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

STRATEGIC POSITION PAPER

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Objective and approach

Project objective

The Queensland Mental Health Commission (QMHC) has commissioned Aspex Consulting to identify reform opportunities that may improve the physical health of people with a lived experience of mental illness (lived experience) or problematic alcohol and other drug (AOD) use. Recognising that experiencing mental illness and/or problematic AOD use leads to poorer health outcomes and quality of life, the QMHC is committed to supporting greater integration between physical and mental health including implementing the *Equally Well Consensus Statement: improving the physical health and wellbeing of people living with mental illness in Australia (Equally Well).*

Equally Well states, 'We will improve the physical health of people living with mental illness by acting to deliver:

- a holistic, person-centred approach to physical, mental health and wellbeing
- effective promotion, prevention and early intervention
- equity of access to all services
- improved 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.

Approach

Reform opportunities to improve the physical health of people with a lived experience of mental illness or problematic AOD use have been identified through a structured approach consisting of the following tasks:

- analysis of data relating to the prevalence of mental illness and problematic AOD usage, together with the socio-demographic profile of people with a lived experience
- summary of the Australian policy context in relation to the physical health of people with mental illness and people affected by problematic AOD use
- literature and environmental scan of strategies, policies and guidelines, relating to the nexus between physical health and mental illness and problematic AOD use
- assessment of the impact of the current service system and program design on the physical health of people with lived experience, including identification of existing models of care
- articulation of the nature of the (mis)alignment of the current service system in relation to physical and mental health and AOD services
- outline of the relevant barriers and enablers of reform at the individual, social and health system levels
- horizon scanning in relation to potential future directions, and the policy and program settings that might underpin future opportunities
- extensive stakeholder consultation program with over 80 individuals from 55 stakeholder organisations.

Purpose of the Strategic Position Paper

This report outlines the key identified strategic action areas.

Background overview

'Large disparities in physical health for those with mental illness is an ongoing health issue, and might even be worsening in some regions. Although this inequity is increasingly gaining attention, further investment, intervention, and research are urgently required to address the premature mortality and lifelong burden of poor physical health associated with mental illness.'[1]

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
- 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.

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 the equity of health and mortality outcomes for people with mental health and problematic substance use.

For people with lived experience, there is a higher reported prevalence of chronic illness across a range of illnesses, including:

- 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.

1. Lancet Psychiatry Commission, 2019. *A blueprint for protecting physical health in people with mental illness.*

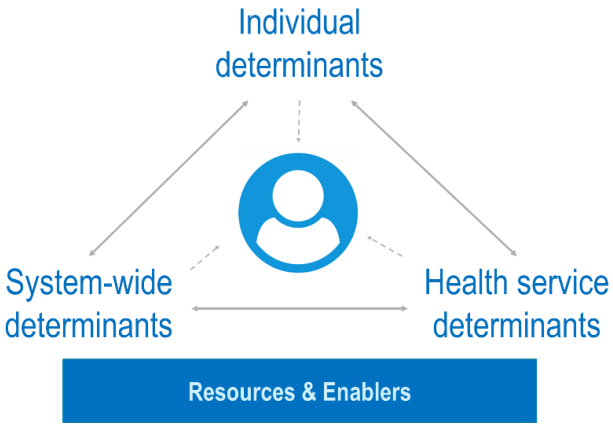
Key issues

Several reform opportunities to embed the *Equally Well* principles have been identified, including service models, models of care and initiatives across a range of sectors. The identified opportunities seek to address one or more of the following core issues:

- ***Addressing social determinants***. This includes the impact of social disadvantage, social stigma and discrimination, lack of connectedness and the additional challenges faced by families and carers who play a key support role.
- ***Improved service integration***. This includes enhancing access to collaborative shared care models through integration of:
  - mental health services, AOD services and general health services
  - primary health, secondary health and hospital services
  - health and social services including housing, family violence services, justice services, education and employment services.
- ***Service access***. There is currently variable availability of integrated service models that embed a person-centred approach to care and effective health promotion, illness prevention and early intervention initiatives.
- ***Sustainability.*** This includes the need for system structures and funding/resourcing that support the ongoing delivery of evidence-based models.
- ***System gaps***. There is an opportunity to further drive policy directions relating to the provision of a holistic, person-centred approach to physical, mental health and wellbeing, and ensure funding models and commissioning approaches facilitate this approach.
- ***Workforce development***. This includes the need to align the capacity and capability of the workforce, underpinned by relevant education and training, with clearly defined roles.

Each opportunity is intended to build on current work and address known gaps/barriers at an individual/social service delivery and/or system level, or build on the underpinning resources and enablers (refer to Figure 1).

Figure 1: Factors influencing physical health outcomes



Case for change

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.

Key reform opportunities

The identified strategic reform opportunities fall within twelve overarching themes, as outlined below.

Figure 2: Key reform opportunities

Each reform opportunity is outlined, with specific strategic action areas identified.

