Improving the physical health and wellbeing of consumers of mental health and alcohol and other drug services

Consultation summary

Queensland Government

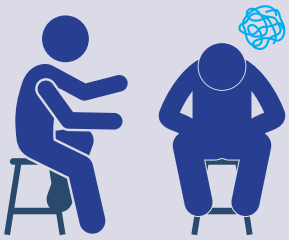
Improving the physical health and wellbeing of consumers of mental health and alcohol and other drug services: Consultation summary

Published by the State of Queensland (Queensland Health), December 2021.

For more information contact:
Mental Health Alcohol and Other Drugs Branch,
Clinical Excellence Division, Department of Health,
GPO Box 48, Brisbane QLD 4001,
Email MHAODB-OCP@health.qld.gov.au,
Phone 07 3328 9538.

An electronic version of this document is available at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/guidelines.

Contents



People with **substance use disorders** and/or **other mental health disorders** have a **2-3 times higher mortality** rate than the general population, resulting in **life expectancy gap of 10-20 years**[1,2].

Up to **three-quarters** of this **mortality** gap is attributed to general medical conditions such as **cardiovascular disease, respiratory disease and diabetes** – diseases which have many modifiable risk factors[3].

Introduction

Compared with the general population, people with substance use disorders and/or mental health disorders are at higher risk of developing a range of medical conditions which can reduce quality of life and increase health service needs[4]. This is evident across the lifespan: antecedents to disease progress after first diagnosis[5-7] and compound with age-related factors leading to heightened risk of disease and functional decline[8,9].

The co-occurrence of two or more chronic disorders is referred to as 'multimorbidity'[10]. Multimorbidity predisposes individuals to a trajectory of disease and functional decline because of the accumulation of risks and vulnerabilities associated with chronic disorders[11]. People with multimorbidity experience high levels of psychological distress, lower quality of life, and poorer clinical outcomes[12-14]. The interaction of co-occurring general medical conditions in people with substance use disorders and/or mental health disorders can exacerbate functional disability, and reduce an individual's ability to self-manage their conditions resulting in worse quality of life than people who only have co-occurring general medical conditions[15]. The causes of this health disparity are complex, and include social inequalities such as low education, high unemployment and housing instability, systems- and service-level barriers such as stigma and fragmentation of care, side-effects of psychiatric medications and polypharmacy, and high prevalence of unhealthy lifestyle behaviours such as smoking, physical inactivity, poor diet and poor dental hygiene[1,2,13,16,17]. Improving prevention and management of multimorbidity is recognised as a priority in national policy and strategic plans[16,18].

Australia's policy context highlights the interrelatedness of mental and physical health and wellbeing, and multi-directionality of substance use disorders, mental health disorders and general medical conditions. The National Mental Health Commission's consensus statement *Equally Well: Quality of Life, Equality in Life (2016)* was Australia's first national strategic document to outline a vision of closing the life expectancy gap between people living with mental illness and the general population. This statement outlines six essential elements based around holistic, person-centered approaches for promotion, prevention and early intervention, including equity of access to quality and integrated health care services.

This vision was reinforced in the *Fifth National Mental Health and Suicide Prevention plan 2017-2022* by including "Improving the physical health of people living with mental illness and reducing early mortality" as Priority Area 5. Actions articulated under Priority Area 5 include providing guidelines and resources to support health services in improving screening and treatment for physical health conditions and risk factors within routine mental health care, and joint service planning and clinical governance activities with PHNs to improve integration of physical and mental health care. *The Queensland Mental Health Commission's (QMHC) Mental Health, Alcohol and Other Drugs Strategic Plan Shifting Minds 2018-2023* further emphasised improving individual, population and whole-of-system outcomes by addressing health determinants using integrated and cross-sectoral models of care, workforce development approaches, and strategic leadership to drive service reform. A subsequent position paper *Improving physical health for people with a lived experience of mental illness or problematic alcohol and other drug use (2019)* commissioned by QMHC identified opportunities for reform to improve the physical health of people with lived experience. Opportunities were categorized as individual-level, health service level, and or systems-level; in brief, these encompassed: promoting individual protective factors and improving healthcare navigation, by implementing multidisciplinary stepped-care models with clear responsibilities to improve care coordination across settings, and utilising cross-sectoral partnership and co-commissioning strategies to support integrated care and social connectedness. Finally, the *Productivity Commission's Inquiry into Mental Health (2020)* recommends substantial reform efforts on multiple levels. To improve care for people with concurrent mental and physical health conditions, governments are urged to commit to implementing Equally Well initiatives, and to establish targets for reducing the life expectancy gap (Action 14.1). Reiterating actions from Equally Well, the report recommends requiring all MHAOD services to screen for physical health conditions, directly provide or establish referral pathways to lifestyle interventions (diet, physical activity, smoking cessation, oral health), support MHAOD workforce development to improve quality of care for people with co-occurring general medical conditions, and provide appropriate health literacy and service navigation for consumers, families and carers. Further, Recommendation 23 is to improving cooperative arrangements between PHNs and HHSs (LHNs in the report) through rigorous joint regional planning and stronger oversight.

