

# Co-designing a service model to improve the physical health and wellbeing of consumers with mental health and/or alcohol and other drug issues

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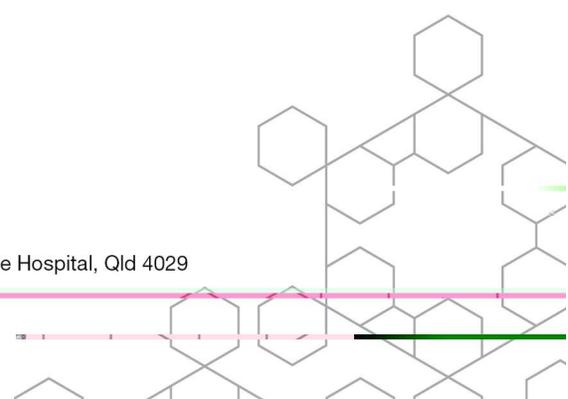
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## 1. Introduction

People with substance use and/or mental health conditions have a 2-3 times higher mortality rate than the general population, resulting in life expectancy gap of 10-20 years. 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. People with substance use and/or mental health conditions are at 2-3 times higher risk of developing these general medical conditions, and are up to 6 times more likely to die from cardiovascular disease, compared with the general population. The co-occurrence of two or more long-term conditions is referred to as ‘multimorbidity’. Multimorbidity predisposes individuals to a trajectory of disease and functional decline because of the accumulation of risks and vulnerabilities associated with disease. People with multimorbidity experience high levels of psychological distress, lower quality of life, and poorer clinical outcomes. The interaction of co-occurring general medical conditions in people with substance use and/or mental health conditions 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. 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. Improving prevention and management of multimorbidity is recognised as a priority in national policy and strategic plans.

Australia’s policy context highlights the interrelatedness of mental and physical health and wellbeing, and bidirectionality of substance use and/or 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 strategic 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, 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 that all Mental Health, Alcohol and Other Drug (MHAOD) services are required 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 their carers.

The aim of this project was to conduct co-design focus groups with mental health staff and consumers, carers and families in North Brisbane to design a service model to improve the physical and mental health and wellbeing of people with mental health issues. To address this aim, specific objectives were to:

- Understand the experiences of consumers, carers, families, and service providers in relation to addressing the physical health and wellbeing of people with mental health issues.
- Use co-design methods to provide recommendations for a service model, or service improvement, that specifically addresses the physical health and wellbeing of people with mental health issues.
- Make recommendations to the Brisbane North PHN on findings of the project and recommendations for future sustainable service models.

## **2. Summary of findings**

Participants acknowledged the interconnectedness of mental and physical health, and the importance of taking a holistic wellbeing approach for recovery. Participants generally felt that the focus on physical health within mental health services and organisations needed substantial development. Areas for development included (1) Improving service navigation and access, (2) Enabling staff to develop rapport with consumers and advocate for their health needs, and (3) Helping people adopt and maintain healthy lifestyle behaviours.

Service navigation was one of the most common barriers to receiving appropriate care for physical or mental health. Participants reported that initial contact points such as call centres and employee assistance programs were unhelpful and in many cases damaging, and general practitioners are often not aware of the community supports available. Establishing pathways for national call centres to direct callers to local mental health service navigation options and positioning mental health support workers in general practice settings, were suggested as strategies to address this issue.

The therapeutic relationship between staff and consumers was acknowledged as important for the recovery journey, and participants reflected negatively on situations in which they did not feel respected within health services. Lived experience workers who can develop rapport with consumers and provide advocacy in situations in which the consumer lacks confidence to articulate their views was considered highly desirable. Common situations in which this support was considered valuable included discussions with general practitioners or psychiatrists about tests, treatment planning, and medication changes.

Healthy lifestyle behaviours such as exercise and diet were acknowledged as important for physical health and integral to recovery. Participants reflected that behaviour change is difficult– particularly during unwell periods – and that there is an absence of support for healthy behaviour change in hospital and community settings. It was emphasised that this support should be adaptable to each individual's recovery journey, provided within safe and welcoming environments such as that established by the existing mental health hubs, and incorporate social support, leisure and recreation. Lived experience workers with specific training in helping people improve physical health and wellbeing into mental health hubs was a suggested strategy.

### 3. Method

Interested individuals were asked to register for the workshops and complete a brief demographics survey about their involvement with mental health services. The co-design workshops were promoted to consumers, carers and staff via email through networks associated with Community QLD, Neami National, Stride, Richmond Fellowship Queensland (RFQ), Footprints Inc., Peer Participation in Mental Health Services (PPIMS), and the Metro North Mental Health Service Consumer and Carer mailing list. Workshops were two hours in duration and catered with morning/afternoon tea. All workshops were audio recorded and transcribed for further analysis. Consumer and carer participants received a \$20 Coles/Myer gift card to compensate incidental expenses involved with attending.

Workshop content consisted of four activity components:

- (1) The first activity was for participants to answer four questions about physical/mental health by writing a word onto stickers and placing them on butchers paper. Questions were:
  - i. *What does physical health mean to you in mental health and recovery?*
  - ii. *What are the influences on your physical health and wellbeing?*
  - iii. *What has been your experiences with physical health in mental health services?*
  - iv. *What could mental health services and organisations do to better address physical health and wellbeing?*

The group was then be asked to explain the meaning behind the words and share their experiences.

- (2) During morning/afternoon tea break, the facilitator gave a presentation about biopsychosocial, lifestyle and environmental influences on physical health and wellbeing and the cycle of disadvantage (Appendix A). Then participants were asked which of these categories had the biggest impact on their health and wellbeing:

- Biological** e.g., Age, genetics, sex/gender, physical and mental functioning
- Psychological** e.g., Knowledge/attitudes, self-esteem/confidence, motivation, symptoms, resilience, personality, emotional stability
- Social** e.g., Social norms, stigma/exclusion, social networks, employment, housing, education, health service staff
- Lifestyle** e.g., Physical activity, nutrition, dental hygiene, sleep patterns, alcohol, smoking, substance use
- Environmental** e.g., Family dynamics, health service quality, community spaces and programs, gestational conditions, climate

...And which of these categories would be most effective to target to improve health and wellbeing:

- Biological** e.g., Better testing to detect risk factors, better medications, mental/physical rehabilitation
- Psychological** e.g., Counselling, education, cognitive therapies, health literacy, behaviour change support
- Social** e.g., Stigma reduction, improving housing / employment, health service experiences/connectivity, social support programs
- Lifestyle** e.g., Programs/services for improving: physical activity, nutrition, dental hygiene, sleep patterns, alcohol, smoking, substance use
- Environmental** e.g., Improved support for mothers and families, improving community spaces and health service capacity

- (3) Participants were then given fake money to the value of \$1,000 (10x\$100 notes). Potential options for investment were placed on the table, and participants asked to invest their money in what they thought the mental health sector needed. Investment options included:
  - i. Healthy activities in community organisations
  - ii. Health education in community organisations
  - iii. Gym membership
  - iv. Healthy food delivered to you
  - v. Flexible funding package to use on anything related to physical health
  - vi. GP who actively monitors health and prescribes lifestyle advice and appropriate medications for physical health

- vii. Support worker who values physical health
- viii. Peer worker to help you engage in activities to improve health
- ix. Peer mentor/peer health coach
- x. Personal training/exercise physiology service
- xi. Dietitian service,
- xii. Individualised wellbeing care coordination

Participants were then told that all their selected activities have now been funded and are doing well; however, we're faced with the same barriers identified in the first activity (e.g. poor access, low engagement etc). They were then given the entire sum of funding and told that the government has commissioned them to fix the problem. The facilitator prompted brainstorming and discussion.

