aspex consulting

QUEENSLAND MENTAL HEALTH COMMISSION

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

A CASE FOR CHANGE

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Foreword

The physical health disparities of people with a lived experience of mental illness (lived experience) or problematic alcohol and other drug (AOD) use are a major policy priority. This is reflected in the substantial number of policy and research reports released over the last decade, both nationally and internationally.

The Queensland Mental Health Commission (QMHC) recognises that experiencing mental illness, particularly serious mental illness, and problematic AOD use leads to poorer health outcomes, lowers life expectancy and results in poorer quality of life.

QMHC has committed to supporting greater integration between mental and physical health through its implementation of the *Equally Well Consensus Statement: improving the physical health and wellbeing of people living with mental illness in Australia (Equally Well Consensus Statement)* launched by the National Mental Health Commission in July 2017. Integration involves national leadership and regional coordination to ensure existing, new and emerging services work together effectively to improve the physical health of people living with mental illness.

Equally Well Consensus Statement: improving the physical health and wellbeing of people living with mental illness in Australia (Equally Well Consensus Statement)

The National Mental Health Commissions *Equally Well Consensus Statement* outlines six essential elements, with actions, that provide guidance to health service organisations to ensure they have the capacity to safely, collaboratively and effectively recognise and respond to the health needs of people living with mental illness. The six essential elements are:

- a holistic, person-centred approach to physical and mental health and wellbeing
- effective promotion, prevention and early intervention
- equity of access to all services
- improving quality of health care
- care coordination and regional integration across health, mental health and other services and sectors that enable a contributing life
- monitoring of progress towards improved physical health and wellbeing.

In light of this context, and consistent with its function, the QMHC seeks to identify reform opportunities that may improve the physical health of people with a lived experience of mental illness or problematic AOD use.

Aspex Consulting has undertaken a scan of the environmental and strategic landscape that impacts on the physical health of people with a lived experience.

The purpose of this summary report is to:

- provide a high-level overview of the burden of disease evidence
- highlight the key directions of strategies, policies and guidelines
- outline identified barriers and enablers at the individual, health system and social levels.

This report is the foundation of ongoing work for the QMHC.

1. Burden of disease

There is extensive evidence of the poorer physical health outcomes experienced by people with a lived experience of mental illness and/or problematic AOD use. Researchers and health professionals are increasingly recognising the interrelationship between physical health and mental health and the co-morbidities associated with problematic AOD use and dual diagnosis.

Understanding the interrelationship between mental and physical health is important in addressing both the equity of health and mortality outcomes for people with mental health and/or problematic substance use.

Prevalence

In 2017–18:

- 1,094,100 Queenslanders experienced mental illness
- 511,200 Queenslanders experienced high/very high levels of psychological distress
- 17.3% of Queenslanders aged 18 and over exceeded the National Health and Medical Research Council (NHMRC) lifetime risk guidelines for alcohol consumption, and 47.8% of Queenslanders exceeded the NHMRC single occasion risk guidelines for alcohol consumption
- 16.8% of Queenslanders aged 14 and over had ever used an illicit substance (the National Drug Strategy Household Survey indicates that 5.6% of the Australian population had used an illicit substance sometime in the last week and an additional 8.6% had used an illicit substance in the last month)
- 15.1% of Queenslanders aged 18 and over smoked tobacco daily.

The prevalence of mental illness, alcohol consumption and illicit substance use in Queensland is high relative to other states and territories as shown in Table 1-1.

Table 1-1: Prevalence, Queensland vs Australia, 2017–18

	QUEENSLAND	AUSTRALIA
Mental illness	22.8%	20.0%
Alcohol consumption exceeding the lifetime/single occasion risk guidelines — *persons aged 18 years and over*	17.3% 47.8%	16.0% 43.2%
Illicit substance use *(ever used) — persons aged 14 years and over*	16.8%	15.5%
Daily tobacco smoking *— persons aged 18 years and over*	15.1%	14.0%

Burden of disease

For people with mental illness and/or problematic AOD use, there is a higher reported prevalence of chronic illness across a range of illnesses, including:

- have higher rates of metabolic syndrome, cardiovascular disease, diabetes, chronic pain, asthma, heart/circulatory conditions and headaches/migraines
- of the estimated 5,785 Australians aged over 15 who die from alcohol attributed causes each year, causes include liver disease, cancer, cardiovascular disease, digestive disease and injuries
- illicit drug use was responsible for 2.3% of the total burden of disease, impacting 102,000 Australians through: chronic liver disease; HIV, hepatitis C and hepatitis B infections; road traffic injuries; and accidental poisoning in 2011.

Further, there is evidence that the side effects of anti-psychotic medications are associated with physical health conditions and complications such as obesity, insulin resistance, type 2 diabetes, poor oral health and cardiovascular disease. There are also known physical health associations with mood stabilisers and anti-depressants.