Recently, the *Being Equally Well: A National policy roadmap to better physical health care and longer lives for people living with serious mental illness* was released (2021)[19]. This report provides recommendations for sector reform on micro-system, meso-system and macro-system levels, and measures of success that were co-designed with people with lived experience. Recommendations include nine components: development of national guidelines for shared care, specific funding for tailored and shared care service provision, removal of financial barriers for relevant medications, establishment of a national network of quality improvement collaboratives, quality improvement monitoring and reporting, service integration and navigation workforce roles and development, recurrent research funding for health system design and delivery, national advocacy and awareness campaigns, and enhanced education and training for health professionals. The roadmap highlights the need for establishing infrastructure and processes to improve continuity and quality of care on all system levels. At a similar time, QMHC released their consultation summary *Lived experience perspective on physical health care (2021)*, in which people with lived experience of mental illness and alcohol and other drug issues were engaged across Queensland to identify priorities for reform. Findings indicated that participants prioritised: (i) co-designed,

inter-sectoral integrated service models focused on health promotion; (ii) capability building for the mental health workforce; (iii) partnerships between health and community organisations to strengthen social connectedness; (iv) strengthening evidence (particularly for alternative therapies); (v) enablers for information sharing between health practitioners; and (vi) oral health support for consumers across mental health and alcohol and other drug services.

The Mental Health Alcohol and Other Drugs Branch (MHAODB) has conducted a series of targeted consultations to inform approaches to improve the physical health and wellbeing of consumers of MHAOD services. Consultation was undertaken with a range of stakeholders, including professional colleges, Department of Health, Primary Health Networks, Statewide Clinical Networks, Lived Experience Leadership Groups, and individual staff nominated by Hospital and Health Services across the state. Consultees were asked to provide strategic views on how MHAOD services should be progressing toward more comprehensive care to prevent and manage multimorbidity, and for exemplars of local initiatives that could be adapted and scaled for implementation. Recommendations produced from these consultations have been aligned with priorities identified in QMHC's *Lived experience perspective on physical health care (QMHC2021)*.

Goal

To reduce morbidity from general medical conditions and improve wellbeing in people with substance use disorders and/or other mental health disorders.

Objectives

(1) To transform intersectoral partnership approaches to meet the health needs of consumers by improving service integration and access to preventative and specialist services.

(2) To optimise workforce development approaches to improve staff capability and leadership in preventing and managing general medical conditions in consumers within their scope of practice.

(3) To transform collaborative care approaches to increase service capability for comprehensive physical health assessments and multidisciplinary interventions.

High level summary

Consultations with key stakeholders were held between March 2021-June 2021. Common themes emerged throughout consultations, broadly representing a view for:

- An integrated, cross-sectoral service model that addresses all determinants of health using collaborative multidisciplinary and stepped-care approaches, incorporating principles of co-location, co-facilitation, service navigation, prevention and community integration.
    - Improved partnerships with primary care and non-government organisations to provide complementary services across the continuum of care.
    - Multidisciplinary approaches within MHAOD services to address physical health and wellbeing, including, e.g., nurse-led clinics for physical health assessment and intervention, specialist lifestyle intervention such as exercise physiology, dietetics, dentistry, and sexual health, and pharmacist-led medication optimisation and medication literacy.
    - Service navigation using defined roles (e.g., GP liaison, nurse navigators, service integration coordinators) or a combination with clear responsibilities.
- Role clarity and ongoing support to develop workforce capacity (time, resources) and capability using practice improvement methodologies to empower staff to contribute meaningfully to improving health of consumers within their scope, leading to improved culture in addressing multimorbidity.
- Better education and training for staff across sectors, including mental health awareness and stigma reduction for non-MHAOD staff to reduce diagnostic overshadowing, and training for MHAOD staff to increase capability in physical health assessment and intervention.
- Improving digital integration, information sharing processes, and care coordination for improving service efficiency and quality of care.

Based on the consultation findings and policy context, a logic model of the suggested approaches, potential outcomes and evaluation is presented on the next page.

Overview of suggested approaches

Improving the physical health of consumers of mental health and alcohol and other drug services
Approaches to improving the health of consumers under the new state-funded mental health and alcohol and other drug services plan (2021-2026)

- HHS resources, systems and expertise.
- HHS partnerships across Primary Health Networks, community-managed organisations, and general practice.

National Mental Health Commission
Equally Well: Quality of Life, Equality in Life

Qld Mental Health Commission
Improving physical health for people with a lived experience of mental illness or problematic alcohol and other drug use

Productivity Commission
Inquiry into Mental Health

Transform intersectoral partnership approaches

Partnership with General Practice
- Improved risk detection and access to treatment

Partnership with community-managed organisations
- Improved community participation and reduced readmissions

Optimise workforce development approaches
- Improved physical health screening, care planning, treatment and referral

Transform collaborative care approaches
- Improved identification of needs and provision of effective treatment for priority groups

Modifiable factors

• Digital integration & information systems • Service integration & access • Social inclusion & equity • Health literacy & self-care • Sexual health • Physical activity • Diet quality • Oral hygiene • Medication optimisation & side-effect management • Tobacco alcohol, other drug use

