

Evaluation of Integrated Chronic Care Pilot

**Final Report
February 2022**

Dr Chris Maylea, Siobhán Bubner, Matthew Dale, Rory Randall, Dr Caroline Johnson, Associate Professor Robyn Martin, Professor Russell Roberts & Erin Myers

Social and Global Studies Centre, RMIT University



**Social and Global
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EQUALLYWELL
Quality of Life Quality in Life



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Executive Summary

This report presents the findings from the final evaluation of the Integrated Chronic Care (ICC) service, conducted by RMIT University's Social and Global Studies Centre (SGSC). ICC is funded by North Western Melbourne Primary Health Network (NWMPHN) and delivered by Neami National (Neami) and cohealth. SGSC leads this evaluation in partnership with Equally Well, Charles Sturt University and Melbourne University.

Neami run ICC in Hume, Moonee Valley and Moreland Local Government Areas (LGA) and cohealth run ICC in Brimbank and Maribyrnong LGAs. Both ICC sites employ one registered nurse and one mental health peer worker, both on fractional appointments. Neami and cohealth have collaborated to commission this evaluation.

The evaluation is in two parts, a midterm review and a final evaluation. This report presents the findings from the final evaluation. Qualitative data have been collected using interviews and focus groups with people who have used ICC services, ICC staff and professional stakeholders. Neami and cohealth have provided limited quantitative data. Due to issues with the quantitative data collection, the evaluation adopted a case study methodology, constructing consumer profiles to illustrate typical and outlier experiences based on qualitative data. During the midterm review and the final evaluation the evaluation team consulted with 52 stakeholders in total (27 consumers, 2 carers, 10 ICC staff and 13 external professional stakeholders).

Overall, the ICC model appears well adapted to improving the physical health of people using mental health services. The pilot was very well received by consumers, who appreciated the compassionate and caring service they received. Professional stakeholders also welcomed the program, pointing to the high levels of demand as proof of the program's value. Tangible outcomes were difficult to identify, but many of the precursors to tangible health outcomes, such as changing attitudes to health, increased health literacy, and better connections to the healthcare system, were evident. There is some evidence of improved screening, but the data do not indicate widespread action resulting from that screening.

Issues of context, particularly Victorian Government coronavirus restrictions, make both service provision and data collection difficult. The underfunded and poorly functioning mental health system limited the potential for care coordination to be effective, particularly for those most at risk of physical health issues.

Neither pilot program had a clear model for peer work, making this aspect challenging to evaluate. Peer work was appreciated when consumers were aware of it, but consumers were often unaware of the peer worker or what they did. Staffing turnover compounded this issue.

Neither pilot program had strong links with the local public mental health service. Other links with external services were also underdeveloped, with most referrals internal to cohealth and Neami. This led to the program working with a group that, while broadly representative of people using mental health services, was not always those who are most at risk of early death.

Despite these identified issues, ICC had real value to consumers and should be seen as a successful pilot implemented into a challenging service context. Evaluation recommendations include ensuring that screening is conducted as per clinical best practice then followed up, that equity of access is ensured, and that a clear and consistent approach underpins the service integration. The evaluation team also recommends that future pilots be of sufficient size and timeframes to minimise staff turnover and meet potential demand. A complete list of recommendations is on page 39.

Acknowledgments

The ICC program runs, and this evaluation was conducted on, the land of the Wurundjeri Woi Wurrung peoples of the Kulin Nation, which was never ceded. The Social and Global Studies Centre at RMIT University acknowledges the Australian Aboriginal and Torres Strait Islander peoples of the nations of Victoria, the custodians of this land. We pay our respects to ancestors and Elders, past and present. We are committed to honouring Australian Aboriginal and Torres Strait Islander peoples' unique cultural and spiritual relationships to the land, waters and seas and their rich contribution to society.

The evaluation team acknowledges the lived experience of poor mental and physical health and foreground the expertise from this lived experience. Equally Well is committed to improving the physical health and wellbeing of people who use mental health services in Australia.

The evaluation team would like to thank all participants who gave considered feedback, and Neami National, cohealth and the North Western Melbourne Primary Health Network for committing to an independent and transparent evaluation process.

Abbreviations and Terms

| | | | |
|-------|--|----------|---|
| ABS | Australian Bureau of Statistics | MBS | Medicare Benefits Schedule |
| AIHW | Australian Institute of Health and Welfare | MPCN | Melbourne Primary Care Network |
| COPD | Chronic Obstructive Pulmonary Disease | NWMH | NorthWestern Mental Health |
| DoH | Commonwealth Department of Health | NWMPHN | North Western Melbourne Primary Health Network |
| DSP | Disability Support Pension | PBS | Pharmaceutical Benefits Scheme |
| GP | General practitioner | PMHC-MDS | Primary Mental Health Care Minimum Data Set |
| HoNOS | Health of the Nation Outcome Scale | PSS | Psychosocial Support Service |
| HREC | Human Research Ethics Committee | RACGP | Royal Australian College of General Practitioners |
| ICC | Integrated Chronic Care | RMIT | RMIT University |
| LGA | Local Government Area | SGSC | Social and Global Studies Centre |
| | | TAC | Transport Accident Commission |

2 Introduction

This report presents the findings from the final evaluation of the Integrated Chronic Care (ICC) service, conducted by RMIT University's Social and Global Studies Centre (SGSC). ICC is funded by North Western Melbourne Primary Health Network (NWMPHN) and provided by Neami National (Neami) and cohealth.

SGSC leads this evaluation in partnership with Equally Well, Charles Sturt University and Melbourne University. The evaluation team includes three lived experience evaluators and academic evaluators with professional backgrounds which include peer work, general practice medicine, nursing, psychology, social work, law and mental health service management.

2.1 RMIT University's Social and Global Studies Centre

SGSC's strategic focus is on social justice, transformative social change and consumer participation. We consider these to be central to all of our research, with these themes uniting researchers across our research programs. We have a strong multidisciplinary membership, including social work, justice and legal studies, law and social policy, and international studies, and are thus able to mobilise purpose-built research teams to address the unique needs and requirements of industry-based research and evaluation. A core focus of our research is analysing and informing the policy process and conducting applied social science research that helps shape effective and equitable responses to social issues.

2.2 Equally Well

Equally Well seeks to improve the quality of life of people living with mental illness by providing equal access to quality health care. Based on the Equally Well National Consensus statement,¹ it champions physical health as a priority. Equally Well ultimately aims to improve the physical health and reduce the life expectancy gap that exists between people living with a mental illness and the general population. Equally Well is based on a model of collaborative action and collective impact, supported by a backbone group of consumers, clinicians, policy professionals and academics, driven by principles of co-design and co-production. This group mobilises, activates and supports other initiatives throughout the mental health sector and the broader community.

Supporters of Equally Well include over 90 organisations, including every Australian government, 14 professional colleges/societies, and numerous other organisations, including many primary health networks and non-government organisations. Under the Equally Well banner, a Being Equally Well national policy roadmap has been launched,² and the Victorian Government has released its Equally Well Framework.³ The Commonwealth Productivity Commission into Mental Health recommended

¹ NMHC, *Equally Well Consensus Statement: Improving the Physical Health and Wellbeing of People Living with Mental Illness in Australia* (National Mental Health Commission, 2016) <<https://equallywell.org.au/wp-content/uploads/2017/03/Equally-Well-Consensus-Statement.pdf>>.

² Mark Morgan et al., *Being Equally Well: A National Policy Roadmap to Better Physical Health Care and Longer Lives for People Living with Serious Mental Illness* (Mitchell Institute, Victoria University, 26 August 2021) ('*Being Equally Well*').

³ Victoria's Chief Psychiatrist and Chief Mental Health Nurse, *Equally Well in Victoria: Physical Health Framework for Specialist Mental Health Services* (Victorian Department of Health and Human Services, 2019) <<http://www.health.vic.gov.au/publications/equally-well-in-victoria-physical-health-framework-for-specialist-mental-health>> ('*Equally Well in Victoria*').

improving the physical health of people living with mental illness as a 'priority' and a 'start now' reform and has called for all Australian governments to implement the Equally Well Consensus Statement.⁴

3 Background

3.1 The physical health of people who use mental health services

People who use public mental health services in north-western Melbourne have a life expectancy of 52 years, which is more than 30 years lower than the Australian population.⁵ For all Australians receiving any kind of mental health care, the median age at death is closer to 69 years,⁶ roughly 13 years lower than the Australian population. Recent studies identify the main contributors to early death for people using public mental health services as cardiovascular disease, respiratory conditions and cancers, together responsible for 82% of natural cause early death.⁷ People diagnosed with psychotic illness are most at risk, accounting for 82% of natural cause early death; however other diagnoses, including bipolar disorder and major depression, are also major risk factors. Early death is often preceded by decades of poor health.

The reasons for the poor physical health of people who use mental health services are complex but include barriers to accessing adequate healthcare, consequences of experiencing mental distress or other symptoms, and harm caused by interactions with the mental and physical health care systems, including medication side effects.⁸ Diagnostic overshadowing, where health professionals focus on mental rather than physical health treatment, is a key contributor, compounded by social determinants such as poverty, joblessness, homelessness, drug and alcohol use and discrimination. People who experience intersectional disadvantage, such as Aboriginal and Torres Strait Islanders, people of refugee background and other migrants, are at increased risk.

People who use mental health services visit their general practitioner more often than the average for the Australian population, but have worse health outcomes.⁹

In response, various Australian governments have initiated strategies to reduce early mortality and improve health outcomes for people who use mental health services. These include chapter five in the Commonwealth *Fifth National Mental Health and Suicide Prevention Plan*, the Victorian Government's *Equally Well in Victoria: Physical health framework for specialist mental health services*, the NSW Government's *Physical Health Care for People Living with Mental Health Issues* and associated implementation strategy, and the *Productivity Commission Inquiry Report into Mental Health*.

⁴ Productivity Commission, 'Mental Health, Report No. 95'.

⁵ Joanne Suggett et al., 'Natural Cause Mortality of Mental Health Consumers: A 10-Year Retrospective Cohort Study' [2020] *International Journal of Mental Health Nursing* ('Natural Cause Mortality of Mental Health Consumers').

⁶ Grant Sara et al., 'Cohort Profile: Mental Health Living Longer: A Population-Wide Data Linkage to Understand and Reduce Premature Mortality in Mental Health Service Users in New South Wales, Australia' (2019) 9(11) *BMJ Open*.

⁷ Suggett et al. (n 5).

⁸ Chris Maylea, Russell Roberts and Christine Craik, 'The Role of Social Workers in Improving the Physical Health of People Who Use Mental Health Services' (2020) 73(4) *Australian Social Work* 490.

⁹ Qun Mai et al., 'Do Users of Mental Health Services Lack Access to General Practitioner Services?' (2010) 192(9) *The Medical Journal of Australia* 501.

3.2 Establishment of ICC

In 2019 Neami and cohealth were funded by the Melbourne Primary Care Network (MPCN), trading as NWMPHN, to deliver ICC services from July 2019 to August 2021. Neami were funded for the Hume, Moonee Valley and Moreland Local Government Areas (LGA) and cohealth for Brimbank and Maribyrnong LGAs. Both ICC sites employed one registered nurse and one mental health peer worker, both on fractional appointments.

The overall objective of ICC, as stated in the original request for tender from NWMPHN, is:

That individuals experiencing severe and persistent mental illnesses who can be or are being appropriately managed in a primary care setting:

- *are supported to achieve improved outcomes, including better self-management, for their chronic conditions;*
- *are offered access to physical and mental health services and supports.*

The original NWMPHN request for tender identified an ‘enhanced care coordination service in a primary care setting to improve the physical health of people experiencing severe and persistent mental illness’. Specifically, the request for tender notes that the ‘funding is to enhance existing service delivery, not to support the establishment of new service.’