- (4) The final activity consisted of five hypothetical situations that were developed based on the literature of barriers to physical health care faced by people with mental illness (*Happell 2012: Perceptions of Barriers to Physical Health Care for People with Serious Mental Illness: A Review of the International Literature*). The five hypotheticals were based on barriers at each phase of: (1) Identification of a health problem; (2) Arrival at health service; (3) Consultation with medical services; (4) Follow-up to identified physical health problem; (5) Ongoing care. The facilitator prompted brainstorming and problem solving; hypotheticals are provided in Appendix 1.

## 4. Results

### Recruitment

A total of 11 workshops were held (eight in-person at facilities of Community, Neami National, Stride, Footprints and RFQ, and three online workshops including with PPIMS members. A total of 48 participants registered, 38 of whom attended the in-person workshops. Registration was not required for online workshops with PPIMS members. Participant characteristics are shown in Table 1.

#### 4.1. Activity 1

When discussing what physical health meant in the context of mental health and recovery, participants unanimously agreed that physical and mental health and wellbeing were interconnected.

*“Physical and mental health are connected. If you suffer from physical health, then your mental health is going to decline as well.”*

*“...everything's connected, and even, it's not just physical and mental, like every part of life encompasses that.”*

*“Physical health is a tool to better mental health. So, I will have a lot of trouble dealing with my mental health if I don't deal also with physical.”*

*“Being physically healthy enables me to live an active life, but then also living an active life makes me feel better.”*

*“If I don't do the right thing with my body, my mental health declines. And when I get really stressed, mentally, I get sick, the two are really linked for me.”*

**Table 1: Participant characteristics (n=48)**

<b>Age range</b>	<b>n</b>	<b>%</b>
18 to 24 years	3	6%
25 to 34 years	11	23%
35 to 44 years	5	10%
45 to 54 years	14	29%
55 to 64 years	13	27%
65 years or older	1	2%
<b>Mental health involvement</b>		
Identify as a consumer	27	56%
Identify as a staff member	22	46%
Identify as a carer	13	27%
<b>Duration of receiving mental health services</b>		
Up to 5 years	12	44%
5-10 years	3	11%
More than 10 years	12	44%
<b>Duration of working in mental health services</b>		
Up to 5 years	16	73%
5-10 years	2	9%
More than 10 years	4	18%
<b>Duration as a carer</b>		
Up to 5 years	7	54%
5-10 years	0	0%
More than 10 years	6	46%

When asked about what the biggest impacts on physical health, lifestyle and routine were acknowledged as essential for self-managing physical and mental health:

*"If I start to feel not so good within my own head, I need to kind of check I've been eating okay, getting enough sleep, getting a bit of exercise, because they're normally the first thing to go. When I kind of get back into a better routine with those things, it gives me what I see is like a platform to stand on."*

*"Good old-fashioned exercise and healthy eating. If I don't go to the gym every day, or go for a run, or something physical, yeah, it just does make a negative impact on my day."*

*"Having support and encouragement is obviously really important. And I also have had that having a reliable routine – things that you get used to doing to sort of build up momentum."*

*"So I use physical activity in lieu of drugs, essentially. And so it really helps provide the fortitude for me to keep going in life."*

Motivation was most frequently acknowledged as being a determining factor for focusing on physical health, with isolation hindering motivation, and social connection assisting motivation.

*It's really easy to just kind of lose motivation, simply to just have really good intentions and things come up, you get tired, you get distracted, other things become a priority.*

*Motivation with daily activities, but also motivation in seeking out healthcare as well, like mental health services as well as physical health services, because you just feel that that there is a barrier that they're not going to listen to you, or they're not going to help you. So you just feel here in this little bubble.*

*"If you're not motivated, you're not going to work on your physical health... you don't care, you shut down in a hole and trying to claw your way back out is quite hard... You have to have people behind you to sort of do that 'village mentality', community and together sort of thing, so you don't feel so isolated."*

*"...isolation – It's how I felt at the time when I was having a decline in physical and mental health. I just felt really hopeless".*

*"And it does come down to lack of support. I'm very autonomous in my life, so I like being by myself. But sometimes you get to a stage where you're like, 'why can't I just find someone that can walk with me?'"*

A lack of human connection, compassion, and rapport was reported as negative experiences within mental health services;

*"...problems with services – not being listened to by the services actually makes you feel sicker. I just got, 'Oh, you're just this diagnosis' [rather than] 'we need to do this to help you'. And then they forced me into DBT when I wasn't ready. So that made me feel worse as well. Then they kicked me out of the service for not doing DBT".*

*"Because I find that they put you on medication, and then they just put you in the corner and leave you. And you have to stay out on you're own, battling your own thoughts and things like that.. they need to have that one-on-one talk with somebody. Just find out what's gone on for them. It's not about 'fixing' it's all about 'listening'."*

However, people often described invaluable support when they could find it, particularly in community settings where organisations were acknowledged as taking a more humanistic approach.

*"Before I came to Community, I felt like I was devalued as a human, that I was just another client, another paycheck, another number, and I just didn't feel that compassion"*

*"See, I really value the mental health services that I get here at Neami, where it's that peer support, that community, that connection, that mentality with people that are around you that have your back."*

*But as far as organisations go, if it wasn't for the organisations I don't know where I would be. I know that there is gaps in you know, there's long waiting lists and things like that. But as far as once you have access to services, I think, yes, they've been a lifesaver for me.*

Considering physical health within the context of having a mental health condition, participants described being dismissed by health professionals when they discussed their physical health.

*"If you do have a diagnosis of a significant mental health condition, often your physical health is dismissed, devalued not understood or people aren't listened to and I think, yeah, that speaks volumes to where we're at when we're looking at that current focus on physical health and wellbeing and mental health services.*

*"The professionals will attribute any of any of your complaints or physical health complaints to your mental illness. So I think that actually, nobody listens to you because you've got a mental illness. And so if you say you've got back pain, they say, No, that's just because she's got something else"*

When health professionals did engage in discussion about improving physical health the conversation was often superficial, and the lack of support services available was demotivating and a barrier to progress.

*"I find it isolating because like, no matter who you talk to, whether it be your GP, your psychologist, your psychiatrist, or whatever, they all tell you that you have to stay physically fit and well. But you're pretty much on your own to do it. I mean, that's the worst thing to say to someone that's depressed or, or whatever. I was, like, "no shit, I know that". But, you know, like, you're talking to someone that doesn't even want to have a shower. But, you know, what can you do to help me – what help is out there?"*

*"...the physical side of things is really like – 'Oh well, you know, three years down the line, okay, you're in recovery from your mental health, but now, you're feeling better to do something about your physical health' – but you're on your own. There's no follow-on from any services or anything to help you do that."*

Physical health support within mental health services and organizations was described as *ad hoc* and inconsistent.