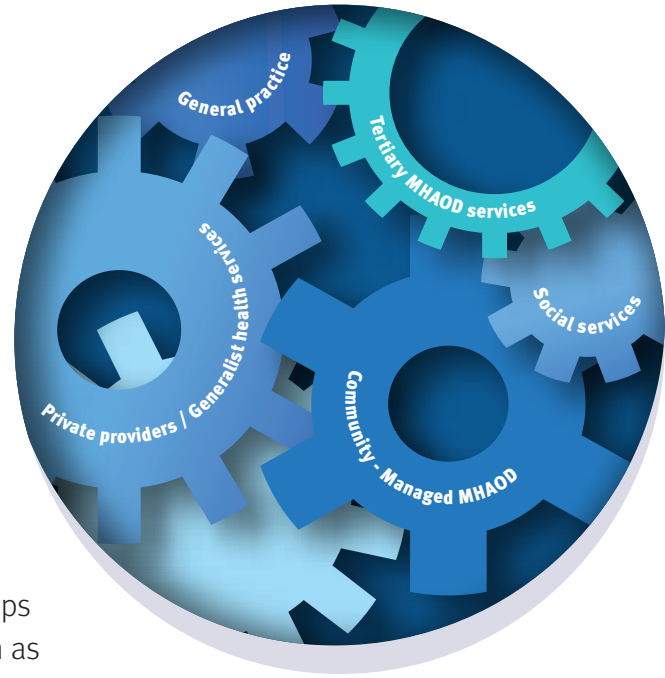
Potential progress indicators

Workforce capability
- Quality of care planning for physical health
- Workforce capability mapping
- Staff attitudes toward/ confidence in addressing physical health within MHAOD services
- Receipt of supervision/ mentoring for physical health

Care indicators
- Physical health screening and assessment
- Physical health interventions
- Smoking cessation intervention
- Physical health in formulation and care planning
- Physical health in care review
- Pharmacotherapy (e.g. polypharmacy, clozapine, metformin, naloxone) and side-effect monitoring and management
- Referrals and attendance to physical health services (e.g. GP, endocrinologist, dentist)
- Transition of Care to GP

Consumer outcomes
- Diagnosed general medical conditions (including pain and oral health problems)
- Disease risks (pathological, physiological and behavioural measures)
- SUABS Substance specific score
- HoNOS physical illness score
- Life Skill Profile self-care subscale
- Consumer experiences (e.g. YES survey)
- Potentially preventable hospitalisation

Transform intersectoral partnership approaches



A biopsychosocial and lifestyle approach is needed to improve the physical health and wellbeing of consumers, and services should aim to improve intersectoral integration across relevant services and organisations to collaboratively provide holistic and person-centred care.

Consultations indicated that improving integration with primary care and community services (including state- and non-state-funded community services) is a priority to improve outcomes for consumers accessing MHAOD services. Interorganisational partnerships should be formalised and principles of integrated service design such as co-location, co-facilitation and shared data access, should be embedded into service models.

Co-location: Physically locating separate services to improve communication, strengthen referral pathways and transition of care, and enhance multidisciplinary involvement in care processes such as care reviews. Although co-location can include co-locating entire teams or services, more commonly, co-location is with one or two staff on a part-time basis (e.g., GP co-located part-time within a mental health service facility).

Co-facilitation: Interventions or therapies being jointly facilitated by staff from different organisations and/or different disciplines (e.g. a nurse and peer-worker co-facilitating a health literacy program). Co-facilitation improves the comprehensiveness of information provided during interventions (e.g., health literacy, behavioural counselling), assists with transfer of knowledge and skills between staff, and can facilitate step-up or step-down of care across sectors.

Data sharing: Non-government organisation (NGO) Health Workers providing mental health services co-located with MHAOD services may be eligible for Read-Write access to CIMHA, conditional on a HHS contract relationship and Director-General approval (CIMHA Business Process - NGO Read-Write CIMHA Access | Queensland Health).

Establishing functional joint governance arrangements between PHNs and HHSs could improve sustainability of intersectoral approaches for regional development of health promotion initiatives. This is aligned with consumer-identified priority (QMHC2021): co-designed, inter-sectoral integrated service models focused on health promotion. The Queensland Alliance for Mental Health (QAMH) and the Queensland Network of Alcohol and Other Drug Agencies (QNADA) can promote and support intersectoral collaboration as part of Regional Planning and at a state wide level as the peak bodies for the NGO sectors .

Metro South Addictions and Mental Health Service (MSAMHS) and Brisbane South PHN (BSPHN) have embarked on a proce ss to co-design a Joint Regional Plan with joint governance processes for this purpose (https://bsphn.org.au/about/key-documents/). This exemplar also enables co-commissioning opportunities: BSPHN and MSMAHS are establishing co-commissioning of a program of therapeutic interventions for child and youth consumers in partnership with Orygen.

Partnership with primary care

Consultations indicated that improving integration with primary care is a priority for MHAOD services. To strengthen integration with Primary Care, HHSs could work with general practitioners to co-design a service model to integrate primary care with MHAOD services, develop Continuing Professional Development accredited training in MHAOD care (e.g. shared care arrangements such as opioid dependence treatment, clozapine) for GPs, and offer GP registrar placement opportunities within MHAOD services in partnership with universities.

Co-locating GPs within MHAOD services could provide stable and opportunistic access to primary care services for MHAOD consumers. MHAOD staff in co-located roles within primary care clinics as part of a step-up step-down service for people with severe mental illness could improve access to preventative services. This could be part of an exchange of clinical capacity with the GP; supporting the relationship with in-kind staff time could reduce financial costs of more resource intensive models.

The Floresco model utilised co-located GP's, NGOs and private providers, demonstrating improved outcomes for consumers[20]. There is an operational model funded by the WQPHN that utilises mental health nurses or people with a Certificate 4 in Mental Health as Care Coordinators. Care Coordinators engage consumers in motivational interviewing to facilitate healthy lifestyle change and community integration, and contribute to upskilling of general practice staff to improve mental health awareness and reduce stigma.