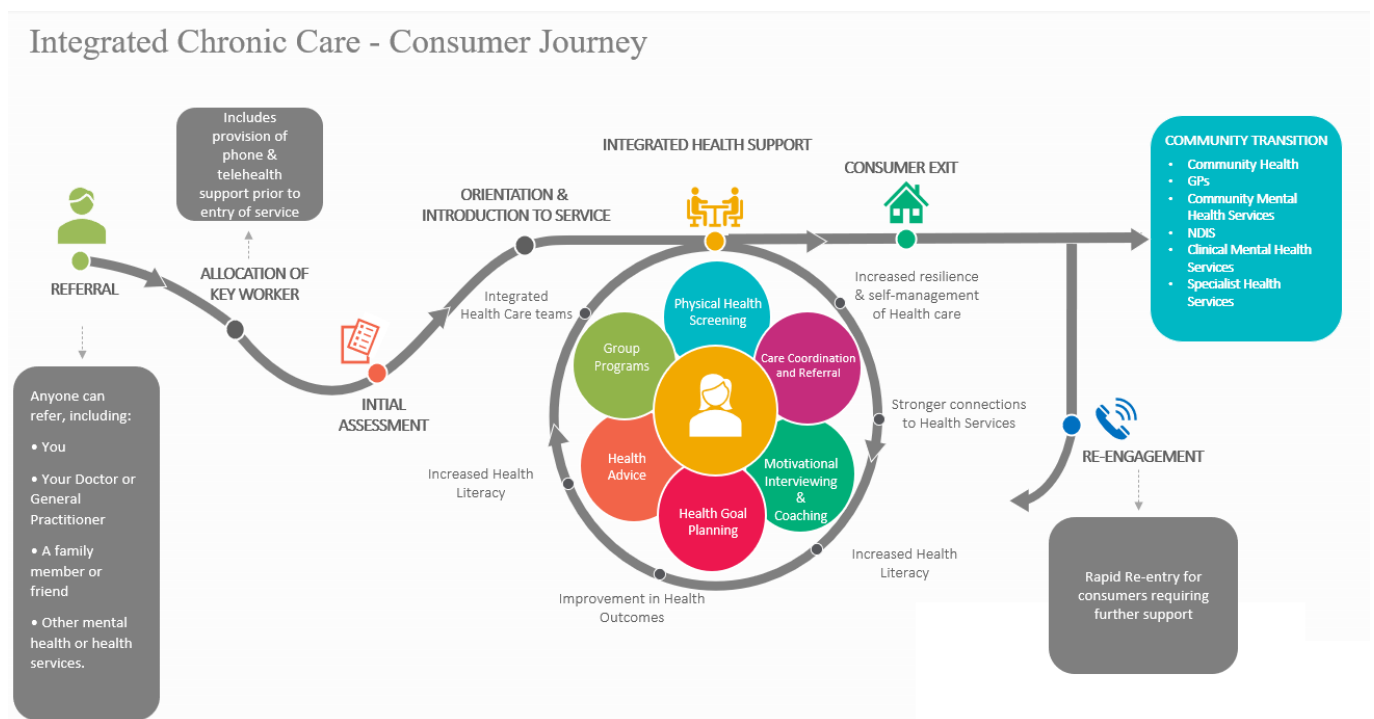


Figure 1 - Neami ICC Consumer Journey

Figure 1 shows Neami’s diagrammatic consumer journey. cohealth has a slightly different approach in that the peer worker does not have a caseload, focusing instead on running groups. The services are delivered using very similar approaches with some differences arising from context.

4 Evaluation Methodology

This evaluation employed a ‘consumer profile’ approach,¹⁰ drawing on thematic analysis of qualitative interview data and linked file reviews to construct consumer profiles representing a diversity of consumer experiences in the pilot. This methodology was chosen as the mixed-methods approach originally planned was not possible with the available quantitative data.

The evaluation employed a suite of data collection methods, including:

- Interviews with people who used ICC (consumers)
- File reviews of ICC consumer files
- Interviews with family members/carers of people who used ICC
- Interviews with ICC staff, including managers
- Interviews and focus groups with cohealth and Neami staff
- Interviews and focus groups with professional stakeholders
- Review of NWMPHN, Neami and cohealth ICC documentation
- Quantitative data from Neami and cohealth.

4.1 Evaluation in partnership

The evaluation was undertaken in partnership between RMIT’s SGSC and Equally Well, with evaluators from Charles Sturt University and the University of Melbourne also included. The partnership extended to Neami, cohealth and NWMPHN to provide an embedded and transparent evaluation process. Equally Well’s expertise in physical and mental health and the extensive network it brings provide essential components of the evaluation.

4.2 Lived-experience lens

The evaluation has been implemented using principles of participatory co-design,¹¹ focusing on valuing and responding to the lived experience of people who currently experience, or have in the past experienced, mental ill-health. The evaluation team includes three lived-experience evaluators. One or more lived-experience evaluators co-facilitated all consumer interviews, coded selected interview transcripts, participated in the thematic analysis of the data, and reviewed the draft report.

4.3 Co-location

The lead consultant (Dr Maylea) was to be co-located on site with Neami and cohealth throughout the evaluation. Due to the Victorian coronavirus restrictions, co-location was not possible. Communication instead took place via video calls, phone calls, and email.

¹⁰ This is more commonly known as a ‘case study’ approach, however the terminology of ‘consumer profile’ is used here to avoid characterising consumers as ‘cases’.

¹¹ Indigo Daya, *The Participation Ladder: A Consumer/Survivor Lens* (2020)
<http://www.indigodaya.com/wpcf7_captcha/2020/10/Participation-ladder_consumer_survivor-lens-2.pdf>.

4.4 Key evaluation questions

In response to the midterm review and consultation with cohealth and Neami, the key evaluation questions shifted to meet the experiences of service consumers and the realities of implementation. As a result, the final key evaluation questions included:

- How have these programs contributed to improving the physical and mental health of people who used them?
- What was the experience of people who used the programs?
- How did the services deliver the programs?
- Who did the services reach, and to what extent were the services effective in reaching the target group?
- To what extent have the programs complied with their program logics?
- What refinements are required to the program logic models?
- To what extent did the services identify and meet consumers' physical and mental health needs, including practical support where needed?
- To what extent did consumers develop skills for self-management of physical health? What factors were critical in the development of self-management skills?
- To what extent were the services integrated into existing primary care and other health services across the regions? What were the key enablers and barriers to integration, and how were these supported or addressed?
- To what extent were effective partnerships established with health and other services? What factors were critical to their effective maintenance?
- How is lived-experience expertise valued and included in the program design and implementation?

The evaluation questions were revised multiple times during the initial stages of the evaluation in response to new data arising. The evaluation questions were cross-tabulated to maintain alignment of the interview and focus group questions and other aspects of data collection.

4.5 Data Collection

Table 1 shows participants by count of data collection method. Nine ICC staff members are counted twice as they were interviewed at the midterm review and the final stage evaluation or participated in an interview and a focus group.

| | Consumers | File reviews | Carers | ICC staff | cohealth/Neami staff (non-ICC) | External stakeholders | Total |
|-----------------------|-----------|--------------|----------|-----------|--------------------------------|-----------------------|------------|
| Midterm review | 16 | 16 | 2 | 16 | 11 | 8 | 69 |
| Final stage | 11 | 10 | 0 | 10 | 8 | 5 | 45 |
| Total | 27 | 26 | 2 | 26 | 19¹² | 13 | 114 |
| Target | 40 | 20 | 0 | ≈10 | ≈10 | 6 | |

Table 1 - Participants by data collection method

¹² 19 interviews were conducted with 10 staff, 9 being interviewed twice or participated in a focus group.

4.5.1 Interviews with people who used or are using ICC

All past or current consumers of ICC were invited to participate in the evaluation. A total of 27 consumers participated in an interview, 16 for the midterm and 11 for the final evaluation. Of the 25 consumers referred by Neami, 17 participated, and of 12 consumers referred by cohealth, 10 participated. A total of 10 consumers referred were either unable to participate in an interview or were unable to be contacted. Although the total number of consumer participants recruited is lower than the target of 40, this does represent 10-20% of consumers who had used the program at the point of recruitment. Qualitative data of this nature are never strictly representative. However, these percentages are high compared to similar evaluations, and the evaluation team is confident in the findings based on these data. Saturation was reached on the key themes presented in the findings.

Participants were diverse in age, ranging from 19 to 65 years, and background, with four using interpreters and several others who spoke a language other than English at home. There were no participants referred who identified as Aboriginal or Torres Strait Islander, although they make up 3% of ICC consumers. Three-quarters of consumers who participated were female, with only one participant identifying as transgender or gender diverse. This roughly correlates with the demographics of ICC consumers, although given the non-random recruitment no claims are made to statistical representation. Two consumers identified that their carers or family members were involved in their engagement with ICC, and those carers were also interviewed.

Interviews with service providers and focus groups were conducted only by the lead evaluator or an academic evaluator, with all consumer interviews conducted by a lived experience evaluator in partnership with an academic evaluator.

4.5.2 File reviews

People who used the ICC programs and participated in interviews were asked to consent to have their ICC files reviewed. All but one participant (n=26) consented. The evaluation team liaised with Neami and cohealth ICC management staff who did not provide direct service to consumers to obtain the health files. This meant that direct service ICC staff remained unaware of which ICC consumers participated in the evaluation project.

4.5.3 Interviews with ICC staff

All ten ICC staff were interviewed; five Neami ICC staff and five cohealth ICC staff. Due to staff turnover, this included the two ICC nurses/care coordinators and three peer workers, as well as managers from each service with an oversight role for the ICC trial. For the mid-term evaluation, nurses/care coordinators and peer workers from Neami and cohealth also participated in a focus group (n= 4) with the lead evaluator, and the ICC nurses/care coordinators completed follow-up interviews with the evaluation team's medical doctor and nurse.

4.5.4 Professional stakeholder interviews and focus groups

In total, 32 professional stakeholders were interviewed for this evaluation, 19 for the midterm and 13 for the final stage. Of those who participated in the final evaluation, 8 were employed by cohealth or Neami in programs other than ICC, while 3 were external. This reflects, as identified below, ICC's reliance on internal referrals. Professional stakeholders were recruited by referral from ICC staff. In total, five Neami and seven cohealth stakeholders who were referred did not participate in an interview. Professional stakeholders who were interviewed included a range of professions: counsellors (n=3), a family violence worker (n=1), a nurse (n=3), physiotherapists (n=3), general practitioners (n=5), National

Disability Insurance Scheme (NDIS) access workers (n=3), psychosocial support workers (n=3), dietitians (n=2), a housing worker (n=1) and physical health care coordinators (n=2).

4.5.5 Review of ICC documentation

The evaluation team reviewed the original NWMPHN request for tender, cohealth's tender documents, position descriptions and establishment plan, progress reports, referral form and screening tool. All of these documents were then integrated into the analysis.

4.5.6 Quantitative data

After the midterm review, the evaluation team worked with cohealth and Neami to redesign the ICC data collection process. Due to the reasons discussed later (see 4.7), demographic data were only available for 20 cohealth and 25 Neami consumers for the period February and October 2021. This timeframe was agreed upon as the midterm review report was published in February 2021, and the latest data capture point for inclusion in the final stage was October 2021. Due to staff turnover, changes to data collection were not implemented until August 2021. As a result no useable pre/post quantitative data were collected. Demographic data has been cited, with caution where appropriate.

Qualitative data were processed in Microsoft Excel by Dr Maylea and presented to the evaluation team for discussion and integration into the thematic structure.

4.6 Data analysis

Analysis was undertaken in two stages - an analysis of all available data and then the construction of consumer profiles based on the key themes which emerged from the data.

4.6.1 Thematic analysis

The interviews and focus groups were audio-recorded, professionally transcribed, and loaded into NVivo qualitative analysis software. All interview and focus group data were coded against the research questions by one evaluator, then thematically coded by the lead evaluator using well-rehearsed conventions of thematic analysis.¹³ Another lived-experience evaluator provided a thematic analysis on a sample of consumer transcripts. The lead evaluator then synthesised the thematic coding. This ensured that at least two evaluators handled the data. There was consistent general agreement in the coding against the research questions, thematic analyses, and file review analysis. These themes were resolved through team discussion to develop the structure for the findings section of this report.