*"There's not enough emphasis for physical health and wellbeing in mental health services. And I agree with my words "afterthought", "sporadic" not focused... Sometimes depends on who you see, which community person you see, but it's not embedded as a routine"*

*"I think they're trying now to think about physical health for people, but it's all these pockets of things that are out there. It's not, not everyone's doing it, and then they're not doing it all the time, and sort of comes into flavour..."*

Acknowledging the negative impact of mental illness on physical health, participants reflected that having support during unwell periods could have mitigated physical health decline:

*"When I'm not well, I completely shut down. Like I get, I get agoraphobic. And I sit, like in one spot in my house, and I'm an emotional eater. So I'll either overeat or not eat at all – swings from one to the other. Physical stuff just gets like, put, like totally not a priority. It's not thought about, I have no interest in it...what you really need is someone to be with you in those low periods and focus on both physical and mental health at the same time"*

*"But if there was something that could have kept that as a focus all this time so that it didn't get so bad, and didn't become such an overwhelming problem now. To have that answerability, all this time. Just to have someone to say 'I know, you're not feeling well, this week, but you know, let's go for a walk or, you know, you'll feel better if you eat veggies instead of crisps'."*

The existing mental health hubs were acknowledged as lacking the required focus on physical health; however, their establishment has created an ideal platform – a safe space and welcoming environment – to integrate a more holistic focus including physical health and wellbeing:

*"...this hub is more mental health focus, but if we were to come to this same sort of setup as a physical health hub, like you've got someone that okay, I'm feeling really strong today. I want to go for a walk. Okay. Let's go to the peer workers support groups that are focusing on physical, focusing on your motivation, focusing on keeping the importance of your physical health"*



*"Combined, it's a safe haven – you're used to it, you're comfortable. Like if they had a physical branch of the service – you know, pop in and know that, 'Okay, I need to help with my health, motivation and a coach, or someone I can check in with'. Help me navigate this way – the whole physical thing."*

When asked about what services should be provided, participants described a vibrant scene involving physical activities, relaxation and mindfulness, healthy cooking, socialization and peer support, leisure and recreation.

*"Group activities... engagement in meaningful activities. I reckon as soon as they've been diagnosed and socializing and they're having the rehab, they should be able to have either someone like us or another service that says, 'there's a group you can go to once a week for fun and socializing', and connect them in and make sure that they're fully connected, not just throw them a link, throw them a phone number because they can't help themselves sometimes, and then they fall down again."*

*A central hub, which has the mental health trained exercise physiologist and mental health trained dietitians, peer workers, psychologists that can offer all of those things and in every catchment area and free or bulk-billed.*

*Like a hub where they have, a nutritional cooking day and they're learning how to cook food basic healthy food. A program where you're meeting friends, it's fun, it's uplifting, you're given self esteem, you know, in confidence to cook these meals, and then you can go home with a printout and a list and then empower them.*

*"...It could be like a university – a Health and Wellbeing University..."*

...And that it was necessary for these services to be readily available to support people in opportune moments.

*"So people with mental health...you know, when they're feeling a bit motivated, you got to catch it to keep it going. Whereas sometimes, it's just a little bit too slow. It's kind of like if it doesn't happen right now, and then it happens three months later and they're over it."*

When asked what kind of person could be employed to act in a role to provide this support, participants agreed that a support worker would be best placed to do so, particularly if it could be a peer support worker:

*"I'd be happy for peer workers – I don't know what other people feel but I feel really good, and really understood, and they have built my confidence and built that level of motivation for me to be better in my journey of recovery"*

*"I would say, not a GP because they have too many hats. Yeah, that's nice to be someone that is really focused on the mental health and physical, the knock on effects of physical health. And, and what is available to that person immediately. It needs to be quicker."*

*"there is that stigma between professionals and users of services. Yeah. And I think again, a good way to, to join that, that distance is by having like a support worker or somebody with lived experience to be able to, you know, bring both sides together."*

However, participants who were acting in peer support roles acknowledged that there would need to be specific training in supporting consumers in the physical health and wellbeing journey.

*"We did one unit of providing social and emotional wellbeing in a 2-year course and it wasn't enough. So maybe the educators might need to look at more education for peer workers, broader education... to improve their confidence in supporting physical health"*

In addition to receiving support for healthy living and community engagement, participants remarked on the importance of having medications reviewed and minimized in the context of their recovery. Engaging in community activities, finding social support, and learning self-management skills were recognized as protective factors that may reduce reliance on medications to manage mental health; however, participants agreed that medical professionals were often not receptive to reducing medications.

*"I have nothing against medications, but I think there's a point in time where they need to be reviewed. I might only need to be on something for six months, but the doctors – once they put you on something that they just pretty much accept that you're going to be on it for the rest of your life. There's no readdressing whether you actually need those meds anymore. Like if you're coming here and doing all these courses, 12-months down the line I might not need the same level of meds. There was one psychiatrist that had me on six or seven different meds, there was no question of dropping any, it was just add, and add, and add, and add."*

*"Weight gain is one of the side effects. And I feel like the GP or psychiatrist is so quick to put you on medication, but then there's no follow-up with where we go to ensure that you maintain a healthy weight. There should be a duty of care against the psychiatrist to actually follow up with you to see where you are in terms of your physical health on those medications."*

Having these support workers take an advocacy role for people when needed was recognized as valuable, and highly desirable when unwell:

*"They're asking you all these questions while your being dulled down on these medications and you're not able to advocate because you've been dulled down on all the medications. Therefore, it's good to have an advocate with you, especially when you're in hospital."*

#### 4.2. Activity 2

When participants were asked to rate which health determinants had the greatest impact on their health and wellbeing, psychological and social influences were rated as the highest (score 65/90), followed by environmental (58/90), lifestyle (49/90), and biological (34/90). When asked which would be most effective to target to improve their health and wellbeing, participants rated psychological (62/90), social (60/90), lifestyle (55/90), environmental and biological (39/90). Participants unanimously reported difficulty in completing this ranking task, and that a multicomponent and holistic approach was required. However, the higher rank applied to psychological and social domains may reflect a preference for more direct support in improving health and social opportunities compared with medical treatments or environmental change.