Partnership with the non-government sector

Consultations indicated that strengthening integration with NGOs to improve continuity of care and step-up step-down approaches is a priority for MHAOD services. Interorganisational collaborative care arrangements between HHS-managed MHAOD services and community-managed organisations could include co-location and co-facilitation principles to improve continuity of care and transfer of knowledge and expertise between staff working with consumers across sectors. Consultation with training organisations (Insight and The Learning Centre) highlighted the benefit of having NGO staff co-facilitate training opportunities to improve knowledge and skills of staff on both sides. This is aligned with consumer-identified priority (QMHC2021): partnerships between health and community organisations to strengthen social connectedness.

In North Queensland, MIND Australia is a state-funded NGO offering community-based services for people with severe mental illness. One of the programs involves co-location of MIND staff within community care units, referral using 'warm hand-over' with MHAOD clinicians, Read-Write CIMHA access to facilitate information sharing and documentation, and step-down of care from Individual Recovery Support Program to Group-based Peer Recovery Support Program. To bridge intersectoral partnerships, MIND peer-workers co-facilitate lifestyle interventions with PCYC Queensland's PHN-funded exercise physiology service, and PCYC Queensland's exercise physiologist provides in-reach exercise interventions to enhance Cairns and Hinterland HHS multidisciplinary metabolic clinics.

The Allied Health Professions Office of Queensland has developed resources to guide staff in investigating partnership approaches in their local HHS regions (https://qheps.health.qld.gov.au/alliedhealth/html/mental-health/models-of-care). This could be used to guide dialogue between HHSs, NGOs, and PHNs, to establish partnership arrangements and a place-based implementation plan for service development in preventing and managing multimorbidity.

Optimise workforce development approaches

Consultations indicated that MHAOD staff need support to develop capability in addressing multimorbidity with consumers. Staff acknowledged that they have the scope of practice to help consumers improve physical health and wellbeing; however, workforce development approaches are needed to develop staff knowledge, skills and confidence in doing so for consumers with diverse needs.

Developing workforce capability is essential for improving quality of care in any area of practice; however, staff also need to be supported to develop leadership to extend capability beyond immediate service provision to facilitate continual quality improvement. Highly capable leaders shape organisational culture. Capable leadership and workforce culture, and addressing the physical health of consumers, are aligned with the National Safety and Quality Standards (Standards 1 and 5).

To promote a state-wide culture that values comprehensive care in addressing multimorbidity, workforce approaches that support development of capability and leadership and maximise transfer of knowledge and skills across teams and services are needed. This is aligned with consumer-identified priority (QMHC2021): capability building for the mental health workforce.

There are numerous ways in which HHSs can support staff in this area, and existing initiatives can be incorporated into state-wide approaches. Some key approaches include:

- **Communities of Practice:** Communities of practices (CoPs) that are appropriately resourced can be effective forums for sharing and disseminating knowledge and best practice. Staff self-select their membership in CoPs based on their professional interest, and contribute to the community based on their capacity and motivation. CoPs can form a platform for sharing resources and promoting service innovations state-wide.
- **QLD Mental Health Clinical Collaborative (MHCC):** The MHCC provides a platform for collaborative engagement to support clinician-driven continuous quality improvement and best practice in mental health and addiction services. By disseminating clinically informative indicator reports and facilitating state-wide peer-group discussion and evidence review, the MHCC creates an environment for service innovation and best clinical practice[21].
- **Capability Framework:** Capability frameworks provide a tool to guide clinicians' practice, and for services to map workforce capability to better understand strengths and areas for improvement, and to identify clinical leaders who could be supported to contribute to developing service culture and continuous quality improvement via focused Leadership groups.
- **Leadership groups:** Comprised of clinicians who are progressing in capability, Leadership groups would provide space for group mentoring, appraisal of contemporary evidence, review of consumer perspectives and outcomes, and supervision pathways. Leadership groups would support development of local 'change leaders' to facilitate continual service improvement; figure 1 provides an overview of capability development and leadership groups.

A suggested approach to integrating these initiatives for workforce development is represented in Figure 2.

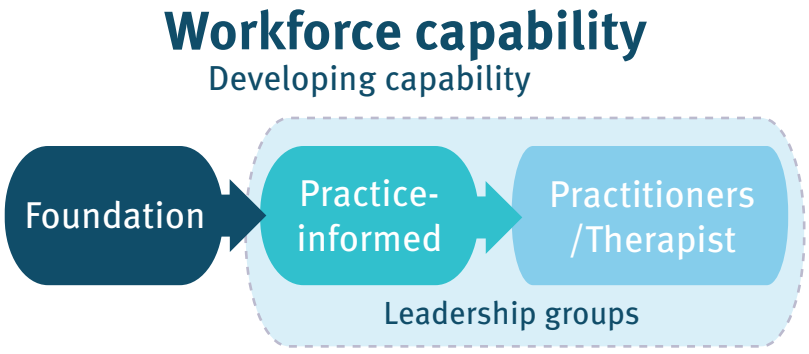


Figure 1

The Physical Health Care Therapies Capability Framework (TCF) outlines capability expectations across levels of complexity and domains of knowledge and skills, research evidence-based practice, and autonomy and supervision.