Individual-level reform opportunities

There are multiple individual factors that contribute to poorer health outcomes of individuals with lived experiences when compared to the general population. These risk factors interact synergistically and compound disadvantage.

The overarching themes in relation to individual level determinants are:

- ***Protective factors***. Protective factors work to improve a person's ability to cope with difficult circumstances, enhance the likelihood of positive outcomes, and lessen the likelihood of negative consequences from exposure to risk. Fostering protective factors can contribute to greatly improved health outcomes for people with non-preventable chronic conditions;[2]
- ***Navigation***. Healthcare navigation can be defined as the processes by which patients and/or their health caregivers move into and through the multiple parts of the healthcare system in order to gain access to and use its services in a manner that maximises the likelihood of gaining the positive health outcomes available from these services.[3]

Protective factors

- 1.1.1 Invest in health promotion and promote health literacy resources.
- 1.1.2 Reduce the stigma and discrimination faced by people with a lived experience through targeted anti-stigma campaigns.
- 1.1.3 Help individuals make healthier choices by reducing the structural obstacles to good health.
- 1.1.4 Co-design lifestyle interventions that address risk factors including smoking, obesity, poor nutrition and lack of exercise.
- 1.1.5 Invest in opportunities for individuals with lived experience to connect into local activities and support services.
- 1.1.6 Promote the importance of the psychological and physical wellbeing of carers and families.

Navigation

- 1.2.1 Jointly develop and promote clear clinical care pathways.
- 1.2.2 Provide access to relevant evidence-based health literacy information.
- 1.2.3 Target investment in care coordinators/nurse navigators and case management support.

2. Australian Health Ministers' Advisory Council. 2017. *National Strategic Framework for Chronic Conditions*.
3. Sofaer S. 2009. Navigating poorly charted territory: Patient dilemmas in health care "non-systems". *Medical Care Research and Review* 66 (1 Suppl): 75S–93S.

Health service delivery level reform opportunities

Health services are instrumental to reduce the burden of disease for people with a lived experience. For a number of reasons, current approaches to healthcare are sub-optimal.

The overarching themes in relation to health service delivery are:

- ***Accountability***. Setting clear role expectations is fundamental to future reform. Clarity of healthcare roles is required for each part of the patient journey — from primary care to specialist care in the community to acute inpatient and outpatient care to subacute care.
- ***Models of care***. Access is required to a comprehensive suite of models of care. This includes brief interventions and bio–psycho–social models delivered by multi-disciplinary teams, consultation-liaison, and in-reach and outreach services.
- ***Coordination of care***. Care coordination is relevant to support the provision of shared care by GPs and specialist services, to support continuity of care over time, and to facilitate step-up and step-down as individuals move between care settings.

Accountability	• 2.1.1 Strengthen accountability mechanisms in relation to the clinical management responsibility for the physical health of consumers with a lived experience within Hospital and Health Service care settings. • 2.1.2 Develop a joint statement between the Royal Australian College of General Practitioners, Australian College of Rural and Remote Medicine, Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists to clarify the role and responsibility of medical practitioners working across primary secondary and tertiary care settings. Allied health professional bodies should also develop position statements regarding accountability of their respective providers. • 2.1.3 Develop a joint communications strategy to reinforce roles and responsibility expectations. • 2.1.4 Review the extent private health insurance provisions create barriers to the provision of integrated physical and mental health service provision.
Models of care	• 2.2.1 Trial the effectiveness of adopting holistic lifestyle screening and assessment. • 2.2.2 Further develop and implement care pathways relevant to primary and secondary care practitioners, clinical mental health services and AOD services. • 2.2.3 Provide access to lifestyle interventions at the point of first presentation of illness to prevent onset of disease. • 2.2.4 Develop and deliver lifestyle interventions on a stepped-care basis including referral to mainstream community-based programs and multi-disciplinary lifestyle intervention programs. • 2.2.5 Review and strengthen Hospital and Health Service models of care for co-occurring conditions and include screening for substance use within mental health settings, assessment of readiness for change, motivational interviewing and defined referral pathways between mental health and AOD treatment services and vice versa. • 2.2.6 Co-design models of care with consumers to ensure services are culturally safe, relevant and accessible to populations including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people and LGBTIQ people. • 2.2.7 Bolster consultation-liaison psychiatry services to acute and subacute inpatient settings to complement the provision of physical health care and acute medical consultations available in Hospital and Health Service mental health inpatient settings. • 2.2.8 Expand service models to enable delivery on an outreach basis to support the provision of services to difficult-to-reach populations including asylum seeker and humanitarian settlers, and people experiencing homelessness.
Collaborative care	• 2.3.1 Develop, implement and evaluate trial risk stratification tools to identify individuals with higher risk who would benefit from collaborative care. • 2.3.2 Develop, implement and evaluate collaborative care models co-designed with specialist colleges and service users.

System-wide reform opportunities

The factors that influence health outcomes for people with a lived experience are multi-faceted. A system-wide lens is relevant to take into account the 'syndemic' nature of the issue.