Qualitative data were processed in Microsoft Excel by Dr Maylea and presented to the evaluation team for discussion and integration into the thematic structure.

4.6.2 File review analysis

The team general practitioner (Dr Johnson) and nurse (Ms Myers) reviewed 16 files for the midterm review. For the final stage, they were joined by the team peer worker (Mx Randall) and reviewed a further 10 files. Dr Johnson, Mx Randall and Ms Myers completed relevant parts of the file review template (see Appendix 2), then met and conferred. This discussion and reports were collated by the research assistant (Ms Bubner) into summaries which, with interview and other data, informed the development of the case studies.

¹³ Virginia Braun et al., 'Thematic Analysis' in Pranee Liamputtong (ed), *Handbook of Research Methods in Health Social Sciences* (Springer Singapore, 2019) 843 <http://link.springer.com/10.1007/978-981-10-5251-4_103>.

The analysis was based on clinical best practice and relevant practice standards. Relevant standards include:

- *Australian College of Mental Health Nurses* “Standards of Practice in Mental Health Nursing” and “Mental Health Practice Standards for Nurses in Australian General Practice”
- *Royal Australian College of General Practitioners* “Guidelines for preventive activities in general practice”
- *General Practice Mental Health Standards Collaboration* “Communication between medical and mental health professionals”
- *Victorian Office of the Chief Psychiatrist* “Equally well in Victoria: Physical health framework for specialist mental health services”
- *Royal Australian and New Zealand College of Psychiatrists* “Keeping Body and Mind Together: Improving the physical health and life expectancy of people with serious mental illness”
- The principles of Intentional Peer Support:
 - Connection
 - Mutuality
 - Exploring worldview
 - Moving toward

These guidelines informed the file review process, though the specific and unique nature of the ICC programs was also acknowledged.

In the final evaluation stage, seven of the files related to ICC consumers who had not yet been exited from the program. This made it difficult to determine if some tasks, for example, appropriate referrals or screening, had been undertaken or were still planned for the future.

4.6.3 Consumer profiles

Five consumer profiles were constructed using a ‘case study’ approach.¹⁴ This approach is advantageous when there is a need to obtain an in-depth appreciation of an issue, event or phenomenon of interest in its natural, real-life context.¹⁵ The consumer profiles, provided in full in Appendix 1, have been constructed from a conglomerate of deidentified consumer experiences identified in the data. This means that all experiences in the profiles were genuinely experienced, but each profile represents the experiences of multiple consumers. These experiences have been constructed drawing on all data sources, primarily consumer interviews, file reviews, interviews with professional stakeholders and demographic data.

The consumer profiles have been developed to reflect both typical and outlier experiences reflecting maximum variation. Lived experience, clinical and academic members of the evaluation team collaborated to identify relevant experiences and reviewed all profiles to ensure integrity with the thematic analysis and respect for the participants.

The profiles have been used in this report to illustrate the consumer experience and, in the absence of statistically reliable quantitative data, indicate the potential of ICC rather than assessing its actual impact. This allows for the evaluation of the pilot programs within their context, irrespective of Victorian Government coronavirus restrictions, staff turnover and other limitations discussed below at 4.7. The

¹⁴ The terminology of ‘consumer profile’ is used here to avoid characterising consumers as ‘cases’.

¹⁵ Sarah Crowe et al., ‘The Case Study Approach’ (2011) 11(1) *BMC Medical Research Methodology* 100.

consumer profile approach allowed the evaluation team to show that, under normal conditions, ICC could improve the mental and physical health of consumers, and to highlight the barriers of context, such as coronavirus restrictions. Excerpts from the profiles are included throughout the text in red italics, and each profile is provided in full in Appendix 1.

Drawing on the results and data from each of the evaluation components, the evaluation team (comprising experts by experience, clinicians, academics and governance experts) discussed the findings, agreed on the major conclusions and developed a set of recommendations.

4.7 Limitations

This evaluation is limited by the quantity of the quantitative data collected by cohealth and Neami. The quantity of the qualitative data is a function of the number of consumers who used the ICC programs between February and October 2021. During this time, the cohealth ICC peer worker retired, and both staff in the Neami program moved to other roles. This staff turnover occurred while further funding for the ICC pilot was being negotiated with NWMPHN. The cohealth ICC program moved from an allied health team to a psychosocial team, resulting in a management change. It is important to note that these staffing and continuity of program delivery challenges are so common as to be almost the norm for small pilot projects of this type.¹⁶ Due to Victorian Government coronavirus restrictions, staff recruitment was slow, which had a flow-on impact on the capacity of ICC. Ultimately, cohealth quantitative data includes demographic data for 20 consumers, and Neami quantitative data includes demographic data for 25 consumers. With a small sample size, it is impossible to determine if trends in the data represent causal factors or are the result of random chance. Demographic data have been used where possible, acknowledging these limitations.

These staffing changes and Victorian Government coronavirus restrictions also contributed to delayed implementation of the changes to data collection recommended in the midterm review. This meant that pre/post assessment of consumers' health metrics, captured by the Health Prompt, was only implemented in August 2021. To attempt to capture data that reflected these changes, data collection was delayed from the initial capture point of May 2021 to October 2021. By the time data capture occurred in October 2021, however, only one Neami consumer, and no cohealth consumers, had completed the Health Prompt both on entry and exit. Similarly, while five cohealth consumers had completed Self-Efficacy Scale assessments, only two had completed these at both entry and exit. Only four ICC consumers had completed the Short Client Experience Questionnaire, and no Neami consumers completed the Your Experience of Service (YES) survey. This means there are no reliable quantitative indicators that can be used to assess the program's effectiveness. For this reason, the evaluation team could not implement the mixed methods approach initially planned and instead adopted the consumer profile methodology described above at 4.6.3.

These limitations are primarily consequences of external forces, i.e. the Victorian Government coronavirus restrictions. However, the programs were particularly vulnerable to these external forces due to the small size of the pilot, job insecurity for staff on short term contracts and program timeframes. It is important to note this is a persistent and widespread challenge noted by Senate, House

¹⁶ See e.g. Russell Roberts and Oliver Burmeister, *Evaluation of Marathon Health's Partners in Recovery Care Coordination Model (Specialist Support Coordination Team Program): Summary of Findings* (Charles Sturt University, 2018).

and Productivity Commission Inquiries into mental health,¹⁷ and in other evaluations conducted by members of the research team. Had cohealth and Neami implemented the data changes as planned in March, rather than August, staff turnover would still have meant there were probably not enough consumers completing the program to generate sufficient data of sufficient quality to undertake a mixed methods assessment. For complex long-term issues such as chronic mental and physical health conditions, small-scale, short-term interventions must maintain service continuity and program integrity to enable accurate statistical analysis of the quantitative data.

Even under ideal conditions, program evaluation of this nature cannot quantitatively assess the impact on the risk of chronic health conditions such as respiratory and cardiovascular disease. While studies have demonstrated the efficacy of similar care coordination models on smoking, alcohol, blood pressure and unplanned hospital admissions and emergency department presentations,¹⁸ the evaluation team are not aware of any studies of care coordination which show improved clinical health outcomes such as reduced incidence of disease or increased life expectancy. These limiting factors have implications for future pilots and program implementation and are discussed in more detail below at 5.6.

A final limitation is that the evaluation team had initially planned to undertake a comparison of the two different ICC approaches. This was not possible as there are only minor differences in the models, and, due to staff turnover, the changes in each program over the life of each program were more significant than the differences between the two programs.

4.8 Ethics

This evaluation project and data collection tools were approved by the RMIT Human Research Ethics Committee (#HREC 22853).

¹⁷ House of Representatives Select Committee on Mental Health and Suicide Prevention, *Mental Health and Suicide Prevention - Final Report* (Parliament of the Commonwealth of Australia, 2021); Senate Community Affairs References Committee Inquiry, *Accessibility and Quality of Mental Health Services in Rural and Remote Australia* (Text, Parliament of Australia, April 2019); Senate Standing Committees on Community Affairs, *Inquiry into Commonwealth Funding and Administration of Mental Health Services* (text, Commonwealth of Australia, 1 November 2011) <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2010-13/commfundmenhlth/report/index>; Productivity Commission (n 4); Royal Commission into Victoria's Mental Health System, *Final Report* <<https://finalreport.rcvmhs.vic.gov.au/download-report/>>.

¹⁸ Scott J Fitzpatrick et al., 'Coordinating Mental and Physical Health Care in Rural Australia: An Integrated Model for Primary Care Settings' (2018) 18(2) *International Journal of Integrated Care* 19 ('Coordinating Mental and Physical Health Care in Rural Australia'); David Perkins et al., 'GP Clinic: Promoting Access to Primary Health Care for Mental Health Service Clients' (2010) 18(6) *Australian Journal of Rural Health* 217 ('GP Clinic').

5 Evaluation findings

Overall, the evaluation findings are mainly positive. The data consistently indicate that the ICC model has significant potential. Overwhelmingly, consumers gave very positive appraisals, and professional stakeholders confirmed high and untapped demand. Both ICC programs were praised for providing compassion in an otherwise uncaring system. Consistently the data indicate that the ICC model has significant potential. There is evidence of enabling care and empowering people to access care, but the immaturity of the program and the issues with data collection mean the evaluation team have not been able to measure tangible health outcome benefits resulting from this enablement and empowerment.

The ICC stood out as providing a caring, compassionate and human connection in a service system where this was a rarity. Despite the challenges of a small pilot buffeted by complexity and contextual chaos, ICC was valiantly attempting to coordinate care that was simply not available. Despite this ICC became very important to people, albeit not necessarily in anticipated ways. Even within this challenging context, the majority of consumers found ICC beneficial. Systemic issues of healthcare access, particularly cost and wait times, meant that the ICC program could not consistently achieve measurable outcomes.

Were the program able to operate without coronavirus restrictions, fully staffed and integrated into a functioning mental health system, the model appears well adapted to providing support. The consumer profile analysis highlights the barriers facing success for consumers in the target cohort, while showcasing sentinel examples in which ICC overcame these barriers and had a meaningful impact on consumers' health.

Several areas require further development and consideration which cannot be attributed entirely to the difficulties of the context. These include the absence of integration with the public mental health system and the subsequent failure to provide services to those most at risk of early death and reduced quality of life. The lack of an explicit model of physical and mental health peer work made evaluating the role of the peer workers difficult. Internally program clarity seems to have improved since the midterm evaluation, but external stakeholders were still not consistently clear about the programs' aims or eligibility criteria.

Overall, the ICC pilot programs performed well in a challenging context, with all available data indicating that the model is suitable for addressing care coordination issues to improve people's physical and mental health in the target cohort.

Extracts from the consumer profiles are emphasised in *red italics*. Direct quotes from qualitative data transcripts are in *dark grey italics*.

5.1 Program context

Both ICC pilots were hampered by context. This section details the impact of Victorian Government coronavirus restrictions and the broader systemic issues of the mental and physical health systems which impacted service delivery. The changes to the programs since the midterm review are also discussed.

5.1.1 Victorian Government coronavirus restrictions

*Natalie desperately wanted to see a dentist because of pain and bleeding in her gums.
The nurse set up an appointment, but it was continually delayed due to COVID*

restrictions. It wasn't until November, several months after engaging with ICC, that Natalie was able to get her gums examined and physically go into the ICC office to have a health check-up. The nurse was finally able to discuss other preventative health screenings relevant to Natalie's demographic, like breast, bowel and cervical cancer, bone density, heart health, and diabetes.