(https://metrosouth.health.qld.gov.au/sites/default/files/physical_health_care_-_full.pdf).

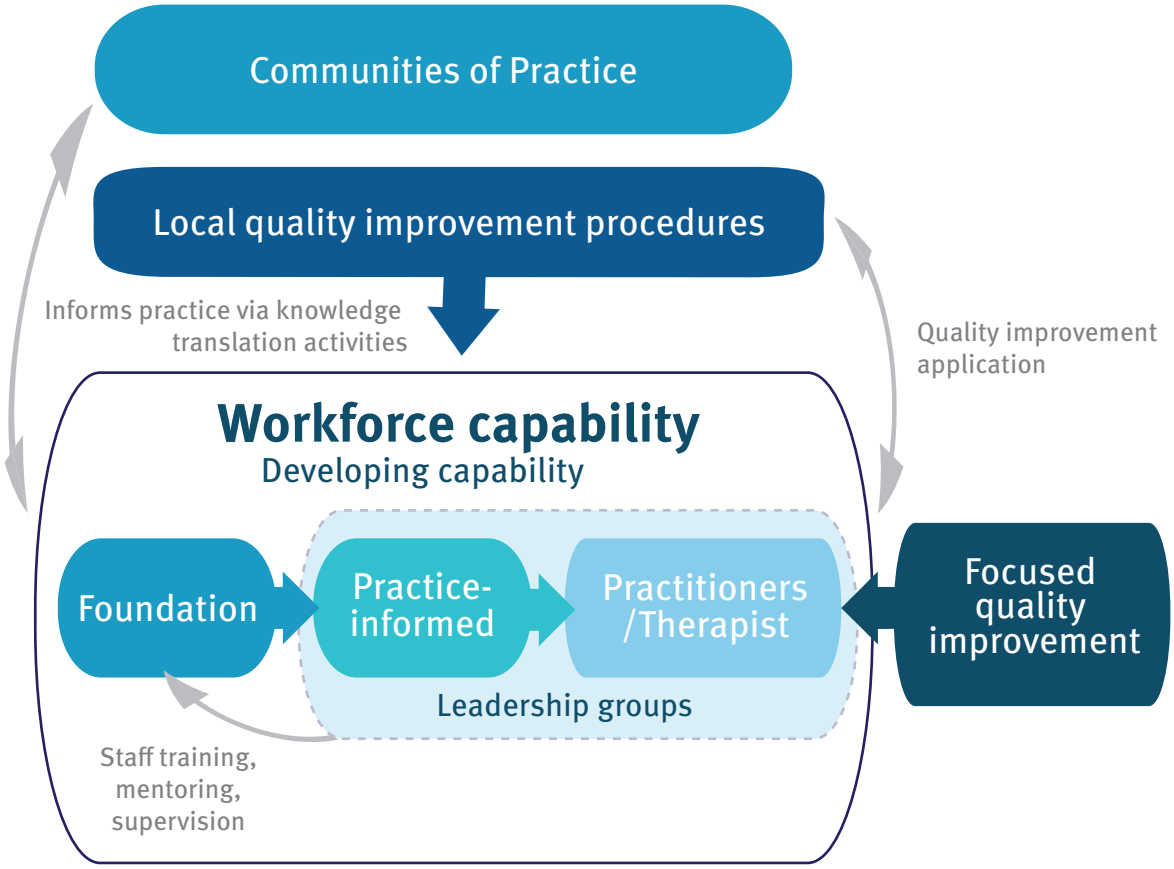


Figure 2: Training and quality improvement in physical health assessment and intervention could be offered to Leadership groups. The MHCC, The Learning Centre, Insight, and Allied Health Translating Research Into Practice (AH-TRIP) provides training and support in implementation and evaluation. Leadership groups could support diffusion of these capability development initiatives through local training, mentoring and supervision, and facilitate continual quality improvement using local processes. A resourced and moderated Community of Practice could enhance the sharing of locally developed resources state-wide.

Transform collaborative care approaches

Consultation indicated that there is a strong need to increase the comprehensiveness of physical health assessments and interventions for a broad range of physiological and behavioural risk factors and general medical conditions. Clinicians emphasised the importance of having defined treatment pathways to address identified physical health risks with consumers, and that having these pathways would reinforce the importance of physical health screening and assessment. This is also aligned with consumer-identified priority (QMHC2021): Jointly develop and promote clear clinical care pathways.

'Collaborative care' commonly refers to multifaceted approaches to care involving case management, a mental health specialist, and a primary care practitioner[22,23]. However, the term can more generally apply to cross-sectoral models to address co-occurring medical and psychosocial issues[24]. Multidisciplinary collaborative care approaches should directly address the risk factors and conditions related to physical health screening and assessment forms, and modifiable factors associated with disease risk (service fragmentation, social exclusion, medication side-effects, substance use, health literacy, self-management, sexual health, physical activity, diet quality, oral hygiene: aligned with consumer-identified priority (QMHC2021) oral health support for consumers). Lived experience roles embedded within collaborative care approaches and Recovery College models to improve physical health and wellbeing are aligned with consumer preferences identified in a project commissioned by the Brisbane North Primary Health Network.

Collaborative arrangements across Hospital and Health Services (generalist, mental health, alcohol and other drug, other specialist services such as pain, endocrine, sexual health etc), and with external providers (e.g., NGOs, GPs, private) should be sought to address physical health during a care episode, and to improve continuity for transitions of care. Given resource limitations, collaborative care approaches should focus on priority groups that are at particularly high risk of developing multimorbidity.