#### 4.3. Activity 3

##### **What would you invest in?**

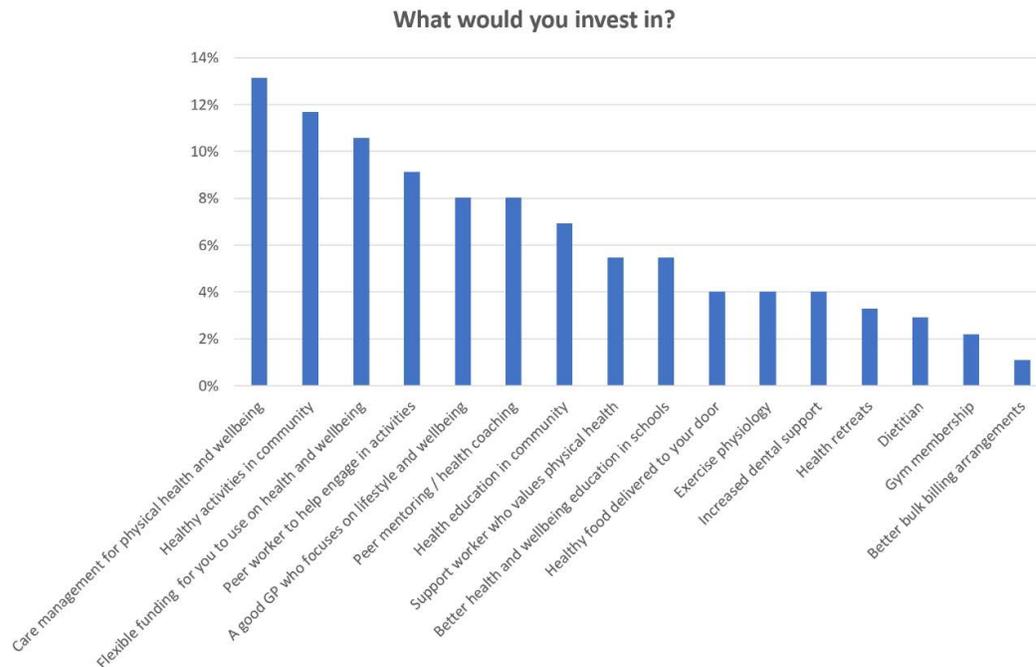
When asked to invest \$1000 of fake money (10x\$100 notes) in physical health initiatives, the most commonly endorsed option was for physical health and wellbeing 'care management'. The facilitator described this option as being similar to case management, but focusing on healthy living, active community participation, and ongoing encouragement and motivational support.

Complementing care management / care coordination approaches, a greater availability of healthy activity programs in the community was the second most endorsed option. This highlights the importance of providing pathways and program options for consumer engagement to be facilitated via a Wellbeing Care Coordination service.

The third most endorsed option was a flexible funding package that consumers could use for anything related to improving their physical health and wellbeing, reflecting the financial barriers experienced by consumers when trying to improve their health.

The next three most popular options included a peer worker to help people attend healthy activities by providing practical and emotional support (e.g. transport, health education, companionship, motivation), and a general practitioner with a holistic understanding of health and wellbeing.

Even though participants valued physical activity and healthy eating, service providers such as exercise physiologists and dietitians were less frequently endorsed compared with 'healthy activities in the community', possibly reflecting a desire for less clinical support.



**“Now you’ve received a stack of funding from the government to fix the problems we identified Activity 1... what should we do?”**

Improving service access and service navigation was consistently recognised as vital to addressing the identified shortcomings of current service delivery.

*“...Sometimes the services you’re looking for are a bit hidden. So while it might seem a waste of time, a proportion of that money should go to advertising... awareness.”*

*“...when I was in the wards, no information was given to me about community organisations like I was in the dark about for 20 years. [Right] I never had services, no community services, no PHN or Neami, because, because I didn’t know I wasn’t told by the psychiatrist or the case managers.”*

*“...like a Community Mental Health Navigator. So that someone, like your GP can refer you to that person or that person, you have a power that one on one with you, and you get the services that you need.”*

*“...maybe somehow making it a little bit easier for people who are chronically ill to get in find those types of facilities...”*

It was emphasised that for such as a service to benefit consumers it would need to operate efficiently, linking people in with the required support in a timely manner, and involve a personalised quality and proactive follow-up.

*“The first referral match to a social worker who has a question and answer sheet a tick box whatever, who then from that can define what service you’re suited to. So there’s a middle person”*

*“There needs to be specialist GP for mental health... not necessarily a GP, but some sort of person that you’d go to initially to get educated about what services are available, and who can direct you immediately to where you need to be”*

*“...there’s too much time, there’s too much waiting for feedback and connection and referrals... suicide can happen in a matter of minutes, the help takes months.”*

*“... a ‘warm’ referral... there’s a difference between giving a list of numbers to someone and making sure that those numbers are the right supports, making sure they have capacity for you at that time, making sure you’re the right fit for that service.”*

*“I like when you get a referral, and the person you’ve been referred to calls you.”*

Participants suggested that access points for a navigation service could be call centres and hotlines, employee assistance programs, inpatient settings and primary care.

*"I think in a lot of ways this already exists... if you see sad or distressing news it says to call lifeline or beyond blue, those organisations should then have referral pathways to all other organisations."*

*"So they rock up to the wards when the person's on the wards, then build that connection there, and carry that connection through. Also do not just offer once and stop, because people with mental illness want shared decision-making more than people in any other area of medicine, but they're also the most likely to not have the self-confidence to step up and say this is what I want."*

*"And I think we would start the best is when they're at their worst in hospital. Cuz a lot of them in there thinking what the hell am I gonna do when I get out of here? Where do I go from here?"*

However, participants also described their experiences with first points of contact such as call centres and employee assistance programs as damaging and contributing to distress.

*"My employer was absolutely woeful when it came to mental health... They give you brochures saying 'we're going to look after you, we're such a great organisation', but the way that they've dealt with me has been absolutely terrible...there was no understanding whatsoever. I've had to fight, just to get the basic rights that they always promise that they will give their employees when they get sick. So I've had to invest in a lawyer and everything just to get the recognition that I've deserved, and to recognise what happened and not be blamed"*

*Participant 1: I've been cut off four times from them and just given up all hope...*

*Facilitator: Did you say you've been cut off by Lifeline?*

*Participant 1: Four times – Yeah. And put on hold for 25 minutes.*

*Participant 2: I got hung up on. By the person on the end of the phone...I got hung up on...*

*Facilitator: It was accidental – the line went dead, or they hung up on you?*

*Participant 2: they hung up me.*

*Participant 3: And their answers are so robotic and rote that you can pretty much tell what they are tell you before you even ring them, there's no there's no connection there. There's no human spirit there, there's just some funny times, that pretty much made me just want to walk in front of a bus mostly.*

*Participant 4: And the other one that 13 numbers mental health help, or whatever suicide prevention – Pathways – I've rung them, I've never ever got called back. So it's a black hole, it's horrible. It really is.*

The My Mental Health service navigation line was recognised as very beneficial.

*"It is very good... They'll do a small assessment with you and then they can refer you to any PHN funded service across the north of Brisbane all at one time."*

Participants suggested that Lived Experience or peer-support workers would be ideal to support people during times of distress, and to help people find the right support. Suggested services that peer-workers could provide included, support people during times of distress, helping with service navigation, supporting healthy behaviour change, assisting consumers to attend health-promoting activities, building trust and rapport with consumers to establish a therapeutic relationship, and advocating to doctors and other health workers for consumers' needs.