At the time of writing, Melbourne had spent more than 260 days under coronavirus stay-at-home orders. This period coincided almost entirely with the data collection period, meaning the evaluation captured ICC working predominantly online, with people who were isolated and at increased risk of stressors on both physical and mental health. Ordinary activities, such as visiting the pool or gym, were not possible, and accessing many services was difficult or impossible. This had a profound impact on all consumers and on service provision. For example, cohealth Consumer 2 told the evaluation team that:

Through the first year of COVID I couldn't see a dentist at all, but I had a broken filling that was cutting my tongue. (cohealth Consumer 2)

For Neami Consumer 6, barriers to service due to coronavirus restrictions were disabling:

[Neami ICC Nurse] helped me a lot, greatly with the dentist. But because there was a lockdown, I was meant to have all my teeth removed because they're all not done well after having chemo. Unfortunately, because of the lockdown, it all delayed and I was meant to have dentures put in. Until now, I'm not able to eat because I haven't got – managed to finish the treatment, because of the lockdown. (Neami Consumer 6)

For service provision, the challenge was not just the restrictions but the primacy that responding to COVID-19 required in the health system:

We've been hamstrung in how we deliver our services in a way that we never have before, so it's been very difficult for us to do face-to-face services, and we've had to manage using any number of remote modalities, which with this particular cohort, obviously is extraordinarily difficult. ... We're pushing up a little bit in regards to the sector across – the way that any conversations out of COVID were always seen as being sort of secondary importance, so it's hard to build partnerships and it's hard to create those pathways; and those relationships in this context because people are distracted. So, business as usual; it's not as interesting and doesn't have the primacy as it should. (cohealth Staff 1)

Even as stay-at-home orders lifted, the remaining restrictions continued to create barriers for people:

I'd meet them at the gym, help to orientate them ... now there's a booking system, so helping them with that ... things that are probably a barrier for some people, if they don't have access to technology, or understand the process. (cohealth Stakeholder 9)

As COVID-19 vaccines became available, ICC assisted with access to vaccines:

She helped me get my vaccination, which I was really worried about, I was scared to get it done; I thought I was going to die, but I needed it done so I could go to the hospital with my daughter. So [ICC] helped me find a local doctor that was doing them, and she booked it in

for me and everything, and all I had to do was turn up with my husband, who's my carer, and I got it done; and then he got his done as well. (cohealth Consumer 5)

The upheaval wrought by the Victorian coronavirus restrictions defined 2020 and 2021 for consumers in the catchment area and defined ICC service provision. The evaluation team has attempted to account for this impact in the evaluation findings, but it is clear that ICC was not able to reach its full potential within this context.

Natalie had a lot of anxiety around getting the COVID-19 vaccine. She had seen confusing and conflicting information online and was worried it would make her [multiple sclerosis] symptoms worse. Natalie talked through these concerns with the nurse, who provided calm and clear advice around the vaccine and its benefits. Once Natalie was ready, the nurse facilitated both her and her son's vaccination appointments. Now out of lockdown, Natalie is slowly getting back to her previous pool and gym exercises. She is on a waitlist for a bulk-billing psychologist but has been warned that, because of the COVID backlog, it could be months before she's able to see someone.

In the interim, she speaks to the ICC peer worker on a semi-regular basis. Previously Natalie didn't know what a peer worker is, but now she feels grateful to know that this kind of support is available to her.

5.1.2 Systemic barriers

Further limiting ICC's potential is the state of Victoria's mental health system, exacerbated by problems with physical health provision. The Royal Commission into Victoria's Mental Health System found that 'services are often inaccessible at the times when they would make the most difference, and the system largely operates in crisis mode'.¹⁹ They also found that services are poorly integrated, and that 'people living with mental illness and other conditions such as poor physical health, disability or substance use or addiction can find it particularly difficult to gain access to services.'²⁰

Consumers who participated in the evaluation consistently noted issues of access, both due to their own situations and problems with the mental health service system:

Often I feel too shit to want to talk to anybody and there's a whole lot of baggage around how mental health – the psychiatrist that threatens to charge you \$140 if you don't turn up and that stuff. There's years of that, and my own, all kinds of angst and guilt and blame and grief around how long my stuff's gone on for and I'm still being on top of me. So I worry about the spiralling down and stuff. (Neami Consumer 1)

This has been noted by the Productivity Commission into Mental Health, which has called for all Australian Governments to implement the Equally Well Consensus Statement, particularly:

¹⁹ Royal Commission into Victoria's Mental Health System (n 17).

²⁰ Ibid.

... requiring all mental health services to screen for physical health conditions that people with mental illness are at higher risk of, and either provide or refer people to other services for early intervention and/or treatment of these conditions.²¹

The Royal Commission into Victoria's Mental Health System has also attempted to address this issue, indicating that:

... the Commission's reforms will see many general health worker roles integrate more closely with the mental health and wellbeing system to support physical health recovery and wellbeing.²²

These reforms are yet to be implemented, meaning the ICC programs operated in a context that care coordination alone could not resolve. The poorly functioning mental health system was only one side of the issue, exacerbated by a systemic lack of specialist pain management services and an absence of incentives for general practitioners to engage with people in the ICC target group. In particular, the lack of chronic pain treatment options meant people were coming to ICC who had nowhere else to go:

A perfectly understandable referral from any community-based GP would be to refer someone with that type of pain to a physiotherapist – you may as well refer them to a balloon twirler; it's totally inappropriate, there's nothing that can be done. ... there's just nowhere else for them to go. (cohealth Staff 1)

Even for people with Transport Accident Commission (TAC) funding, services often cost money:

The clients that are getting the help from TAC, they expect that they won't have to pay anything, that TAC will cover it all. But quite often, there's a gap to pay. (Neami Stakeholder 2).

For those relying entirely on the public health system, care coordination could not fill all the gaps.

5.1.3 Changes since the midterm review

The evaluation team made several recommendations in the midterm review report,²³ most of which were implemented during 2021. For example, peer supervision is now consistently available for peer workers, physical health screening tools are more appropriate, and eligibility criteria have changed to focus on prevention and early intervention. The qualitative data from the service providers reflect a sense of having 'landed' and of a mature, developed program:

I think that we've landed in a really good space with it with an enormous amount of consideration and thought had always gone into it, as it always does, but I think where we've landed now for all the players – our clients, for our structure, and for [staff] in this specific program – is really useful and really effective – significantly so. (cohealth Staff 1)

²¹ Productivity Commission (n 4).

²² Royal Commission into Victoria's Mental Health System (n 17).

²³ Chris Maylea et al., *Evaluation of Integrated Chronic Care Pilot Midterm Report* (report, RMIT University, 11 March 2021) <https://rmit.figshare.com/articles/report/Evaluation_of_Integrated_Chronic_Care_Pilot_Midterm_Report/14024183/2>.

However, as noted above at 4.7, staffing turnover and other factors meant that the changes were not made until mid-2021 and are not visible in the data collected. Despite delaying the final stage of the evaluation to allow more time for data collection, insufficient pre/post quantitative data were available to enable a statistically valid assessment of the impact of these changes.

I feel like we're in a position now where we can collect that [data], but it's still too early. So, with the health assessment, for example, what we're looking at is paired health assessments from start and finish of the program, so we can clearly see where there's screening, we can clearly see changes in activation measure, we can clearly see change in health behaviours. So, they're our three sort of things there. But that isn't there yet. The other one is around the YES surveys, and once again, I was checking that yesterday, and we've got 100 percent offering for everyone stepping out of the program and a zero percent people taking it. (Neami Staff 1)

Some recommendations were not implemented, and the issues that led to these remain present in the data collected in the final stage of the evaluation. These are primarily the lack of an explicit model of peer work adapted to physical *and* mental health (discussed at 5.3.6 and 5.4), access to the service for those most at risk of early death (discussed at 5.2) and mechanisms to strengthen coordination with NorthWestern Mental Health (discussed at 5.5.1). Other issues identified at the midterm review appear to have been largely resolved, including internal program clarity and duplication of National Disability Insurance Scheme access services. In particular, improved screening processes (discussed at 5.4.1) and aligned data collection processes (discussed at 4.7) have been implemented, although there has been insufficient time to measure their impact reliably.

Since the midterm review the cohealth ICC program has shifted within cohealth, from the allied health team to the psychosocial team which includes cohealth's Psychosocial Support Service (PSS). This appears to have been very beneficial, with streamlined intake and referral processes, changes to supervision and professional support. This has implications for future programs as discussed at 5.6.1.

The contract between the services and NWMPHN was revised to better to reflect the evolving nature of the pilot. Primarily, this reflects a shift toward prevention by changing the ICC eligibility criteria to include those 'at risk' of one or more physical chronic conditions. 'At risk' is not clearly defined but is assessed based on the likely presence of severe mental health issues, physical health risk factors, health behaviours, literacy and behavioural activation as indicated by the screening tool, and an openness to improve health expressed by the consumer.

The contract still stipulates three types of support packages, brief, moderate and comprehensive, but does not indicate specific targets for each category. Instead, the target is for a minimum of 60 clients to have their care coordinated per year and to maintain a total number of active consumers of no less than 24 eligible consumers.

5.2 Consumer cohort

Demographic program data is generally consistent with expectations. As discussed above at 4.7 data was only provided for 20 cohealth consumers and 25 Neami consumers for the period February to October 2021. Neami worked with 18 female, 5 male and 2 non-binary consumers (cohealth gender data were not provided). This gender breakdown reflects broader trends in which men engage in healthcare less than women, but should be addressed in future programs as men are at higher risk of

early death (Recommendation 2.a). cohealth consumers ages ranged from 23 to 79 (av. 49), while Neami consumers ages ranged from 19 to 62 (av. 41). This reflects a broad population coverage.

Samir is a 60-year-old male and lives in Deer Park. He came to Australia as a refugee 5 years ago. Shortly after arriving, Samir got his license and began working as a taxi driver. Things were going well for him until he was in a car accident and badly injured his back. Samir got compensation from TAC and started receiving Centrelink, but his Centrelink payments were reduced after he gambled using his TAC funds. Samir was stuck. He couldn't work due to his chronic back pain, and he couldn't afford the pain medication he needed because of his low-income. After the accident he wasn't able to drive anymore, which made it difficult for him to get to appointments. His English was limited, and he began to feel increasingly isolated. One day Samir self-harmed and was taken to hospital. When he was discharged, he spoke to his GP about the issues he was having, and the GP referred him to ICC.

Of 25 Neami consumers, only 2 identified as Aboriginal, while none of the 20 cohealth 2021 cohort of consumers identified as Aboriginal. This is not necessarily a cause for concern, as both catchment areas are well served by the Victorian Aboriginal Health Service, which provides a comprehensive health service, the NWMPHN funded *Indigenous Australians' Health Program – Integrated Team Care*, and cohealth's own *Aboriginal and Torres Strait Islander Access and Support Program*. Given the complex interplay between mental and physical health, culture and colonisation, it appears that these specialist care coordination services are likely more appropriate for Aboriginal and Torres Strait Islander people. Even if this were not the case, as only 0.4-0.5% of the catchment identify as Aboriginal, a random sample of 20 people in the catchment would not be expected to include any people who identified as Aboriginal. Further research is required to understand best practice physical health care coordination models for Aboriginal and Torres Strait Islander people who use mental health services.