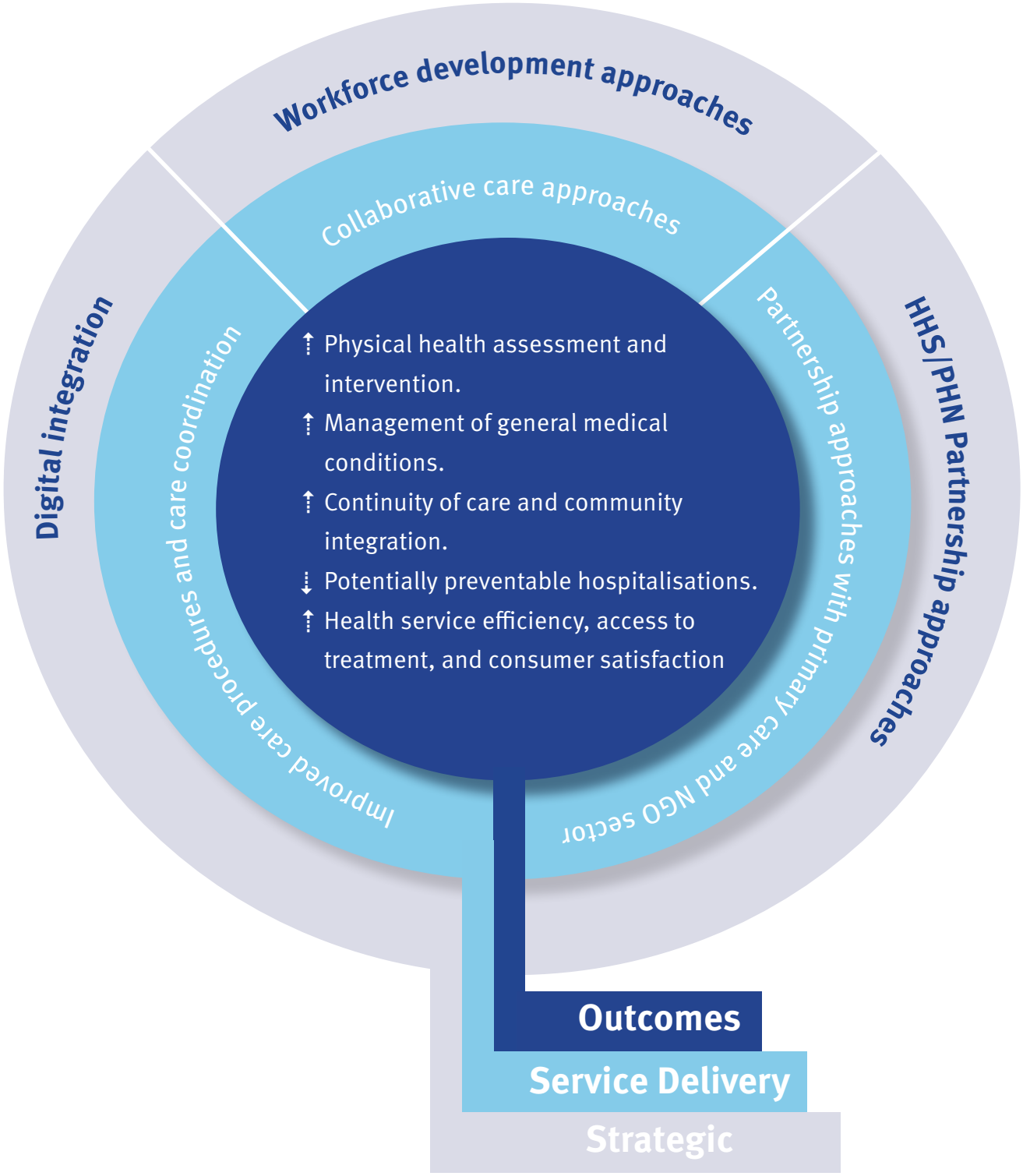
The Victorian Department of Health and Human Services have published a framework to guide mental health services in addressing the physical health of consumers using strategies such as interprofessional leadership and culture, and models of care[25] that could assist as a supplementary resource.

(1) Sunshine Coast: a multidisciplinary clinic in a Community Care Unit including a GP, exercise and dietetics, sexual health, podiatry, sleep, and dental health[26].

(2) Metro South: Nurse-led model involving physical health assessments and health literacy, peer-worker, occupational therapist, exercise physiologist and dietitian on a rotating basis.

(3) Cairns & Hinterland: Metabolic clinic based on the Diabetes Prevention Program involving endocrinologist, behavioural therapy delivered by a psychologist, dietitian and exercise physiologist. Evaluation of these clinics is in process.

Proposed roadmap to improving physical health and wellbeing of consumers of mental health and alcohol and other drug services



Interdependency of Roadmap elements

The Roadmap to improving physical health and wellbeing of people with substance use disorders and/or other mental health disorders is a multi-level strategy for supporting region-based initiatives to improve the physical health and wellbeing of MHAOD consumers. Elements are divided into (1) systems-level, (2) intersectoral-level, and (3) workforce-level, with emphasis on (A) strategic or (B) service-delivery strategies.