*"A lot of the responses were about coordination of care and peer health coaching, so how about we combine those two and give the funding to someone to roll it out!"*

*"I think anyone who can build a really good rapport and trusting relationship and develop that,"*

*"What do you think's the value of lived experience in supporting physical health? You've got some more authenticity on how to help people. Because you have lived, you've felt their pain."*

*"Peer-workers to build rapport to have conversations about health that consumers may not be comfortable having with e.g. doctors or other clinical staff. "*

It was acknowledged that high staff turnover, short funding contracts, and frequent organisational changes and reform in funding structures made it difficult for this essential recovery-oriented relationship building to occur. Stability for staff was acknowledged as a strategy of providing stability for consumers.

*"the problem with me is having to speak to somebody new every time. Whenever I do that, it's really traumatising."*

*"I've gone like three different psychologists just this year, and I've had to re-spill my whole traumatic history and it actually increases my depression..."*

*"Maybe the support worker, when they sign into their contract, whatever it is, that they guarantee, they get some guarantee of staying there for two years". "Longer term funding for 5 years or 10 years, whatever it is."*

Acknowledging the unpredictability of mental health and/or substance use issues, when asked how problems could be detected and addressed early, participants noted that establishing mental health management plans during periods of wellness could guide mental health staff and organisations about actions to take during unwell periods. It was noted that although Wellness Recovery Action Plans (WRAP) are sometimes used, having the plan somewhere that could be accessed by health professionals was a challenge.

#### 4.4. Activity 4

Hypothetical scenarios were designed based on evidenced barriers to physical health care at each of five phases: (1) Identification of health problem and reaching health service; (2) Arrival at the healthcare service; (3) Consultation with medical services; (4) Follow-up to identified physical health problem; (5) Ongoing care. The hypothetical scenarios, and the framework that these were based on, is provided in the Appendix.

Common themes emerged across all the hypothetical scenarios that were consistent with the concepts expressed in the previous activities. Participants suggested that a support worker who could act as a mentor, advocate, service navigator and health coach for consumers could address most of the challenges presented in hypothetical scenarios. The support worker would need capacity within their role, and the interpersonal capability, to develop rapport with the consumer over the course of their recovery journey. It was discussed that this therapeutic relationship would form the foundation for sharing health concerns that the consumer may not feel comfortable sharing in clinical situations. The support worker would then be able to support the consumer by articulating the health context for the consumer, advocating for care in difficult discussions such as requesting medication reviews, explaining outcomes to consumers, and helping them make positive changes in a coaching / mentoring capacity. This support worker would require training in developing a recovery plan that incorporates available community services and programs, and in supporting consumers through healthy behaviour change in a humanistic and person-centred way. Lived experience / peer mentors were acknowledged as being ideal for this role.

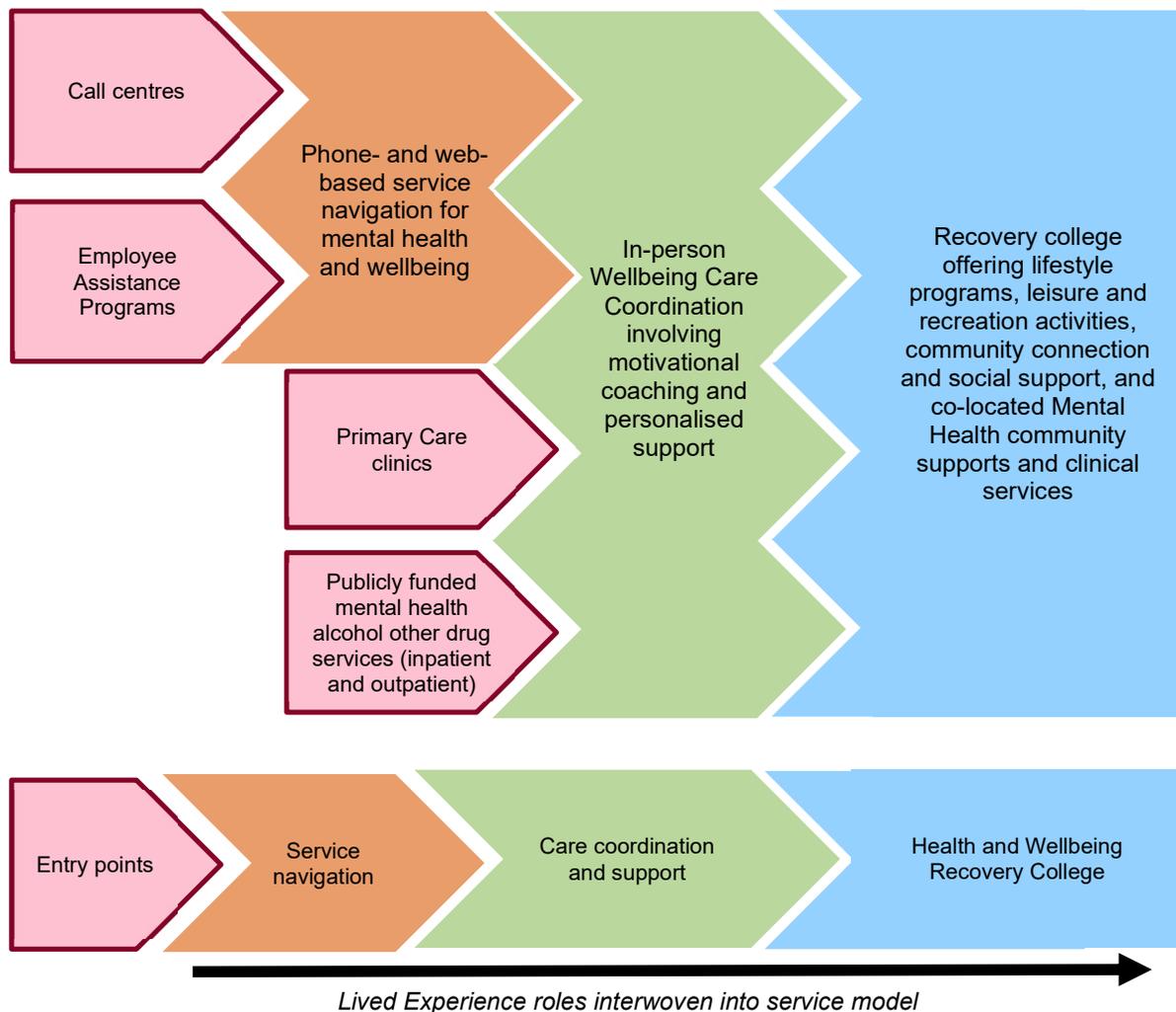
Hub models were recognised as a convenient and common-sense approach for provision of health and wellbeing services and programs in the context of a socially supportive and inclusive environment. Including healthy living programs co-facilitated by 'mental health savvy' clinical staff and people with lived experience was suggested as the most acceptable and recovery-oriented approach to providing health education and intervention. Co-locating a general practitioner with special interest in mental health and substance use issues into these hubs was seen as a comprehensive approach to providing a one-stop-shop for consumers to meet their health needs. Integrating Lived experience / peer mentors into these hubs to support consumers through the journey of healthy behaviour change was also highly regarded. The necessity for a flexible approach to tailor support to consumers' unique journeys was emphasised: It was discussed that a Lived experience / peer mentor would need the ability to visit consumers in their homes or on inpatient wards during unwell periods to reduce languishing and could carry positive momentum forwards during well periods for continued health improvement. Ideally, the lived experience / peer mentor would also be able to provide practical support, such as transporting consumers to the Hubs or other health services when needed to improve access.