In contrast to the situation for Aboriginal and Torres Strait Islander people, for people born overseas, particularly those who use interpreters, there are no alternative specialist mental and physical healthcare coordination services. For cohealth consumers, 20% of clients used an interpreter, while 60%

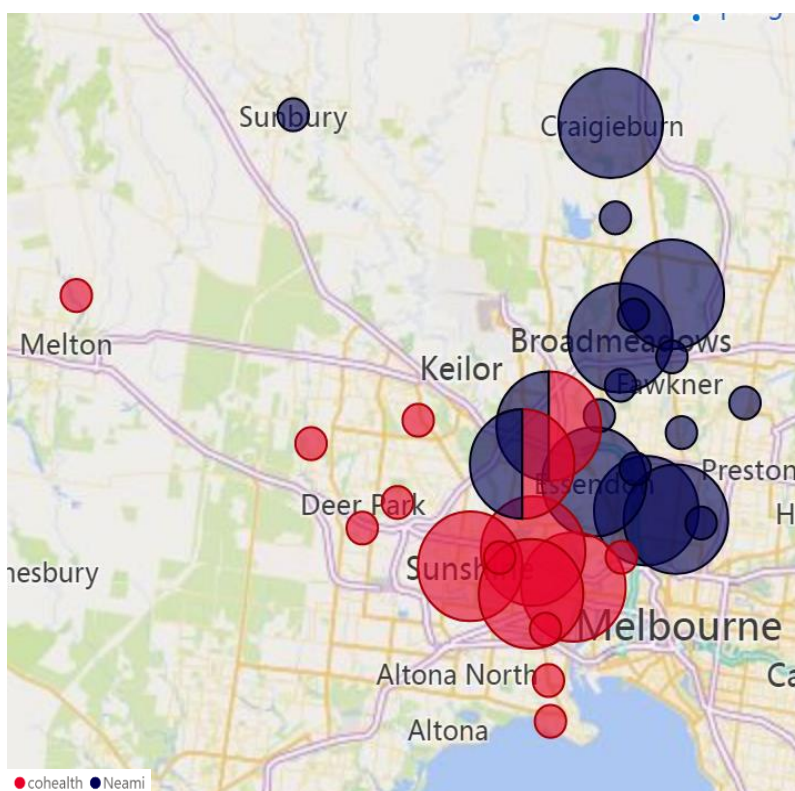


Figure 2 - Consumers' locations

were born overseas. For Neami consumers, 8% used an interpreter, while 28% were born overseas. In the catchment area, roughly 45% of people were born overseas, and the same proportion does not speak English at home. With the available data, it appears cohealth is receiving referrals that reflect the catchment's diversity, but that Neami may need to develop strategies to address this (Recommendation 2.b).

Eligible Neami consumers live in Hume, Moonee Valley and Moreland LGAs with cohealth consumers from Brimbank and Maribyrnong LGAs. Figure 2 shows consumers' locations, with larger circles indicating more consumers from those suburbs. This data suggests that both programs are accessible to people across their respective catchment areas, generally reflecting population density.

5.2.1 Diagnoses

Multimorbidity for physical health diagnosis was high, with an average of 2.3 (cohealth) and 2.5 (Neami) physical health diagnoses per person. Mental health multimorbidity was also high, with 2.3 (cohealth) and 3.6 (Neami) mental health diagnoses per person.

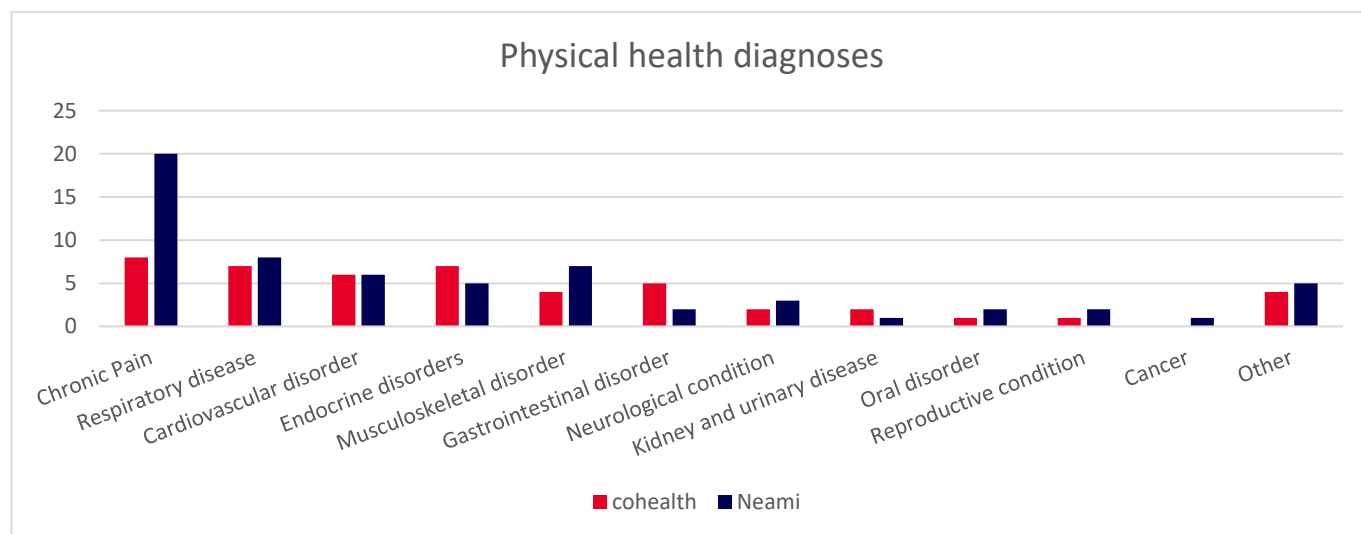


Figure 3 - Physical health diagnoses

As at the midterm review, a diagnosis of chronic pain was most common for both programs, but more so for Neami. This likely reflects a lack of specialist chronic pain services and effective treatments available, as noted above at 5.1.2.

Natalie is 55 years old. She is female and lives with her adult son in a small unit in Broadmeadows. Natalie was diagnosed with multiple sclerosis (MS) in her late 30s and experiences chronic pain in her back and legs. During the 2021 COVID lockdown, Natalie's pain was exacerbated because she couldn't do her usual exercises like pool and gym therapy that helped manage the symptoms. Natalie began feeling deeply depressed. One day she called Beyond Blue for support, and they gave her the contact number for her local PSS.

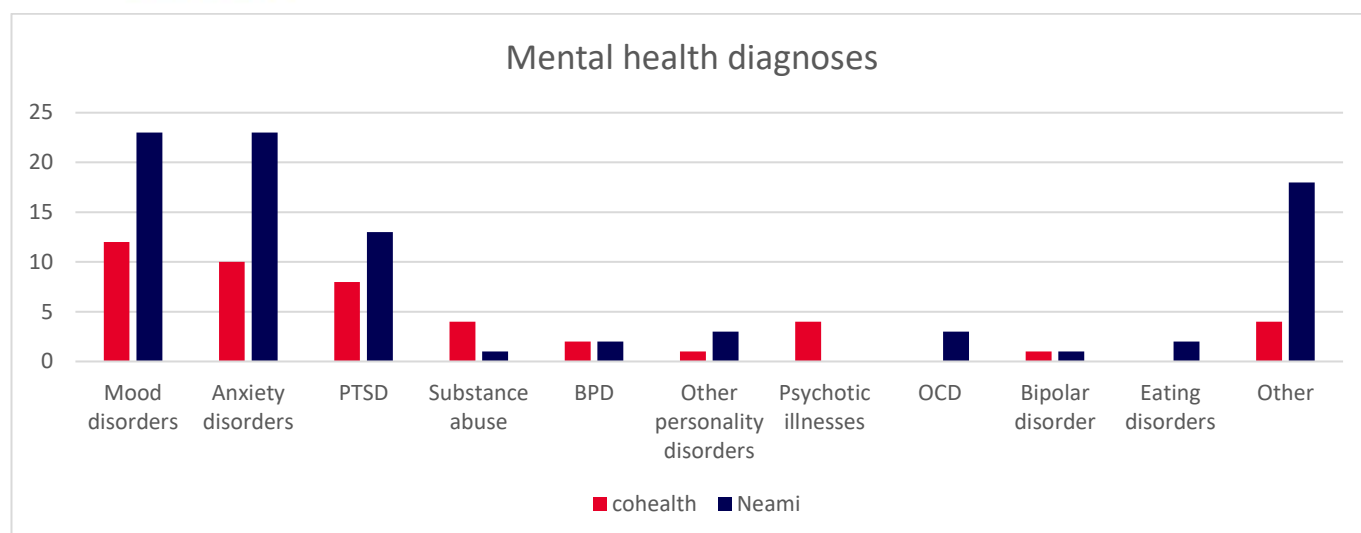


Figure 4 - Mental health diagnoses

These data indicate that while both programs are working with eligible people, neither program is working with those most at risk of early death from preventable physical health conditions. ICC appears to be working with a broad spectrum that generally reflects those who experience increased morbidity and mortality in people using Medicare Benefits Schedule (MBS) mental health services and Pharmaceutical Benefits Scheme (PBS) mental health-related prescriptions,²⁴ but not those most at risk who are using public mental health services.²⁵ This group of people still experience increased morbidity and early mortality, dying 10 to 12 years earlier than the average population, but not to the same extent as people using public mental health services, who die 20 to 30 years earlier than the average population. The larger group is much larger, constituting around 10% of 25-54 year olds, while around 1% of Victorians use a public mental health service in a given year. As discussed below at 5.6.4, it may be that ICC is best positioned to provide access for this larger group, given the system's inability to address the breadth and depth of resources required for those facing highest levels of complexity and disadvantage.

People diagnosed with a psychotic illness are at very high risk of early death from physical health conditions.²⁶ cohealth has four consumers with this diagnosis recorded in the data provided, and Neami has none. While cancer is the third-highest contributor to early death for people using public mental health services in the catchment²⁷ and a major cause of premature death for the Australian population overall, only one Neami consumer recorded in the data provided had a cancer diagnosis, and cohealth had none. This may reflect the greatly reduced life expectancy of people with a cancer diagnosis or simply be an aberration in the data. In addition, the number of people in the pilot with cancer is less important than the number of people in the pilot with a very high risk of developing cancer. The file audits show that increased screening for cancer risks is occurring, but screening does not always result in clinical follow-up (Recommendation 1).

²⁴ Australian Bureau of Statistics, 4329.0.00.006 - *Mortality of People Using Mental Health Services and Prescription Medications, Analysis of 2011 Data* (Australian Bureau of Statistics, 8 September 2017).

²⁵ Suggett et al. (n 5).

²⁶ Ibid.

²⁷ Ibid.

Remmy is 34. They are non-binary and live alone in Coburg. Remmy has been engaged with psychiatric services since they were a teenager and has been admitted twice to a NorthWestern Mental Health (NWMH) inpatient unit. Despite repeated requests, Remmy's GP didn't use their preferred pronouns. Already deeply distrustful of health professionals, Remmy disengaged from the GP's clinic. Remmy mentioned this to their private psychiatrist, who then referred them to PSS. PSS then referred Remmy to ICC for support engaging with a new GP.

The data indicate that some service provision is to those at greatest risk of early mortality, as the leading causes of early death for public mental health service users in the catchment are cardiovascular disease and respiratory conditions, both of which are represented in the ICC consumer data. Despite this, the absence of psychotic illness and cancer diagnoses in the data potentially indicates significant service provision gaps (Recommendation 2.c).

These data must be understood in the context of an appropriate and intentional shift in both programs to a preventative approach, with the broadening of the admissions criteria to include those 'at risk' of developing chronic health conditions. As noted above at 5.1.3, the eligibility criteria for ICC shifted to include those 'at risk', making it more difficult to determine if the programs are reaching their target group for physical health. Leila's consumer profile exemplifies this group, where there are multiple indicators for increased risk, but no chronic physical health condition.

Leila is 41 years old. She is female and lives in Footscray with her partner. Leila was engaged with a community mental health service for support with generalised anxiety disorder. They referred her to a local health clinic for general physical health support. The Primary Health nurse at the clinic then made an internal referral to the ICC program for care coordination. She initially engaged with the ICC nurse and peer worker through health screenings and regular phone calls, and was then invited to join their 12-week group program. Leila was hesitant about this. Her fluctuating anxiety sometimes made it difficult for her to leave the house and she was also dealing with physical health problems due to long-term smoking and weight gain from antidepressants. She had gained 45 kilos since starting Lexapro six months ago. Leila felt like the extra weight dragged her down, making everything she did feel like more effort.

The lack of a clear definition of the target group, particularly what constitutes a 'serious' condition, appears to have resulted in ICC providing service to a population that is broadly representative of people using mental health services rather than those most at risk of early death. This is an important consideration for future service development, as this broader population appear more likely to benefit from care coordination and may be better suited to ICC's model.

5.3 Program narrative

The ICC programs appear to be implemented as intended. This section describes the overall consumer experience, characterised by care and compassion. The program elements are then described, focusing

on the consumer experience, providing compassionate care, supporting system navigation and care coordination, and developing health coaching and literacy. Some casework and support work is being provided. Finally, peer support is discussed.