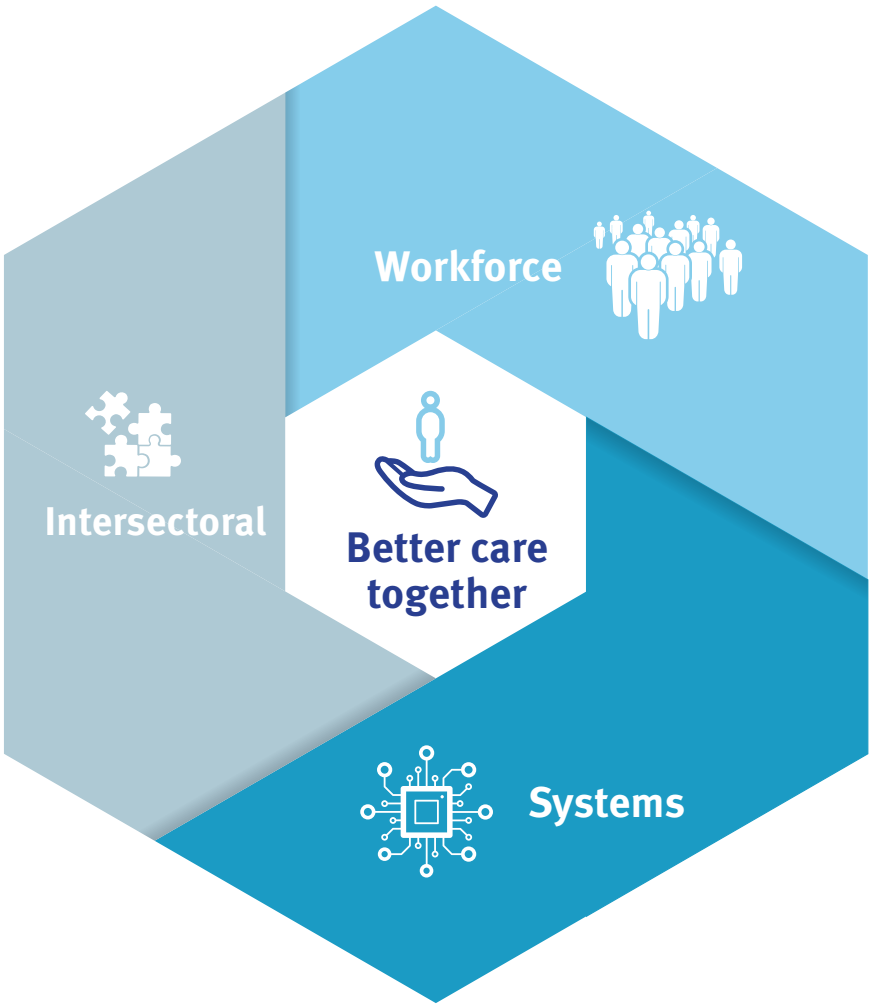
The interdependency of these elements presents challenges that can impact the effectiveness and sustainability of approaches which should be considered in service innovation and quality improvement.

Workforce approaches: Collaborative care approaches may improve physical health assessment and intervention for consumers involved; however, without implementing a workforce capability and leadership development strategy, the broader workforce culture in addressing physical heath may be negatively impacted, and diffusion of these efforts is likely to be contained. Workforce development approaches may broaden the impact of collaborative care approaches; however, without intersectoral partnership approaches, consumers may lack the support required post-discharge which may reduce longer-term effectiveness.

Intersectoral approaches: At the intersectoral level, partnerships with primary care and NGO sectors can improve continuity of care, community participation, and access to treatment; however, without functional HHS/PHN joint governance, these partnerships may lack sustainability.

Collaborative HHS/PHN arrangements resulting in co-commissioning of services would enable a comprehensive and sustainable approach to address community needs; however, without systems-level improvement in care procedures and coordination, there may be fragmentation and duplication resulting in inefficiency.

Systems-level: At the systems level, improving care procedures and coordination by establishing administrative controls and service navigation mechanisms can improve efficiency and the patient experience; however, without digital integration and information collection and sharing processes, clinicians and consumers may lack the information required to address health needs, which can result in low quality care. Improved digital integration and information sharing processes can improve health service efficiency and ensure clinicians and consumers have the information required to address health needs; however, without workforce development approaches, these health needs may go unmet.



State-wide priorities

To reduce morbidity from general medical conditions and improve wellbeing of consumers, objectives are to transform intersectoral partnership approaches, optimise workforce development approaches and transform collaborative care approaches. Services are encouraged to promote and undertake innovation aligning with these objectives and suggested approaches.

Systems-level elements on the Roadmap are being addressed in the MHAOD Healthcare Digital Information Strategy 2021–2026 which seeks to leverage existing capability and transform care to a digitally enabled environment. This is consistent with consumer-identified priority (QMHC2021): enablers for information sharing.

Terminology

Substance use disorders and other mental health disorders: Consistent with the Co-occurring substance use disorders and other mental health disorders: policy position statement for Mental Health Alcohol and Other Drugs Services[27], the term 'substance use disorder' is used as per the DSM-5 framework and includes intoxication and withdrawal but excludes substance-induced mental disorders such as psychotic or mood disorders. Substance use disorder is used throughout this policy position statement as an abbreviation for disorders within the ICD-10 classification of Mental and behavioural disorders due to psychoactive substance use. The term 'other mental health disorder' is used to describe mental and behavioural disorders, and includes those substance use disorders which DSM-5 calls substance-induced mental disorders, but excludes other substance use disorders.

