator, Adelaide PHN; Harry Lovelock, Director, Policy and Research, Mental Health Australia; Ivan Frkovic, Commissioner, Queensland Mental Health Commission; A/Prof Vinay Lakra, President, RANZCP; Judy Bentley, Lived Experience Australia ACT representative; Julianne Bryce, Senior Federal Professional Officer, Australian Nursing and Midwifery Federation; Kerry Hawkins, Commissioner, National Mental Health Commission; Treasure Jennings, Commissioner, Mental Health Complaints Commissioner; Robyn Callaghan, Board member, Mental Health Complaints Commissioner; Ms Rosie Forster, Executive Manager, Practice, Policy and Partnerships, RANZCP; Dr Carolyn HULLICK, Clinical Director, Australian Commission on Safety and Quality in Health Care; Anouk Sherman, Engagement and Program Manager, Mitchell Institute, Victoria University; Stella McNamara, Policy and Research Analyst, Mitchell Institute, Victoria University.



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