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POSTER ABSTRACT

GP and mental health shared care in the community: formalising relationships to improve consumer outcomes

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Introduction: People living with severe & enduring mental illness have a 14-23 year reduced life expectancy compared to the general population, primarily due to cardiovascular disease and metabolic syndrome rather than suicide. Mental health consumers tend to receive poorer quality physical health screening and have reduced access to health care, as well as being less likely to engage in healthy lifestyle behaviours.

Short description of practice change: Sydney LHD, in collaboration with the local Primary Health Network, has introduced a Mental Health Shared Care program across ten community mental health teams. This uses a mental health shared care checklist to formalise agreements between care coordinators, consumers and their GPs.

Aim and theory of change: The aim is to improve the physical health of mental health consumers through integrated care provision, while improving lines of communication between public mental health services and primary health. The checklist sets out clear lines of responsibility for the individual services to undertake, including actions related to screening, information sharing and physical health interventions.

Timeline: There was a successful pilot in 2017 with two of the smaller teams. Since January 2018 the program has been implemented across all care coordination teams in Sydney LHD. The checklist itself sets out expectations in line with an annual cycle of care.

Highlights: From the pilot stage until present, engagement with the program has increased from 5% to 33% of community consumers receiving joint physical and mental health care across service domains, translating to approximately 600 current consumers being engaged with the program, plus many more who have since been discharged from mental health services. The program is now moving into a phase of reviewing whether the checklists are being adhered to, e.g., tracking the annual physical examinations with GPs.

Comments on sustainability: The program is not without its challenges, but despite these there is good evidence emerging that formalising share care arrangements with GPs leads to improved health screening for mental health consumers. With continued effort, including the creation of senior clinician enhancements to drive the program, there is every reason to think the program will be sustainable.

Comments on transferability: There are approximately 1000 GPs within the Sydney LHD boundaries. A snapshot audit shows current mental health consumers are engaged with 771

different GPs. If the program can have success in Sydney LHD then it would undoubtedly be transferrable to other areas.

Conclusions: Formalising Mental Health Shared Care with GPs can lead to improved screening, detection, treatment and management of the physical health of mental health consumers, and greater communication between mental health services and primary health networks.

Discussions: The challenges of implementing this model are plentiful, ranging from amotivation of consumers to time constraints on GPs and care coordinators. However with the commitment of all to address the significant health disparities that exist within this vulnerable cohort, significant advances can be made.

Lessons Learned: Mental Health Shared Care can lead to improved integration of physical and mental health in people with severe mental illness.