5.3.1 The consumer experience

After the group sessions the peer worker would check in with her and Leila appreciated these conversations. The peer worker seemed to have a genuine interest in her interests, values and priorities, taking the time to explore Leila's world view and history. Leila always felt supported and respected, and that she was in the driver's seat when it came to making decisions about her medication and healthcare. The peer worker also supported Leila to reflect on her goals around education, employment and social connections, facilitating a holistic approach to her health.

All consumers interviewed identified positive experiences. For example:

I've only got positive things to say about the program. It's linked me into different services that I wouldn't have been able to link myself into, or didn't have the courage, or didn't have the right words to join. (cohealth Consumer 5)

Sometimes these positive experiences could be linked to tangible outcomes, discussed below at 5.4. Often, however, they were more of a 'vibe', as for Neami Consumer 1:

I get huge amounts of demoralisation and grief around – and anxiety and guilt potentially, or shame around managing and not managing my health issues. So basically, it was really – it was good for that, but the best thing – so that was the vibe I was getting off – from [Neami ICC Nurse]. I just really loved [Neami ICC Nurse]'s vibe, that – I don't know – on the ground nurse vibe. with the peer worker... I really felt like these are my people in the health system. (Neami Consumer 1)


This was reflected by cohealth Consumer 2:

There was lots of positive energy in the room, ... it was the first time I'd actually got to meet them in person, which was for me extremely fabulous because they'd been so amazing on the phone separately; and they provided nutritious snacks and food. ... I found their energy and set up and everything very – it was just positive, this light-filled room. (cohealth Consumer 2)

Despite a lack of physical health indices, cohealth Consumer 2 attributed ICC to assisting with their very survival:

I don't know, without cohealth and the like, so many of us would not have made it this far. (cohealth Consumer 2)

As noted above at 5.1.2, a lack of available options to coordinate for people meant that ICC were not always successful. For many consumers their stressors were too great to be resolved through care coordination alone:



They tried a lot to help me by talking to me. That lessened the burden. But the thing is, when you live in problems always, like for example, I've got problems with my husband, so I mean, it feels good to go out and talk, but then you always come back to the same problems. So, the breather was just in the going and talking to them, but then the problems hasn't finished. (Neami Consumer 6)

This overall positive experience is at odds with the lack of tangible outcomes identifiable in the data, but appears largely the result of the caring and compassionate service delivery consumers received.

The nurse and peer worker at ICC worked with Remmy to determine their priorities and connect them with an appropriate GP. This was difficult at times, because Remmy could be hard to contact and often missed appointments. One day Remmy mentioned that they found phone calls anxiety-provoking and preferred text messages. The ICC team noted this in their file, and started using text messages as the main communication method with Remmy. From that point onwards, communication between Remmy and the ICC team was much easier.

5.3.2 Care and compassion

The ICC nurse managed to find a suitable GP and organised regular case conferences over Zoom for everyone to meet and discuss Remmy's goals and care plan. Halfway through the first meeting, Remmy burst into tears. Alarmed, everyone stopped to console them and find out what was wrong. Wiping away tears, Remmy said "I've never felt this cared for in my life." Slowly, through these meetings, Remmy began to trust that the GP had their best interests at heart and became more receptive to the GP's suggestions.

Consumers consistently identified that their primary experience was one of being listened to and cared for. This is the element of ICC from which all its success flows. cohealth Consumer 1 was characteristic in this:

Like, sometimes she rings me, and we'll have a 40-minute conversation just about living – what I do and keeping busy and whatever – and she talks to me like a friend, not like she's a nurse or whatever. So although I haven't met [cohealth ICC Nurse] in person, I thought that I know her; I'm connected to her. (cohealth Consumer 1)

Even consumers who found little tangible support from the program noted the compassionate way in which they were provided with options:

I found her really good and really approachable, really helpful for everything – she's listened to you and she just trying her best. I don't know the programme that allows her to go beyond that – because there's no other options available for her to help me. (Neami Consumer 2)

Although consumers were explicitly not able to achieve their goals, such as cohealth Consumer 4's desire to stop taking antidepressants, consumers still appreciated the human connection:

I've tried to get off my antidepressants, but I just can't do it. ... So definitely, especially since we've been in lockdown, them ringing me has just been wonderful. (cohealth Consumer 4)

Consistently, when consumers were asked to point to tangible improvements to their mental and physical health, they instead referred to the care and compassion they experienced as valuable. This reflects the issues discussed above at 5.1.2, in that caring and compassionate service delivery is experienced as rare and valuable even without tangible outcomes. Empathetic practice has, in any case, been shown to not only improve satisfaction but also assist with the management of chronic health conditions and to improve clinical outcomes.²⁸ In mental healthcare it is well established that fostering hope is a central component of recovery.²⁹

5.3.3 System navigation and care coordination

By this point, Olivia had been a mental and physical healthcare consumer for many years. She had a high level of health literacy and, for the most part, self-managed her and her family's healthcare. However, working with ICC, the PSS and now NDIS for her two children, she began to feel overwhelmed by the number of people and appointments she had to keep track of. Sometimes she wasn't even sure what the difference was between ICC and the PSS, as they seemed to do similar things. At one point, Olivia was liaising between the nurse at ICC, her social worker at Anglicare, the Autism Services team for her children and the Brotherhood of St Laurance for NDIS support coordination. She was also in regular contact with a family violence worker, lawyers at a community legal centre and Child Protection. It was a never-ending, exhausting whirlwind of phone calls, filling in forms and travelling to and from appointments. While she appreciated the support, she didn't know how she was going to sustain this level of engagement with so many services.

Both ICC programs provided system navigation and care coordination. This included identifying appropriate referrals then facilitating what was required. Consumers described this as 'basic stuff' or 'little things':

That was the basic stuff I just needed, because the ICC program wasn't the mental health support. It was the coordination. (Neami Consumer 1)

And:

²⁸ Frans Derksen, Joziën Bensing and Antoine Lagro-Janssen, 'Effectiveness of Empathy in General Practice: A Systematic Review' (2013) 63(606) *The British Journal of General Practice* e76.

²⁹ Beate Schrank et al., 'Determinants, Self-Management Strategies and Interventions for Hope in People with Mental Disorders: Systematic Search and Narrative Review' (2012) 74(4) *Social Science & Medicine* (1982) 554 ('Determinants, Self-Management Strategies and Interventions for Hope in People with Mental Disorders').

She has done things like called a pathology clinic to see if there's anything special I need to do for a specific blood test and, yes, the little things like that to support me that take time out of my day. (Neami Consumer 5)

These 'little things' were highly valued and included assistance filling out forms for a rehabilitation program or referring back to a prescribing psychiatrist for a medication review. It is not difficult to see how ensuring a person's blood test was able to occur or that a medication review was conducted could make a substantial difference to their health, albeit those long term impacts are difficult to quantify precisely.

The care coordination role was also highly valued by stakeholders, such as this practice nurse:

It's just great to have that person liaising on the doctor's behalf, on my behalf, and have the time to spend, and looking at holistic health, I guess is what the word is, with that patient, and making sure other services, that they're linked into. Yeah, I think it's really beneficial. (cohealth Stakeholder 4)

Care coordination was restrained by the limits of the healthcare system, which was ill-equipped to respond to the complex and varied needs identified by ICC consumers. Neami Consumer 4 did not have a Health Care Card and so was not eligible for many no-fee services, but could not afford fee-paying services, making care coordination difficult:

I just think that it was the wrong service for me. ... What I was looking for was access to physios and to mental health professionals that I could afford. But that's not really, I guess, what the program does. (Neami Consumer 4)

5.3.4 Health coaching

The ICC team would call Natalie once a week, alternating between the nurse and the peer worker. Even before the COVID lockdown, Natalie was socially isolated, so she found these phone calls comforting, knowing that every week on a Wednesday at 4pm she would hear from someone. The nurse and peer worker sent Natalie many online resources, like links to Ted Talks about managing chronic pain, YouTube exercise tutorials, and websites with information on portion size and nutrition.

ICC is providing health coaching, both one on one and in organised groups. For example, cohealth Consumer 1 was provided with an app to help quit smoking:

She gave me this app about smokers, and how you can stop the smoking, and how you reduce it down slowly. I gave it a crack, I done well, but I don't know how, after a month I went back to it. (cohealth Consumer 1)

Another consumer was given an app to assist with exercises:

That has all my exercises in it, it tells me when to do them and how to do them; there's videos and good descriptions on what, and how it should feel. ... then we spoke again maybe

two weeks ago, and we changed my exercises to something a little bit more challenging, which was really good. (cohealth Consumer 5)

Much of the health coaching was less tangible, aimed at building confidence or just creating links with services:

If we can see an increase in things like hope and empowerment – reports of hope and empowerment from consumers and we can see an increase in engagement, then I feel like that gives us enough to go “OK, we’re headed in the right direction.” (Neami Staff 1)

5.3.5 Health literacy

To her surprise, Leila found the group sessions to be both enjoyable and helpful. She appreciated the opportunity to share her experiences and find solidarity with the other group members. The content was useful too, providing information on diet, exercise, the benefits of meditation and mindfulness, and how to access NDIS and other support services.

ICC provide health education, aimed at improving health literacy, with the long-term intention of equipping consumers to navigate the healthcare system with more confidence. This is provided both through organised support groups and one to one education. Some consumers identified that this was helpful, even lifesaving:

[The group] was mainly focused on like, just general knowledge about everything, about our health, they got all these speakers, like dietitians, what’s it called? Occupational therapist, physio, stuff like that. And, just tried to get you active and helps with your wellbeing, stuff that’s really helpful for a person’s general knowledge, to how to live life. (cohealth Consumer 1)

There are also limits to what health literacy can achieve, as Neami Consumer 4 noted. As noted above at 5.3.3, they could not access services they couldn’t afford, so health education was not useful:

My medical literacy and mental health literacy [is good]. [ICC] just was all... pitched below my level of understanding, especially with the chronic pain group. It was a lot of mindfulness and I've done all of that before. (Neami Consumer 4)

5.3.6 Casework and support work

Samir began working with the ICC nurse. She arranged interpreting services and assisted him with a range of practical things, like calling his utility services and advocating on his behalf to have a payment plan, even bringing food to his house. The nurse organised transportation to and from appointments.

In addition to health care coordination, much of the ICC work is related to getting consumers to a point where it is possible to focus on their health care, particularly physical health care. Many consumers would come to ICC in crisis:

You do end up doing quite a bit of support work with people, because something that's almost a crisis comes up – you've got to help them; you're not going to focus on health goals that week if they're almost homeless. (Neami Staff 3)

Often, consumers would present to ICC for a health referral, only for the ICC staff to identify underlying barriers. This example of a consumer with diabetes initially appeared to be a problem with access to food and ultimately turned out to be a lack of cooking skills:

I have a client at the moment who – she's got complex PTSD and intellectual disability, and she's been seeing the dietician and the diabetes nurse – she cannot retain the information, so they've started bringing her son into the appointments, but the problem is that he probably has some of those similar issues. And they've understood the instruction of, "Go to the foodbanks and get the food parcels. You need to be doing that instead of going to the drive-thru." So they're going to maybe four foodbanks a week picking up food parcels, bringing it home, but they don't actually have those skills to work out how to cook rice, or what would you put with rice. So, it's the follow through of that whole process of looking at somebody as a whole. (cohealth Staff 2)

5.3.7 Peer support

The peer support element of ICC has been the most difficult to evaluate. The evaluation team are unaware of evaluations of any other similar programs that operate in a mental and physical health context, meaning there is no established model of best practice.³⁰ There is a broad and deep evidence base for peer work in mental health³¹ and an evidence base for specific physical health peer support, such as diabetes,³² but very little evidence to help shape an approach suitable for a broad mental *and* physical health context.

In addition, both ICC programs were without peer workers at key periods of the evaluation. Both cohealth and Neami have implemented changes to better support the peer workers since the midterm review, including increased support and supervision, development of communities of practice and clearer delineation of roles between the peer workers and nurse. Neami has a long history of employing mental health peer workers, and cohealth has, more recently, invested a significant effort in increasing its peer roles, including a peer cadet program.