The overarching themes in relation to system-wide reform opportunities are:

- ***Population health***. The reach of population-level health interventions has the potential to yield substantial improvements in awareness and improvements in risk factors. Health promotion and illness prevention strategies can be cost-effective and can be tailored for at-risk population groups. Attitudinal change can be incorporated within social marketing strategies to address barriers to effective care arising from stigma and discrimination.
- ***Place-based strategies***. Place-based health promotion and illness prevention strategies can enable targeting of communities and population groups with social, economic and health disparities.
- ***Partnerships***. Aligned endeavours are required beyond the health sector and need to encompass whole-of-government approaches. This is important to recognise the social determinants of health. Accordingly, there is a need to look beyond the role of the health sector to include policies relating to housing, education, employment, transport, sport and the arts, as well as the justice system. Partnerships are relevant between levels of government, local, state and federal governments.

Population health	• 3.1.1 Provide supplementary health professional education and tailored information materials to increase the relevance of general population health promotion strategies to people with a lived experience and those at risk of both poor physical and mental health. • 3.1.2 Continue current comprehensive implementation of biomarker screening across clinical mental health and specialist AOD treatment services. • 3.1.3 Develop, implement and evaluate comprehensive screening and holistic risk factor assessments across primary health, clinical mental health and specialist AOD treatment services. • 3.1.4 Implement systematic and comprehensive prevention strategies, with a priority focus on smoking cessation, across clinical mental health and specialist AOD treatment services. • 3.1.5 Develop prevention strategies for oral health for implementation across clinical mental health and specialist AOD treatment services and public-funded oral health services.
Place-based	• 3.2.1 Prioritise areas with the highest burden of disease and socio-economic disadvantage for co-designed, inter-sectoral strategies focused on health promotion and integrated service models.
Partnerships	• 3.3.1 Strengthen partnerships between QMHC, Queensland Health, Health & Wellbeing Queensland, Hospital and Health Services, Primary Health Networks, health and social care services, community and voluntary organisations, and other government sectors to enable holistic strategies for health promotion. • 3.3.2 Strengthen partnerships between Primary Health Networks and Hospital and Health Services and implement co-commissioning strategies to support integrated care for consumers with a lived experience. • 3.3.3 Strengthen partnerships between health and community organisations to strengthen social connectedness.

Resources and enablers

This section outlines key considerations to achieve the identified strategic priorities. These considerations are applicable across individual, health service and system levels.

The four key themes in relation to resources and enablers are:

- ***Funding and commissioning***. Funding and commissioning strategies have a key role in shaping the available service responses relevant to local communities.
- ***Workforce***. The further development of workforce capacity and capability underpins many of the opportunities to improve the physical health of people with lived experience.
- ***Digital health***. Digital health strategies can support improvements in service access, integration and quality.
- ***Research and evaluation***. Monitoring of progress towards improved physical health and wellbeing is a key tenet of the *Equally Well Consensus Statement*. This requires commitment to research and evaluation.

Funding & commissioning	• 4.1.1 Independent review of the capacity of funding models to support patient-centred models of care. This includes funding mechanisms for primary care, pharmacy and dental care, among other service streams. • 4.1.2 Investigate and implement co-commissioning strategies that facilitate pooled funding between different entities and levels of government to facilitate wider access to appropriate service models.
Workforce	• 4.2.1 Clarify professional roles. • 4.2.2 Invest in capability building to strengthen the skills and competencies of the workforce. • 4.2.3 Review clinical guidelines and lifestyle screening tools. • 4.2.4 Promote workforce development and efficient and effective workforce models.
Digital health	• 4.3.1 Enhance availability of digital health strategies, as they relate to information availability for individuals with lived experience and their carers/families. • 4.3.2 Invest in critical information technology enablers that enable information sharing between health practitioners.
Research & evaluation	• 4.4.1 Invest in performance monitoring, targeted research and evaluation to strengthen the evidence base. • 4.4.2 Invest in data capture systems and data monitoring to drive uptake of evidence-based approaches. • 4.4.3 Establish shared ‘performance measures' that assess performance of the system as a whole.

Key partners

It is expected that future design work will include consultation with consumers and carers, or their representatives. Other key stakeholder groups to further the reform opportunities may include, but are not limited to:

- colleges and professional bodies
- Health & Wellbeing Queensland
- Department of Housing & Public Works, Digital Technology & Sport
- Queensland Health (Hospital and Health Services and the Department of Health)
- Primary Health Networks
- service providers, including non-government and private providers
- private health insurers
- peak bodies
- QMHC
- research bodies.

LIST OF ABBREVIATIONS

ACRRM	Australian College of Rural and Remote Medicine
AOD	Alcohol and Other Drugs
GDP	Gross Domestic Product
HHS	Hospital & Health Service
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning
NHMRC	National Health and Medical Research Council
PHN	Primary Health Network
QMHC	Queensland Mental Health Commission
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RANZCP	Royal Australian and New Zealand College of Psychiatrists

DISCLAIMER