Population groups

Some population groups show higher rates of mental health and AOD related problems than the general population. These groups includes persons who are: Aboriginal and Torres Strait Islanders; from culturally and linguistically diverse backgrounds (with mental illness only); of low socio-economic status; living remotely or rurally; in prison; homeless; and those who identify as lesbian, gay, bisexual, transgender, intersex or questioning (LGBTIQ).

Reasons for higher prevalence rates are multi-faceted and include increased behavioural risk factors, social determinants, and lower levels of access to timely, appropriate and responsive health care.

Social and workforce participation

Community engagement and social participation contribute positively to overall wellbeing. However, those with a lived experience have higher levels of social isolation and reduced participation in community activities.

Workforce participation rates are lower for people with a lived experience. In the workplace, employees with mental illness are more likely to be absent from work. Higher rates of premature mortality, and the lower productivity of those in work, further contribute to lost productivity for people with a lived experience. The influence of mental illness on the workforce participation rate is such that realistic improvements in mental health could improve workforce participation by 30%.

Economic impact

In addition to workplace participation and productivity losses, mental illness and problematic AOD use have significant economic impacts, including the direct cost of health care and law enforcement costs.

The overall cost of mental illness to the Australian economy in 2014 was estimated at $56.7 billion, equal to 3.5% of Gross Domestic Product (GDP). In addition, the cost of co-morbidities associated with premature death in those with mental illness was estimated at $45.4 billion, or 2.8% of Australian GDP in 2014. The most comprehensive data, from 2004–05, shows that problematic AOD use was estimated to cost the Australian economy $55.2 billion. This includes costs to the health system, lost workplace productivity, AOD attributable crime costs and road accidents.

2. Policy context

The physical health disparities of people with a lived experience of mental illness or problematic AOD use is a major policy priority. This is reflected in the substantial number of policies and strategies released over the last decade.

At a national level, this includes:

- *Fifth National Mental Health and Suicide Prevention Plan,* which elevates the importance of the physical health needs of people who live with mental illness
- National Mental Health Commission's *Equally Well Consensus Statement,* which outlines six essential elements that provide guidance to health service organisations to ensure they have the capacity to safely, collaboratively and effectively recognise and respond to the health needs of people living with mental illness. The six essential elements are:
  - a holistic, person centred approach to physical and mental health and wellbeing
  - effective promotion, prevention and early intervention
  - equity of access to all services
  - improving quality of health care
  - care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life
  - monitoring of progress towards improved physical health and wellbeing
- The *National Alcohol Strategy 2018–2026,* which provides a national framework to prevent and minimise alcohol-related harm among individuals, families and communities by promoting and facilitating collaboration, partnership and commitment from the government and non-government sectors
- The *National Drug Strategy 2017–2026* seeks to provide a national framework to identify priorities for action relating to alcohol, tobacco and other drugs and to guide coordinated action to prevent and minimise harm to individuals and communities. The strategy recognises the harm associated with alcohol, tobacco and other drugs on individuals and broader communities including health-related harm such as chronic conditions and preventable diseases and co-morbidities with mental health.

An environmental scan has been conducted including a high-level review of strategies, policies and guidelines at international, national and jurisdictional levels. Key themes from the environmental scan include the need for:

- broader recognition of, and response to, the poorer physical health outcomes for people with mental health and problematic AOD use
- provision of comprehensive and integrated physical and mental health and social support services
- recognition by primary care providers that mental health and substance use responses are a core component of their work, which are synergistic with physical health care
- improved coordination and collaboration between specialist and general health service providers
- workforce development that provides appropriate training and requirement for health professionals and specialists providing mental health and drug and alcohol services to ensure physical health needs are met.

The environmental scan highlighted the strategies, policies and guidelines at both international and national levels that seek to address and champion improvements in physical health outcomes for people with lived experience of mental health and problematic AOD use.

At a national level, relevant documents have been highlighted where physical health for targeted populations has not been specifically outlined as a priority area, identifying gaps in the policy context.

Further, it is recognised that a failure to translate public policy into service models may limit physical health outcomes for those with a lived experience. As such, any subsequent project phases will need to seek to assess progress to date against the key directions of relevant national and Queensland documents. This includes key service providers: Aboriginal and Islander Community Controlled Health Services; Non-Government Organisations; Primary Health Networks; primary health care providers; Queensland Hospital and Health Services; and private service providers.

The environmental scan has further highlighted that requisite components of optimal models of care may include:

- *assessment* — that is multidimensional (medical, functional, and social)
- *targeted* — to those most likely to benefit
- *planning* — involving evidence-based care planning
- *alignment* — where care is matched with patient goals and functional needs
- *training* — that includes patient and care partner engagement, education, and coaching
- *communication* — including strong coordination and communication among and between the patient and care team
- *monitoring* — that uses proactive tracking of the health status and adherence to care plans
- *continuity* — through seamless transitions across time and settings.