Abbreviations

GP: General Practitioner

HHS: Hospital Health Service

MHAOD: Mental Health Alcohol and Other Drugs

MHAODB: Mental Health Alcohol and Other Drugs Branch

MHCC: Mental Health Clinical Collaborative

NGO: Non-government organisation

PCLO: Primary Care Liaison Officer

PHN: Primary Health Network

QAMH: Queensland Alliance for Mental Health

QMHC: Queensland Mental Health Commission

References

1. Firth J, Siddiqi N, Koyanagi A, et al. The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. The Lancet Psychiatry. 2019;6(8):675-712.

2. World Health Organization. Management of physical health conditions in adults with severe mental disorders: WHO guidelines. 2018.

3. Lawrence D, Hancock KJ, Kisely S. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. BMJ. 2013;346.

4. Momen NC, Plana-Ripoll O, Agerbo E, et al. Association between mental disorders and subsequent medical conditions. New England Journal of Medicine. 2020;382(18):1721-1731.

5. Pillinger T, McCutcheon RA, Vano L, et al. Comparative effects of 18 antipsychotics on metabolic function in patients with schizophrenia, predictors of metabolic dysregulation, and association with psychopathology: a systematic review and network meta-analysis. The Lancet Psychiatry. 2020;7(1):64-77.

6. Bioque M, García-Portilla MP, García-Rizo C, et al. Evolution of metabolic risk factors over a two-year period in a cohort of first episodes of psychosis. Schizophrenia Research. 2018;193:188-196.

7. Morgan C, Dazzan P, Lappin J, et al. Rethinking the course of psychotic disorders: modelling long-term symptom trajectories. Psychological Medicine. 2021:1-10.

8. Vetrano DL, Rizzuto D, Calderón-Larrañaga A, et al. Trajectories of functional decline in older adults with neuropsychiatric and cardiovascular multimorbidity: A Swedish cohort study. PLoS medicine. 2018;15(3):e1002503.

9. Bartels SJ, DiMilia PR, Fortuna KL, Naslund JA. Integrated care for older adults with serious mental illness and medical comorbidity: evidence-based models and future research directions. Psychiatric Clinics. 2018;41(1):153-164.

10. World Health Organization. Innovative care for chronic conditions: building blocks for action. 2002. In. Geneva2013.

11. Calderón- Larrañaga A, Vetrano DL, Ferrucci L, et al. Multimorbidity and functional impairment–bidirectional interplay, synergistic effects and common pathways. Journal of Internal Medicine. 2019;285(3):255-271.

12. Marengoni A, Angleman S, Melis R, et al. Aging with multimorbidity: a systematic review of the literature. Ageing Research Reviews. 2011;10(4):430-439.

13. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. The Lancet. 2012;380(9836):37-43.

14. Prados-Torres A, Calderón-Larrañaga A, Hancco-Saavedra J, Poblador-Plou B, van den Akker M. Multimorbidity patterns: a systematic review. Journal of Clinical Epidemiology. 2014;67(3):254-266.

15. Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. The Lancet. 2007;370(9590):851-858.

16. NMHC. Equally Well: Improving the physical health and wellbeing of people living with mental illness in Australia. In. Canberra, Commonwealth of Australia: National Mental Health Commission; 2016.

17. Duggan M. Beyond the Fragments: Preventing the costs and consequences of chronic physical and mental diseases. Melbourne: Australian Health Policy Collabortion;2015.

18. Australian Government Department of Health. Fifth National Mental Health and Suicide Prevention Plan. In: Department of Health, ed. Canberra: Commonwealth of Australia; 2017.

19. Morgan M, Peters D, Hopwood M, et al. Being Equally Well: Better physical health care and longer lives for people living with serious mental illness. In: Mitchell Institute VU, ed. Vol Technical Report 2021.03. Volume 1. The Project Report. Melbourne2021.

20. Page I, Beere D, Diminic S, Harris M. Floresco Centre service model evaluation. 2018.

21. Plever S, McCarthy I, Anzolin M, Emmerson B, Khatun M. A collaborative approach to improve the assessment of physical health in adult consumers with schizophrenia in Queensland mental health services. Australasian Psychiatry. 2016;24(1):55-61.

22. Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. Archives of Internal Medicine. 2006;166(21):2314-2321.

23. Bower P, Gilbody S, Richards D, Fletcher J, Sutton A. Collaborative care for depression in primary care: making sense of a complex intervention: systematic review and meta-regression. The British Journal of Psychiatry. 2006;189(6):484-493.

24. Lee SJ, Crowther E, Keating C, Kulkarni J. What is needed to deliver collaborative care to address comorbidity more effectively for adults with a severe mental illness? Australian and New Zealand Journal of Psychiatry. 2013;47(4):333-346.

25. Department of Health Human Services. Equally well in Victoria: Physical health framework for specialist mental health services. In: Department of Health & Human Services, ed. Victoria2019.

26. Lalley NA, Manger SH, Jacka F, Rocks T, Ruusunen A, Barron L. The Mind-Body Well-being Initiative: a better lifestyle for people with severe mental illness. Australasian Psychiatry. 2021:1039856220978864.

27. Co-occurring substance use disorders and other mental health disorders: policy position statement for Mental Health Alcohol and Other Drugs Services. Queensland Department of Health, Brisbane: Mental Health Alcohol and Other Drugs Branch; 2021