### 5. Conceptual model

To address participant concerns that their needs were not being met at first contact points such as call centres or employee assistance programs, phone- and web-based services that provide navigation support could be integrated into these contact points so they become *entry points* to local services as required.

To address participant concerns that there is a lack of support, awareness and integration of available services amongst health professionals operating in primary care and hospital health service settings, a care coordination service could be established in these settings. Care coordination staff could have minimum qualification of a Certificate 4 in Mental Health, and have completed upskilling in local service availability and individualised support. Care coordinators could be co-located in primary care and HHS settings.

To build on positive feedback about the Mental Health Hubs, and respond to feedback that they could have a stronger physical health focus, these hubs could evolve into Health and Wellbeing Colleges. Recovery Colleges are a course-based model in which consumers are considered students, and course content is co-produced and co-delivered between health professionals and people with lived experience. They are strengths-based approaches delivered in inclusive and socially supportive environments focusing on skill building and empowerment for community integration, self-care and healthy living.



## 6. Recommendations and policy alignment

Components of the conceptual model are presented against the Productivity Commission's Inquiry into Mental Health Action statements (labelled as **PC Action** below):

- National call centres for mental health (e.g. Lifeline) and Employee Assistance Programs should direct callers/ employees seeking assistance to local phone- and web-based mental health navigation services such as My Mental Health in Brisbane North. This would provide direct guidance to people in distress about what services may be available, consistent with **PC Action 15.1 – Linking people to the services they need**, and **PC Action 15.2 – Online navigation portals to support referral pathways**.
- Wellbeing Care Coordinators in Primary Care settings is being trialled in other regions in Queensland (e.g. West Queensland Primary Health Network). These coordinators can be mental health nurses or people with a Certificate 4 in Mental Health. Their role is to support care coordination and community integration of people with mental illness, and to provide mental health awareness training to general practice staff. This approach is consistent with **PC Action 15.1 – Linking people to the services they need** and **PC Action 15.4 – Care Coordination Services**, and it can also reduce stigma in health settings which is consistent with the values of **PC Action 8.1 – National stigma reduction strategy**.
- Having a strong health and wellbeing focus in these Recovery Colleges would increase prevention, early intervention, and management approaches for people with co-occurring general medical conditions. This is consistent with **PC Action 14.1 – Improving care for people with concurrent mental illness and physical health conditions**, particularly the *Start later* actions referring to physical health screening, lifestyle interventions, and smoking cessation support. The Recovery College model may be adapted to criteria related to the upcoming Head to Health adult mental health centres that have been articulated in the Commonwealth budget.
- Recovery Colleges involve co-production and co-facilitation between health professionals and people with lived experience, and are commonly open to people across the spectrum of mild to severe symptoms of mental health issues and their families and carers. This is consistent with **PC Action 22.4 – Enhancing consumer and carer participation**. This approach also promotes meaningful interactions between people with and without mental illness which can reduce stigma, and is consistent with the values of **PC Action 8.1 – National stigma reduction strategy** and **PC Action 16.6 – Targeting stigma among health professionals**.
- Opening Health and Wellbeing Recovery College participation to families and carers of people with mental health issues and/or substance use disorders is consistent with values in **PC Action 18.1 – Family and carer inclusive practices**.
- Continuity of care could be improved by involving HHS-employed clinicians in co-production and co-facilitation of Health and Wellbeing Recovery College courses, and implementing eligibility criteria that does not discriminate consumers based on illness severity (mild-moderate vs. severe) or which support they may be currently receiving (e.g. state-funded vs. federal funded). This process could be facilitated by establishing functional joint governance and co-commissioning arrangements between Primary Health Networks and Hospital and Health Services, similar to early work occurring between Brisbane South PHN and Metro South Addictions and Mental Health Service. This is consistent with **PC Action 17.2 – Guarantee continuity of psychosocial supports**.
  - To address challenges with federal funding for Head to Health adult mental health centres being allocated to services for people with mild to moderate symptoms, co-commissioning and co-facilitation of Recovery Colleges could increase access and broaden eligibility to consumers across the 'stepped-care' continuum and in different phases of recovery.

- Pathways to access Health and Wellbeing Recovery Colleges should be integrated into online navigation portals (e.g. HealthPathways), consistent with **Action 15.2** – *Online navigation portals to support referral pathways*.
- Integrating Lived experience / peer mentors into Health and Wellbeing Recovery Colleges is consistent with **PC Action 16.5** – *Strengthen the peer workforce*. Ongoing learning from this process should be synergistic with iterative development of a comprehensive training program for peers to develop and expand a recognised scope of practice for this workforce.
- By co-locating and integrating general practitioners into these Health and Wellbeing Recovery Colleges, GPs will receive exposure to recovery-oriented practice and the benefit of non-pharmacological interventions. Promoting the role of Lived Experience / peer mentors as consumer advocates for medication reviews could form a platform for trials of social prescribing and medication de-prescribing initiatives, consistent with **PC Action 16.3** – *Improved mental health training for medical practitioners*.
- Providing longer-term funding for Care Coordination and Recovery College services would enable more comprehensive development of workforce capability, and enable support workers to develop the necessary rapport with consumers to act as a mentor and support the recovery journey. This is also consistent with **PC Action 17.1** – *Extend the contract length for psychosocial supports*.
- A comprehensive evaluation plan should be embedded in the development and implementation of this model, including consumer outcomes and costs of service delivery, consistent with **PC Action 24.10** – *Strengthening monitoring and reporting* and **PC Action 24.11** – *Requiring cost-effectiveness consideration and pilot trials of new programs*.

The Equally Well Consensus statement has been the main policy driver for service reform to address the physical health and wellbeing of people with mental health and/or substance use issues since its publication in 2016. The concept model and recommendations proposed from this consultation would promote:

**Essential Element 1:** *A Holistic, Person-centred approach to physical and mental health and wellbeing*

A Recovery College model would expand the role of peer workers to be integral across consumers' recovery journeys, and drive improvements in peer work training to facilitate expansion of scope to encompass care coordination, mentoring and advocacy, co-facilitation of courses with clinicians from a variety of disciplines, and community stigma reduction. Recovery Colleges are strengths-based and focus on empowering consumers, families and carers with knowledge and skills to manage their conditions and determine their own individualised care journey.

**Essential Element 2:** *Effective promotion, prevention and early intervention*

Connection of call centres and employee assistance programs with local/regional phone- and web-based mental health navigation services for linkage with services and referral pathways could reduce the potential for people in distress to feel isolated and without support. Once available support is accepted, physical health and lifestyle assessments can inform care coordination and course selection if attending Recovery College courses. Support for smoking cessation, improving lifestyle factors, and improving health literacy can all be offered in a socially supportive and inclusive environment. Broad eligibility criteria encompassing the general public, and co-facilitation of courses with health professionals, reduces stigma and increases mental health awareness which improves social equality and promotes help-seeking behaviour. Collaboration between PHNs and HHSs for delivery of Health and Wellbeing Recovery Colleges would support continuity of care for early detection and treatment.