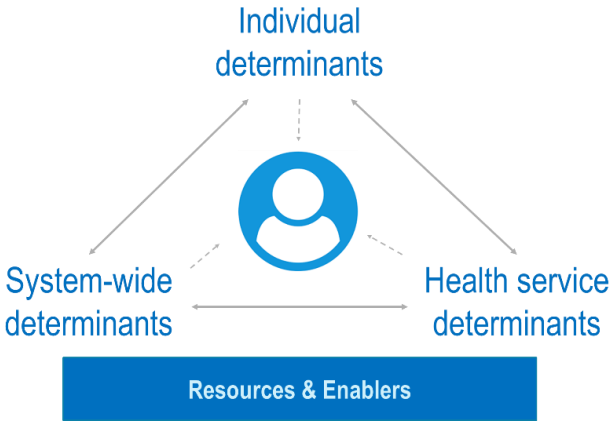
A select number of exemplars have also been identified from jurisdictions that have sought to put policy into practice. These exemplars provide insights into:

- assessable outcome measures for individuals with direct linkages to health system performance, including making funding contingent on meeting set goals
- a holistic approach that targets youth psychosis, a cohort that has been identified by the Productivity Commission as able to have a significant impact on productivity given the lifelong implications of youth mental illness
- a population health approach to raising awareness that has been evaluated as having an impact on stigma-reduction
- integrated primary care programs that have improved the physical health outcomes for people with lived experience.

3. Barriers and enablers

The factors influencing the poorer physical health outcomes of people with a lived experience of mental illness and/or problematic AOD use are multi-faceted. A schema relevant to conceptualising these factors is shown in Figure 3-1.

Figure 3-1: Factors influencing physical health outcomes



The key barriers and enablers that influence poorer physical health outcomes of people with a lived experience of mental illness and/or problematic AOD use are outlined. The identification of key barriers reveals existing gaps within the current strategic and environmental context that contribute to the poorer physical health of people with a lived experience in Queensland, while the identification of key enablers provides direction relating to core components of the desired future state.

It is important to emphasise that these are generalised findings from a wide range of research. It is also important to avoid shifting the onus of responsibility onto individuals for the worse health outcomes that they experience. A fundamental point of the three-tiered model (individual; health system; social determinants) is to explicitly recognise the links between *individual health outcomes*, their experience of and access to the *health system* and more broadly the wider *social context* within which individuals live.

Individual determinants

Barriers include the stigma and discrimination faced by individuals and the negative consequences this has for seeking access to treatment. Individuals with a lived experience are more likely to be socially disadvantaged, have lower levels of educational attainment, and face difficulties with employment and housing. These factors combine and contribute to poorer health outcomes, and diminished health literacy. The experience of living with a mental illness can bring additional challenges including treatment side effects from anti-psychotic medication. More generally, the higher rates of smoking, poor nutrition and insufficient physical exercise further contribute to poorer physical health outcomes.

Enablers build on the person's empowerment and strengthen their capacity for self-management. This includes strategies to acknowledge and encourage participation in decision making about their care, implementation of targeted lifestyle and chronic disease prevention initiatives tailored to people with a lived experience including outreach models. The role of the peer workforce provides a bridge to further connect with individuals and promote recovery.

Table 3-1: Individual determinants — barriers and enablers

BARRIERS	ENABLERS
▪ Stigma and discrimination ▪ Preparedness to seek treatment ▪ Low health literacy ▪ Prevalence of risk factors ▪ Side-effects of medications	▪ Self-management ▪ Consumer participation in care ▪ Access to information ▪ Lifestyle interventions ▪ Outreach support ▪ Peer workforce

Social determinants

Social determinants are fundamentally important and are associated with the poor physical health outcomes experienced by people with a lived experience. These include social disadvantage, social stigma and discrimination, lack of connectedness and the additional challenges faced by families and carers who play a key support role.

Addressing these social determinants requires inter-sectoral planning and place-based strategies to address the diversity of service responses that are relevant inclusive of health, education, employment, housing and justice services. Recognising and strengthening the links to the community and voluntary organisations is also relevant and links to a broader society-wide focus on addressing stigma and discrimination.

Table 3-2: Social determinants — barriers and enablers

BARRIERS	ENABLERS
▪ Social disadvantage ▪ Social stigma and discrimination ▪ Social isolation ▪ Lack of support for carers and families	▪ Social networks ▪ Anti-stigma campaigns ▪ Inter-sectoral planning ▪ Place-based strategies ▪ Recognise and support carers and families ▪ Voluntary and community organisations

Health-system determinants

Multiple barriers are present in the health system to effectively manage the physical health of people with a lived experience. These include the attitudes, skills and competence of the health workforce that may reinforce stigma and/or give insufficient focus to the management of co-morbidity physical health issues.