³⁰ Research in this area is developing. For example, Neami, in partnership with the University of Wollongong, are attempting to build an evidence base for Peer Health Coaching: <https://www.neaminational.org.au/what-we-do/research-and-evaluation/projects/health-prompt-review-2/> Preliminary findings from this study show changes in health behaviours such as exercise and diet, but long term results have not yet been established.

³¹ Janet Meagher, *Peer Work in Australia: A New Future for Mental Health* (Flourish Australia, 2018).

³² Edwin B Fisher et al., 'Contributions of Peer Support to Health, Health Care, and Prevention: Papers from Peers for Progress' (2015) 13(Suppl 1) *The Annals of Family Medicine* S2 ('Contributions of Peer Support to Health, Health Care, and Prevention').

Consumers who were aware that they had worked with a peer worker did value the interaction. These echo the well-established evidence base for peer work in mental health settings, and it appears similar benefits may be applicable in the physical health context:

"How are you doing? What are you going through?" and, "I know what you're going through, so let's have a chat about that." And I found it really helpful to do that because at the time, I didn't have anybody I could speak to who knew what I was going through or could help in any way. I think they just helped by allowing me to speak and be heard by somebody else without feeling judged or feeling like a weirdo or etc. (Neami Consumer 4)

Stakeholders who had worked with peer workers echoed this positive appraisal:

"Let's have more peer support workers." ... I just think that shared experience, that lived experience is really important and yes, some health – or different allied health professionals will have that, but it's not necessarily a hat or a badge that we can put on when we work with clients, whereas the peer worker really can offer that deeper level of support if that's what people do need. (cohealth Stakeholder 10)

This experience was not universal, however, with professional stakeholders commonly misunderstanding the peer work role:

Evaluator: What's your understanding of the role of the peer worker?
cohealth Stakeholder 5: Basically, as a day-to-day support person for the client.

Neami Stakeholder 3 encapsulated this sentiment, as they expressed full support for the principle of peer work but were unable to say if it had been implemented in ICC:

Neami Stakeholder 3: I think lived experience is really important when considering particularly peer support workers, and obviously, but also for complicated referrals between different types of health services. It is often helpful to have people who have had experience – lived experience themselves, but also the empathy to understand how really challenging it is to be someone who is – or to care for someone who is chronically unwell. I don't think it's essential for all the roles, but I think it would be incredibly beneficial.

Evaluator: In your interaction with the program so far, are you aware of whether they explicitly implement any of those principles?

Neami Stakeholder 3: I have no idea.

Consumers echoed this lack of clarity:

It was jointly run just between [cohealth Nurse] and [cohealth Peer Worker]; they both shared the same role and conducted it together in unison, I guess. So [cohealth Peer Worker]'s a mental health professional, she has a lived experience, and she's been like a mental health worker or – I don't know what the right title is, to be honest. (cohealth Consumer 2)

Other consumers were not aware they had worked with a peer worker, were not offered a peer worker or were not even aware that peer workers were available:

Well, this program, you introduced me – you're talking about peer workers and group sessions, and can I ask for all that or should that be offered to me? (cohealth Consumer 4)

Neami Consumer 2 was aware of the Neami peer worker when referred to by name, but had no knowledge of peer work or the role of the peer worker:

Evaluator: Speaking of lived experience, did [Neami Nurse] ever mention the peer worker in the programme?

Neami Consumer 2: What, peer work?

Evaluator: Peer worker – did anyone ever talk about a peer worker that's available?

Neami Consumer 2: ... I don't know what it is.

There are a number of potential reasons for this, including the staffing change for the peer workers in both programs. It is also important to note that this is not a reflection on any single peer worker, but on the absence of a model of peer work and on the small size of the pilot, as discussed at 5.6.3. However, the issues highlighted in the interview data were strongly reinforced in the file review analysis, in which peer support worker engagement ranged from extensive to non-existent. When it was present, the International Peer Support Principles could sometimes be identified in the use of consumer-led goals and peer support worker's notes written in the consumer's own language. At times, the files documented how peer support workers encouraged reflection of values and priorities and supported goals peripheral to physical health. At other times, the files indicate that the peer support workers took on what was essentially a case management role. This was especially evident at Neami during the period when ICC was between nurses.

Ultimately, the staff turnover in the peer work roles combined with an absence of a clear model of peer work adapted to physical health makes the peer work element of ICC difficult to evaluate (Recommendation 6). Where it worked well, it appears to have significant potential, but further research is required to determine models of best practice (Recommendation 7).

Meanwhile, the ICC nurse used brokerage funding to buy Leila a gym membership and some new runners. A physiotherapist organised by ICC accompanied Leila to the gym on several occasions, showing her how to use the equipment and designing an exercise regime together. After starting the exercise regime, and a couple of consultations with a dietician organised by ICC, Leila found her mood improving and her energy increasing. For the first time in a long time, Leila felt optimistic about her future, and more comfortable in her weight. Her engagement with the peer worker had been particularly transformative, and she decided she wanted to support others the same way. After she exited from the ICC program, Leila enrolled in a Certificate IV in Mental Health Peer Work and is now working towards becoming a qualified peer support worker.

5.4 Outcomes

Insufficient data was provided to validly assess changes either in physical health indicators or physical health outcomes. One stakeholder, a dietitian, did indicate they had seen a change in physical health indicators:

For the people I've seen one-on-one, being able to get their pathology. So I can say, "Your average blood sugar levels have started to come down," or, "Your cholesterol level has dropped. That's really good." (cohealth Stakeholder 10)

This was the only example of this, and this stakeholder could not indicate how widespread or long-lasting these changes were. No other stakeholder indicated that these sorts of changes were occurring. This is not unexpected, given the long term and ongoing conditions that ICC is targeting:

With a lot of my caseload, everyone has really long term, chronic health conditions, so it's not about outcomes. You may get a very slight improvement on your chronic fatigue syndrome symptoms, but it's not like you're going to suddenly –after 6 months your chronic fatigue will go away, you know? (Neami Staff 5)

This was also reflected in the consumer participant data:

Look, to be honest, my physical health hasn't changed much. Sometimes I cry. Sometimes I pray. It hasn't changed much. I don't know what to do. (Neami Consumer 6)

Rather than focus on significant life changes, the ICC model understands that small changes can have long term positive effects while acknowledging that these are difficult to measure:

Very small things can be big wins with our clients. So there might only be minor things that happen that they take control over, but it's a big deal. And even just the fact that it might just be that they get linked in with services that can help them on an ongoing basis. (cohealth Stakeholder 5)

As noted below at 5.3.6, often consumers' health outcomes were blocked by other factors in their lives. For example:

I've just begun therapy... with a family violence counsellor, so just the idea that a group therapy would allow people to enter an independent management of their own health issues is a bit of a stretch in my estimation. (cohealth Consumer 2)

This was also recognised by ICC staff:

[I'm] not seeing any changes in this person's diet or any of their chronic disease indicators; their bloods are staying the same. And then it's when you go into their home and you're like, "Oh, they're a hoarder; there was no space to do the food prep." That's what was going on. (cohealth Staff 2)

The data do indicate other, non-health-related outcomes, which reflect the holistic approach to care taken by the ICC programs. For example, cohealth Consumer 1 attributed their experience with ICC to their decision to study to become a peer worker:

I am where I am today, I suppose, thanks to their help and encouragement. Like, I'm doing a Cert IV Mental Health, can you believe it? Me! Who would think me, out of all people? Yes, it's been good. (cohealth Consumer 1)

Despite the difficulty in both achieving and then measuring changes in health outcomes, there are some outputs that are clearly present in the data, particularly increased screening.

5.4.1 Increased screening

The ICC nurse was finally able to discuss other preventative health screenings relevant to Natalie's demographic, like breast, bowel and cervical cancer, bone density, heart health, and diabetes. Not all of these screenings were conducted, however Natalie had the information she needed to make decisions about which screenings to prioritise.

Much of the decreased life expectancy associated with people who use mental health services is attributed to reduced screening caused by diagnostic overshadowing, where a person's mental health diagnosis becomes the focus of their health care provision.³³ It appears that ICC is contributing to addressing this issue by increasing clinical screening:

[I] had several female clients getting breast exams and mammograms that just wasn't previously accessible to them before, partly because of English as a second language, and health literacy, not understanding how to access the services, but also I think not being aware of the need for preventative checks and things like that. (cohealth Stakeholder 7)

This is largely focused on through the Health Prompt, a tool that is used to develop a plan based on a combination of best practice clinical screening and the priorities identified by the consumer.

The general reflection on the Health Prompt is really good. So, I'm not hearing complaints either from consumers, through to staff, or from the staff being like "this is a clunky tool to use," or "this isn't appropriate," or similar kind of reflections, which is really helpful. I think, it speaks better as well, into the goal directive care plan. Almost anything that's ticked as a no, that needs follow-up, can then potentially be something that is naturally turning into a goal. (Neami Staff 2)

The Health Prompt is not always ideal in all cases, and sometimes a different approach is required:

I've tried to use the Health Prompt in initial assessments, and sometimes it works; sometimes people are really ready to just be like, "Yes, these are the things. I've got enough health literacy to tell you what this stuff means, and I can use a Likert scale and grade how well my relationship is with my GP," but some people just haven't got that skill, and you're never going to get anywhere. (cohealth Staff 2)

In any case, inasmuch as increased screening is, in itself, an outcome, ICC is achieving this outcome. There are still improvements to be made to the screening process, particularly in documenting risks of

³³ Morgan et al. (n 2).

physical health. For example, none of the files reviewed included documentation of family medical history, while other files noted risk factors but did not document any follow-up screening, while evidence of age-specific screening tools such as HEADSS was not recorded (Recommendation 1).

5.4.2 Less tangible outcomes

Many consumers noted changes that are difficult to quantify but nevertheless have significant potential to contribute to improved health outcomes. For example, cohealth Consumer 5 indicated a changing relationship to diet and to their mental health:

I'm less anxious about foods and diet now that I've spoken to professional people. I'm less anxious about my voice hearing because I've been in contact with people who are also voice hearers, and they've also sent me links to TED Talks. (cohealth Consumer 5)

Professional stakeholders reported improved relationships with clear potential to contribute to improved health outcomes:

It's really brought about a change in her attitude. She's now more cooperative with me. She knows we talk about her. We've actually almost completed the NDIS application. (cohealth Stakeholder 1)

Other stakeholders indicated that service linkages had improved:

I think it was really successful at helping people get better linked into already existing services instead of some programmes that try to reinvent the wheel or add new things on, it seemed to just be really utilising existing programmes but helping get people connected more directly and addressing barriers that were in place. (cohealth Stakeholder 7)

Perhaps the most nebulous outcomes identified related to improved self-understanding. This is different to health literacy and is more akin to reflexivity or reflective skills. Neami Stakeholder 10 suggested ICC was helping people understand themselves better:

It was more understanding a bit more about their social history and their background, and their specific health conditions and their specific eating behaviours and patterns, and what influences or changes that. ... It might be, "Oh, I have diabetes. I want to manage my sugar levels well, but my mental health might get in the way," or, "I'm not motivated to make those changes." (cohealth Stakeholder 10)

This example of a person whose outcome is an understanding that they are not motivated to make changes neatly captures the very small steps required to enact lasting change in this area. This correlates with other evidence that ICC is employing motivational interviewing as an evidenced-based approach to encouraging behaviour change. For that consumer, understanding that they are not ready to tackle a certain issue might mean they are able to focus on other issues or simply experience less disabling anxiety. These less tangible outcomes are crucial steps to achieving the long term goals of improved measurable health outcomes.

Olivia always prioritised her children and, at the very least, was grateful to have the ICC nurse remind her not to neglect her own needs. The nurse also ran tests to check

her blood sugar, cholesterol, iron levels, and her kidney, liver and thyroid health. Olivia spoke on the phone a few times to the peer worker, but really felt that it would be better to have those conversations in person. After six months of working with ICC, Olivia exited from the program. This decision was made in consultation with the nurse, and Olivia was confident that she had enough supports in place going forward.

