Shared guidelines and protocols to achieve better health outcomes for people living with serious mental illness

Morgan, Mark; Hopwood, Malcolm J.; Dunbar, James A.

Published in:
Medical Journal of Australia

DOI:
10.5694/mja2.51711

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Shared guidelines and protocols are needed to overcome evidence-to-practice gaps in the care of patients living with serious mental illness

People living with serious mental illness have poor physical health leading to many years lived with chronic diseases and an average loss of 20 years' life expectancy. Most of this excess morbidity and mortality is avoidable through the implementation of well accepted preventive measures. Fragmentation of care between hospital, specialist and general practice services was identified as a key barrier to better physical health care by consumers and health experts in the Being Equally Well roadmap.[1] Intersectoral service and care planning with collaborative agreements, clinical information exchange and patient recall systems have been identified as successful components of better care.[2] This article outlines how intersectoral coordinated care could be improved by intercollegiate co-designed clinical guidelines and implementation of formalised shared care protocols that address evidence-to-practice gaps in the care of patients living with serious mental illness.

Clinical guidelines provide an accepted and accessible set of evidence-based recommendations and consensus statements that describe best-practice. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) published clinical guidelines in 2016 to help psychiatrists manage and monitor schizophrenia and related disorders.[3] These guidelines include a recommendation that patients see their general practitioner to manage physical health risks and chronic diseases. There are recommendations about smoking cessation, choice of antipsychotic medication, and frequency of monitoring for cardiometabolic risks. The Royal Australian College of General Practitioners (RACGP) also produces guidelines for preventive activities in general practice including screening interventions, smoking cessation, and the management of diabetes.[4] The Being Equally Well roadmap calls for the RANZCP and RACGP to co-design a single clinical guideline that makes evidence-based recommendations for the management of physical health risks in people living with serious mental illness. The Box describes the current Australian delivery of clinical activities demonstrating both overlap and gaps identified by members of clinician working groups in the Being Equally Well project.[1]

Clinical protocols outline how to implement the recommendations from clinical guidelines. Protocols describe who does what, when, where and how at a local level. Shared care protocols are specifically designed to allocate responsibility across different services so that monitoring and clinical interventions do not fall in the gaps between fragmented services. Shared care protocols have been long established for maternity care and increasingly there are shared care protocols for use of specific high risk medications, including clozapine for schizophrenia. The features of successful shared care protocols include co-design between providers and patients, agreed monitoring

Typical Australian provision of clinical activities identified by the Being Equally Well project[1]

Clinical activity*	General practitioner†	Community Mental Health Service and mental health nurses‡	Hospital	Private or public outpatient psychiatrist§
Diagnosis of severe mental illness	++		++	++
Initiation of psychiatric medication			++	++
Monitoring psychiatric medication	+	++		++
Adjusting psychiatric medication				++
Managing medication related side effects	+	+	+	+
Managing acute exacerbations of mental illness	+	+	++	++
Managing long-term physical health risks	+			+
Facilitating and tracking regular follow up	+	++		+

* + = clinical activity conducted for some patients; ++ = clinical activity conducted for most patients. † Not all patients access GP services. ‡ Many areas lack these services. § Many access barriers including cost and availability. ◆

Mark Morgan[1]
Malcolm J Hopwood[2,3]
James A Dunbar[4]

1 Bond University, Gold Coast, QLD.
2 University of Melbourne, Melbourne, VIC.
3 Royal Australian and New Zealand College of Psychiatrists, Melbourne, VIC.
4 Deakin University, Warrnambool, VIC.

mmorgan@bond.edu.au

doi: 10.5694/mja2.51711

frequency, clear delineation of responsibilities for parts of the care package, shared or accessible clinical records, and pre-planned actions for emerging problems.[5,6]

The existence of intercollegiate clinical guidelines and agreed carefully constructed shared care protocols is not enough to ensure uptake by the providers of patient care.[7] There is a need for a multifaceted change management approach so that care providers are aware of the protocols and educated about how to apply them.[8] Improved care often comes at the expense of increased workload for individuals. Direct financial incentives for completion of bundles of care is one way to overcome the cost of providing more comprehensive care.[9] Novel use of real-time computer decision support can provide prompts to follow protocols.[10] Templates for recording patient data can also improve adherence to protocols.[11] Performance indicators in the form of audit and feedback can be provided to individual clinicians and clinical microsystems to encourage continuous quality improvement. Iterative plan–do–study–act cycles backed by audit data, leadership training, and sharing of innovations have been shown to improve care quality in the Australian Primary Care Collaboratives.[12]

Here, we have described the rationale for intercollegiate clinical guidelines and shared care protocols tailored to local context for the care of people with serious mental illness. We have briefly listed some of the components required to implement guidelines and protocols. Now, investments are needed to support people with serious mental illness to be equally well.

Acknowledgements: The Being Equally Well project has been partially supported by grant funding from the Australian Department of Health to the Mitchell Institute at Victoria University for the Australian Health Policy Collaboration, a network of chronic disease and population health academics, clinicians, experts, and advocates who participated in this project. This supplement was financially supported by the Mitchell Institute, Victoria University, and by grant funding from the Australian Department of Health for the Australian Health Policy Collaboration. The work was supported and led by the Australian Health Policy Collaboration of Victoria University. We also acknowledge the people with lived experience, carers and clinicians who contributed to the work of Being Equally Well.

Open access: Open access publishing facilitated by Bond University, as part of the Wiley - Bond University agreement via the Council of Australian University Librarians.

Competing interests: No relevant disclosures.

Provenance: Commissioned; externally peer reviewed. ■

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