The separation of primary care from specialist mental healthcare and AOD treatment services is a structural feature of the Australian health system that has led to fragmented care. Out-of-pocket costs and sparsity of coverage in rural and remote areas diminish access to treatment. Fee-for-service remuneration of GPs through the MBS and lack of interoperable IT systems and access to electronic health records is a further challenge to shared care between primary health care and specialist mental health care and AOD treatment services.

There are many enablers. One of the most important enablers is the focus on health promotion strategies that are tailored to people with a lived experience. Taking a population health approach has been identified as exceptionally relevant and effective.

A range of other enablers include the routine provision of integrated care and collaborative care programs, provision of holistic care that includes a whole-person perspective, and routine screening and monitoring of physical health needs. Such models of care need to be aligned to best practice, evidence-based guidelines and in a favourable organisational and workforce context.

To this end, there is a role for workplace anti-stigma campaigns to address cultural issues, workforce training and redesign to ensure competencies and alignment of programs to ensure clarity of roles between parts of the health system, especially between primary care and specialist mental health and AOD treatment services.

More broadly, funding incentives can powerfully influence health service providers' responsiveness to service model and practice changes aligned with evidence guidelines; digital strategies can enhance program delivery; and relevant analytics and monitoring can promote accountability and tracking of outcomes at a system, program and organisation level.

Table 3-3: Health-system determinants — barriers and enablers

BARRIERS	ENABLERS
▪ Stigma and discrimination ▪ Skills and competencies ▪ Diagnostic over-shadowing ▪ Fragmented care ▪ Lack of role clarity ▪ Access ▪ Misaligned financial incentives ▪ Digital health limitations	▪ Targeted health promotion and illness prevention programs ▪ Focus on life stages ▪ Routine screening and monitoring ▪ Integrated care ▪ Person-centred, holistic care ▪ Health literacy ▪ Workplace-based anti-stigma campaigns ▪ Workforce training ▪ Role clarity ▪ Funding and accountability ▪ Digital health ▪ Data and analytics

4. The case for change

The *Environmental Analysis and Research Report* highlighted the following:

- the burden of disease, relating to the prevalence of mental illness and problematic AOD use in Queensland
- the interrelationship between physical health and mental health and the co-morbidities associated with problematic AOD use and dual diagnosis
- the prevalence of mental illness and problematic AOD use for various population sub-groups
- the protective factors associated with mental illness and problematic AOD use
- the economic impact at a national level of mental illness and problematic AOD use
- policy positions across Australia in relation to physical health of lived experience of persons with mental illness and persons affected by problematic AOD use
- an overview of the current Queensland service system and the core roles within the system
- an early indication of the key themes of initiatives that incorporate the elements identified as contributing to improved physical outcomes for people with lived experience
- the factors influencing the poorer physical health outcomes of people with a lived experience of mental illness and/or problematic AOD use at an individual, social and health system level
- enablers of the desired future state.

A key message from the literature is that a substantial proportion of the higher burden of disease for people with a lived experienced of mental illness or problematic AOD use is potentially preventable. The evidence is clear that the current system fails to deliver optimal physical outcomes for people with a lived experience of mental illness or problematic AOD use, and that this has a significant impact on the social and economic participation of individuals, and the cost of health care. There is a clear need to ensure the development of intersectoral policies and health service interventions to address the physical health needs of those people with a lived experience.

The World Health Organization provides a framework for health promotion and disease prevention through population-based interventions, including action to address social determinants and health inequity, noting that:

> "Health promotion is the process of empowering people to increase control over their health and its determinants through health literacy efforts and multisectoral action to increase healthy behaviours. This process includes activities for the community-at-large or for populations at increased risk of negative health outcomes. Health promotion usually addresses behavioural risk factors such as tobacco use, obesity, diet and physical inactivity, as well as the areas of mental health… drug abuse (sic) control… (and)… alcohol control."

Recognised support mechanisms for health promotion and disease prevention include:

- multisectoral partnerships for health promotion and disease prevention
- educational and social communication activities aimed at promoting healthy conditions, lifestyles, behaviour and environments
- reorientation of health services to develop care models that encourage disease prevention and health promotion.

The applicability of such mechanisms to the Queensland context will be explored in subsequent project phases.

LIST OF ABBREVIATIONS

AOD	Alcohol and Other Drug
GDP	Gross Domestic Product
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning
MBS	Medical Benefits Scheme
NHMRC	National Health and Medical Research Council
NICE	National Institute for Health and Care Excellence
QMHC	Queensland Mental Health Commission

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