**Essential Element 3:** *Equity of access to all services*

Supporting development of Lived Experience / peer mentor roles to offer advocacy for people with mental health and/or substance use issues could improve equitable treatment in hospital and specialist health services. Integration of GPs or other professionals such as nurses or pharmacists into Recovery Colleges

would require funding commitment; however, this would greatly improve equity of access and may be consistent with the proposed Commonwealth supported adult mental health hubs (details yet to be released). Telehealth / eHealth technologies could be integrated into these Recovery Colleges, which may be pertinent in regional and remote areas where access to technology and health professionals are greater barriers for consumers. Involving Aboriginal and Torres Strait Islander leaders, and representatives from other cultural groups in these colleges would improve cultural safety for consumers and cultural awareness of all staff.

***Essential Element 4: Improved quality of health care***

Physical health and wellbeing should be central in course offerings of Recovery Colleges. Health and medication literacy, and side-effect management, could be integrated into courses on physical health and wellbeing. The involvement of Lived Experience / peer advocates could support consumers in discussions with pharmacists, GPs and psychiatrists about medication reviews. The involvement of other professions such as dentists (e.g. for mobile assessments) in these hubs would increase access to services that address important health issues for this group. Including assessments and care planning for people who wish to engage with adult mental health hubs in this capacity would improve quality of care in this area; however, it should be maintained in parallel with Recovery Colleges so the student/learning atmosphere is not overshadowed by more clinically-oriented care.

***Essential Element 5: Care coordination and regional integration across health mental health and other services and sectors which enable a contributing life***

Health and Wellbeing Recovery Colleges could form a platform for engagement with professional colleges, associations and societies to advocate for enhancing tertiary education of professionals to work in mental health settings. Nurses and peer workers involved in these hubs with a physical health focus would increase care coordination. Care coordination with primary care clinics could involve mental health awareness opportunities for general practice staff to reduce stigma and increase understanding of diagnostic overshadowing and the need to address physical health concerns. Collaborative arrangements with PHNs and HHSs for this purpose could prioritise physical health of consumers.

***Essential Element 6: Monitoring of progress towards improved physical health and wellbeing***

Monitoring of physical and mental health outcomes of participants of these hubs will contribute to improving understanding of the bidirectional relationship between mental and physical health, and to establishing the cost-effectiveness of holistic approaches to care.

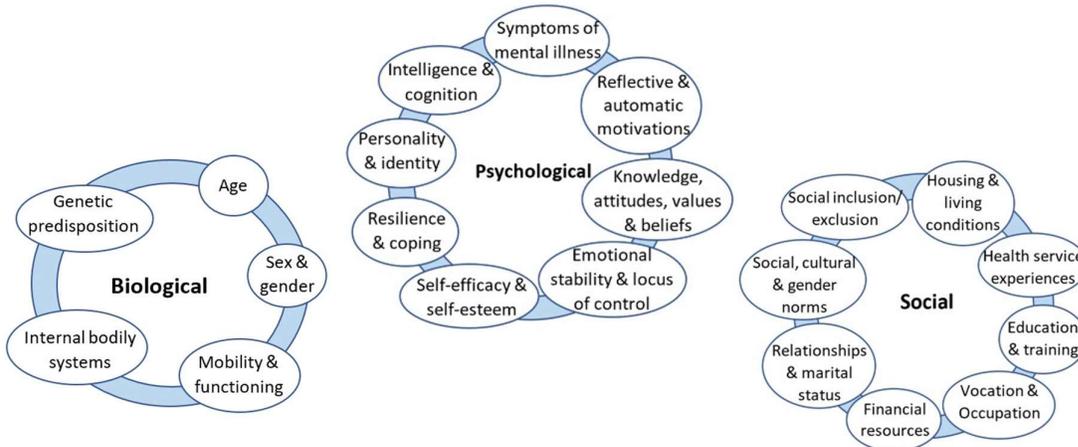
**7. Appendix**

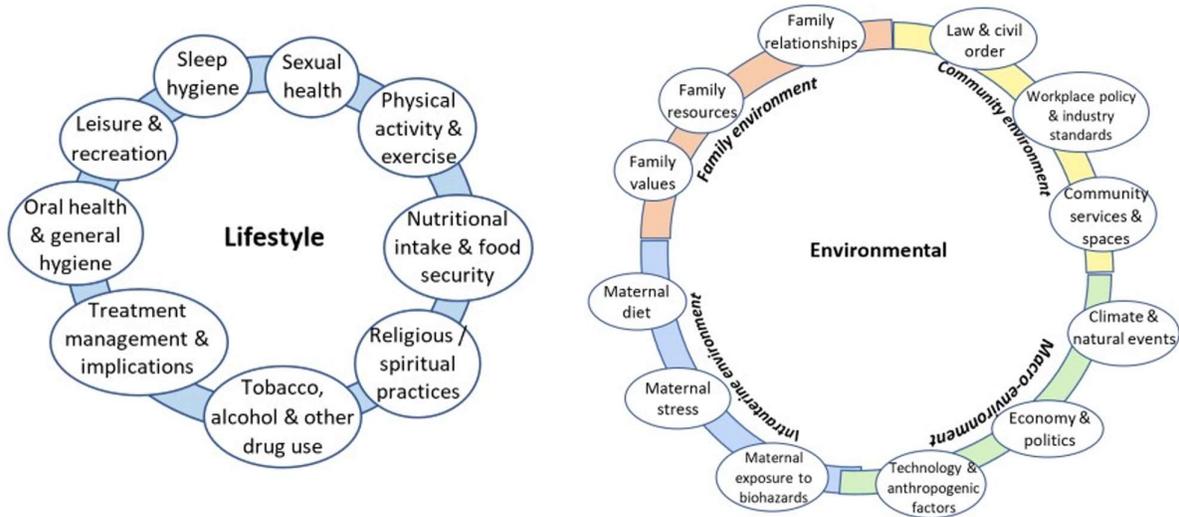
**7.1. Biopsychosocial, lifestyle, environmental presentation slides**

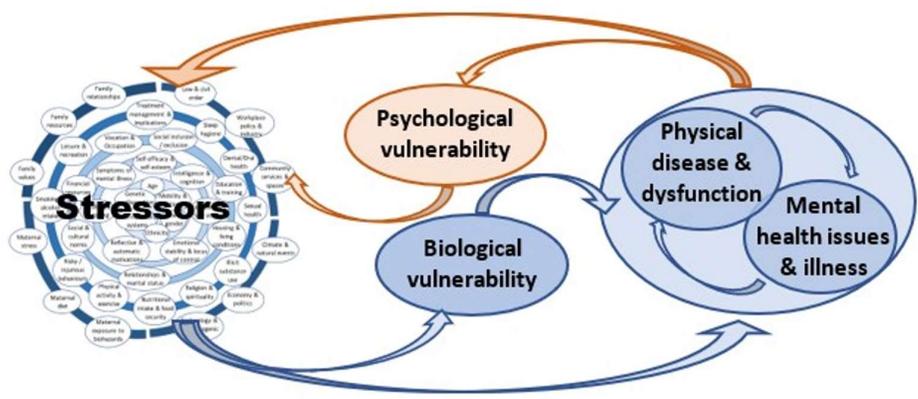
**Physical health and Wellbeing**



Our health and quality of life is influenced by a complex interplay of **biological, psychological, social, lifestyle** and **environmental** factors.

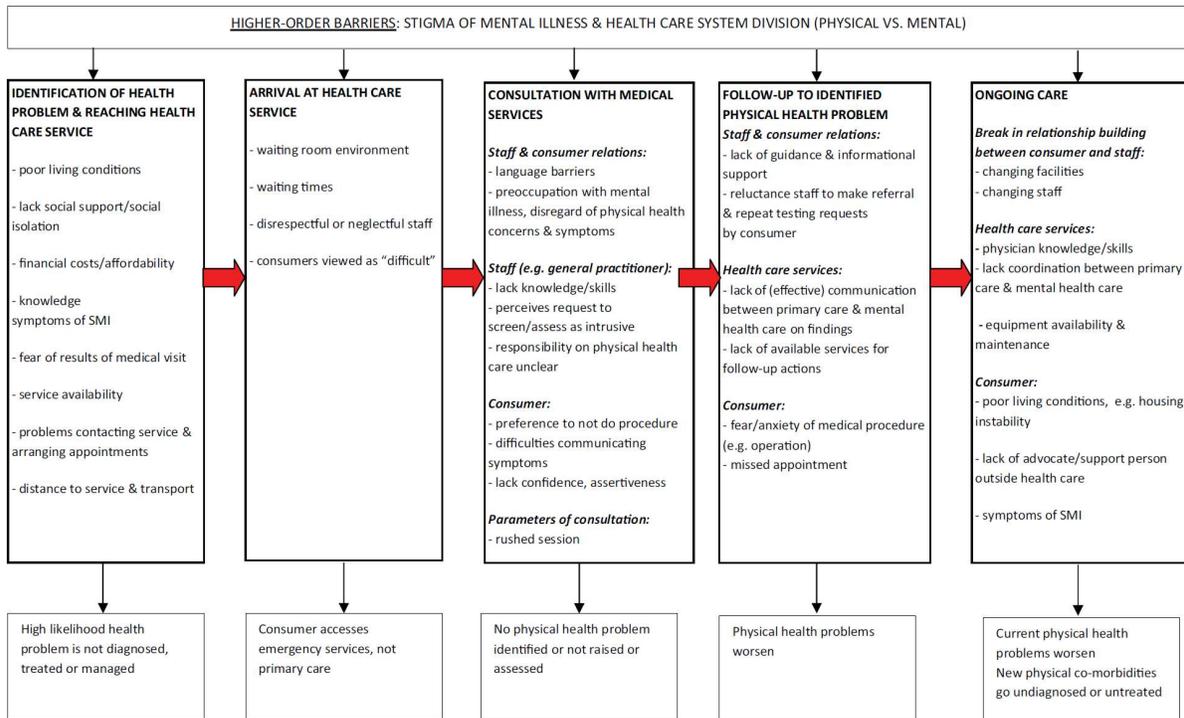






## 7.2. Hypotheticals

Hypothetical scenarios were developed based on the systematic review *Perceptions of Barriers to Physical Health Care for People with Serious Mental Illness: A Review of the International Literature* (Happell 2012), in which barriers to physical health care were identified across five phases in the health care process.



### Promotion, prevention and early intervention

- Julie's put on weight since starting her medications, and struggles to get outside because of anxiety.
- She used to have a part-time job and walk every morning to the bus, but since becoming unwell she left her job and hasn't felt comfortable enough to look for another job.
- Her doctor has started her on Metformin to help manage her blood sugar which has been getting higher
- She wants to do some kind of exercise but struggles with motivation, she doesn't like team sports but might like group-based activity with the right people.
- She often resorts to 'easy meals' rather than trying to cook anything that takes much preparation.

### Identification of health problem and reaching the health care service.

- Sam lives in a government housing facility, and he doesn't have any close friends or family that he can talk to about personal matters.
- He often gets blood in his stool.
- He's anxious about talking about it, and thinks that speaking about it to his support worker or doctor (who he rarely sees) won't do anything anyway.
- He smokes and drinks a lot of soft drink, and he's concerned he might have to change
- If the doctor did take him seriously, Sam's afraid of additional testing or other requirements such as appointments. He's afraid of the potential results of tests, and of potential implications (e.g. additional medications or expensive treatment).
- He doesn't have a car and doesn't like public transport, and since he moved, the GP he knows is far away.

### **Arrival at healthcare service and consultation with medical services**

- Julie gets diagnosed with diabetes.
- She's now able to access a few sessions with a dietitian through Medicare and the Chronic Disease Management plan.
- At the session, the dietitian asks her about macronutrients, but Julie can't recall much detail about what is in the ready-made meals she sometimes gets from the supermarket.
- Julie gets hungry late at night because of medications and snacks a lot. In an effort to reduce calorie intake, the dietitian says that she needs to stop eating after 7pm.
- Julie feel the dietitian doesn't respect her because she communicates impersonally, doesn't try to explain things properly, and doesn't listen about her medication side-effects.
- Julie is given some common health recipes but many of them require ingredients she doesn't buy, like salmon, ginger and fish sauce. Some of them require equipment she doesn't have, such as a food processor.
- Julie has to pay a gap fee for the session, and decides not to go back.

### **Follow-up to identified problem**

- Sam starts getting pain in his tooth. He hasn't been to a dentist in years and is afraid of dentists generally.
- His support worker help him to make an appointment.
- The dentist takes a scan and can see areas of concern. Sam downplays the pain.
- The dentist gives Sam a tooth care pack, and instructs him to improve his brushing and flossing (without teaching him how). Sam's told to keep monitoring the area of pain and to return if it gets worse.
- Sam still doesn't know how to improve his teeth 'brushing technique', has liked flossing, and has no intention of going back unless the pain is unbearable.
- The dentist doesn't discuss potential reasons for tooth decay such as substance use or medication side-effects (e.g. dry mouth), or provide advice for receiving support for high soft-drink intake.
- The dentist doesn't update anyone else involved with Sam's care about the meeting, or call Sam again.

### **Ongoing care and management**

- Andrew gets chronic pain from musculoskeletal complications in his spine, which is getting worse. His regular GP moved away, and he gets support from a local mental health organisation, and a psychiatrist.
- Every time Andrew wants to discuss his pain his GP asks him about his psychosis. His GP doesn't want to prescribe pain medication because his file mentioned substance use issues over five years ago.
- His psychiatrist has changed a number of times in the last year, and is generally only interested in controlling mental illness symptoms. There's never time to build a relationship for discussing other things that matter.
- Nobody has tried to assess his pain or find the cause, and Andrew doesn't have family or a carer to speak for him or search for alternative options for addressing his pain.