5.5 Specific considerations

This section addresses two key issues which emerged from the analysis; integration with service networks and the program staffing profile.

5.5.1 Integration with service networks

Figure 5 shows that most cohealth referrals are internal, with cohealth referrals from other cohealth allied health or medical services, and most Neami referrals coming internally from Neami's Psychosocial Support Service (PSS). The very small number of referrals from the public mental health service, NorthWestern Mental Health (NWMH), is a cause for concern. It should also be noted that consumers accessing primary care through other clinics may have inadvertently missed out on ICC.

Figure 5 also shows that the majority of referrals out of both programs are for physical health issues, including primary healthcare, with a diverse range of services included in the 'Other' category, including family violence, housing and disability services.

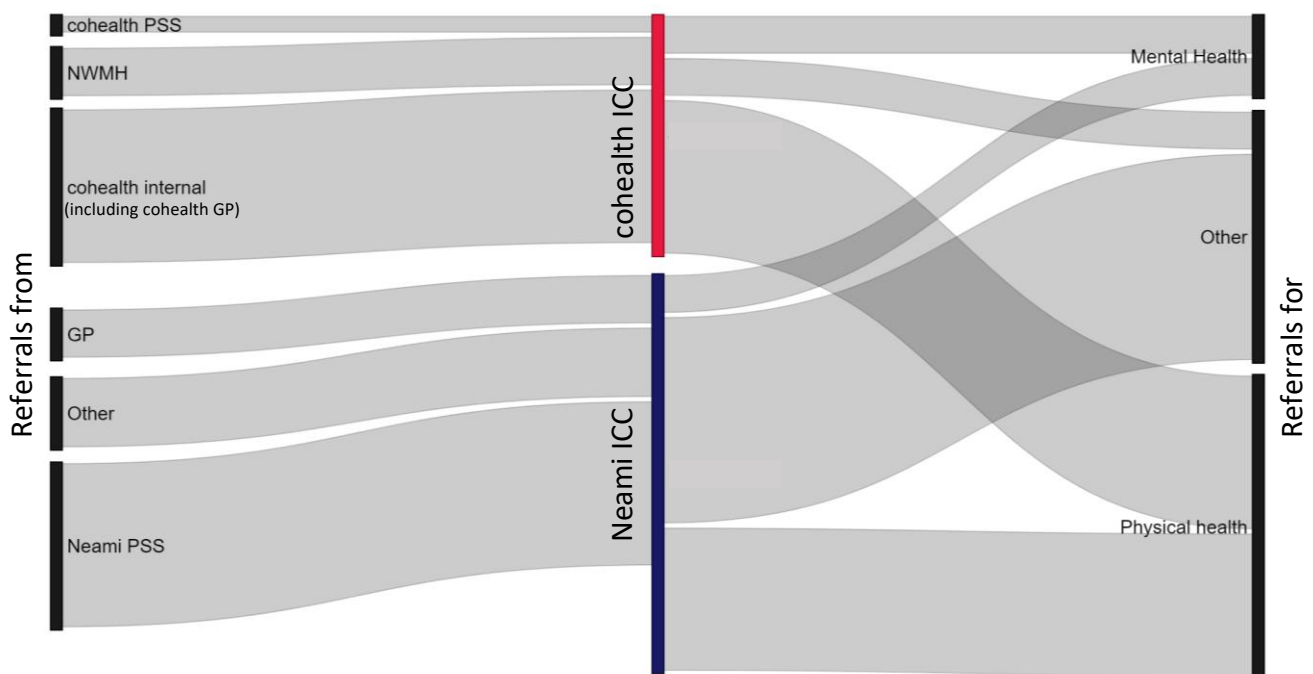


Figure 5 - Referral mapping

Neither ICC program is receiving significant numbers of referrals from NWMH. The reason for the lack of engagement with NWMH is not entirely clear, with all data indicating that ICC is open to referrals and that NWMH is working with consumers who would be eligible for the programs. Both cohealth and Neami had made attempts to promote ICC to NWMH, with limited success. Staff and stakeholders suggested coronavirus restrictions, staffing turnover for both ICC and NWMH and time pressures for

NWMH key clinicians as possible barriers. There also appeared to be some lack of clarity as to who, in cohealth and Neami, had responsibility for maintaining relationships with NWMH at various levels. This should be a key area of focus for future programs of this nature (Recommendation 8).

There also appear to be limited connections with primary healthcare outside of cohealth clinics. For a PHN funded program this may be a cause for concern, although given both programs were most often at or close to capacity promotion to external primary care clinics may not have been a useful use of resources.

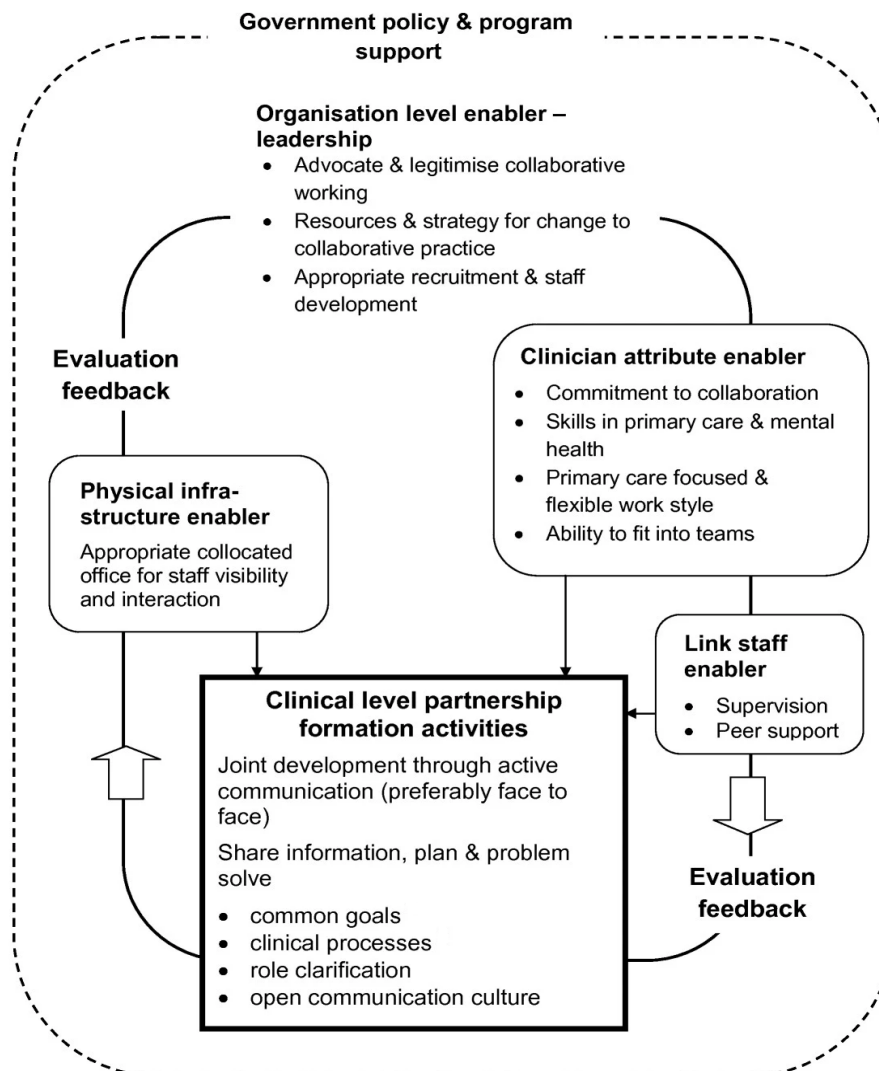


Figure 6 - Inter-relationship between developmental factors for building effective service linkages in primary mental health care

To illustrate the multi-layered complexity of service network integration, Figure 6 reproduces a diagram from Fuller et al.³⁴ In the case of ICC, it appears that service integration with services outside of cohealth and Neami failed at multiple points, including the organisational level. The data indicate only limited and ad hoc strategies to promote service integration with NWMH for both programs.

Responsibility for service integration was shared amongst direct service staff, team leaders and senior management, and as such was dispersed and not well coordinated. Future service delivery should ensure a coordinated approach to service integration (Recommendation 8), with sufficient capacity to

meet the demand generated by service promotion (Recommendation 11). When services are running at or near capacity, service promotion and partnership development is futile, as new partnerships will be unable to refer into the program.

³⁴ Jeffrey D Fuller et al., 'Building Effective Service Linkages in Primary Mental Health Care: A Narrative Review Part 2' (2011) 11(1) BMC Health Services Research 1.

Where good relationships did exist, such as with Neami's PSS service and various internal cohealth services, referrals appeared to run smoothly, but the data do not indicate broad and deep integration with the service system outside of cohealth and Neami. As both programs were able to reach their targets when fully staffed, this is only a concern inasmuch as the actual group supported is not reflective of the program target group, those most at risk of early death in the cohort.

5.5.2 Staffing profile

Although not initially an area of focus for the evaluation, the question of which staffing profile best suited ICC regularly emerged in the data. This was often in the context of the nurses not appearing to do a significant amount of clinical work, giving rise to the question whether a social worker or support worker might be able to perform a similar role. Clinical stakeholders consistently identified that the nurse could translate for the client in medical contexts in a way that would not be possible for other professionals:

I don't have the medical background or knowledge and it does seem to just be approached differently by GPs if it's coming from a nurse, I think. (cohealth Stakeholder 7)

And:

But I wouldn't have really known where to start, whereas she knew, having that nursing background. (cohealth Stakeholder 8)

This was also reflected by ICC staff:

With my nurse hat on, I understand how the discharge paperwork works, I know that it takes 24 to 48 hours to write a discharge summary and for it to get sent out, I understand that it will be faxed rather than sent electronically; I understand how the consent process works in terms of getting the information from another GP and what we have to do to update our records, and what would happen with medication, so I understand the implications of taking an overdose of that drug, and why they didn't change it to this drug – all of those things. So it's important from that service navigation aspect and being able to do that, and then having the understanding of how GPs work..." (cohealth Staff 2)

It appears that while the role could be performed by other professionals, this communication with medical practitioners, particularly GPs, means that nurses are best suited for interfacing with medical practitioners. Other professions might bring other skills - for example, social workers may have a better grasp of broader structural factors or have more advocacy experience. Further research is required to understand the factors which are most important in this kind of care coordination.

The evaluation team also considered if nurses with physical health or mental health backgrounds would bring different skills to the role, given that different nurses in the care coordination roles did have these backgrounds. It appears, from the available data, that both types of experiences and training are important, and that what skills are required depends on whether the ICC program was based in a mental health or physical health-focused organisation or team. Ideally, nurses would have expertise and experience in both mental and physical health care (Recommendation 3).

As discussed above at 5.3.7, the peer work role was insufficiently well defined to evaluate thoroughly. The data indicate that where peer work roles were well understood, these were highly valued irrespective of the peer worker's experience. It appears from the available data that experienced peer

workers are more likely to be successful in roles without clear models. In this situation, where no pre-existing model exists for physical and mental health peer work, peer workers who can draw on a diversity of experiences to develop a bespoke model will find more success (Recommendation 4). It also appears important that peer workers should be able to intentionally reflect on and share their own experiences of both mental and physical health challenges (Recommendation 5). More research is required to support the development of this area of peer work practice (Recommendation 7).

5.6 Implications for future service development

This section discusses key areas for consideration for future service development that are not necessarily relevant to the current ICC contract but will be relevant for other services or future programs. These include the location of care coordination services, and duplications, redundancies and sector fragmentation. The evaluation also identified issues with the size and scope of the pilot that reflect consistent themes from other similar programs. Finally, the evaluation team found that without systemic reform, care coordination is limited in what it can achieve, particularly for those most at risk of early death from preventable physical health conditions.

5.6.1 Program location

During a meeting with the nurse, Remmy disclosed that they had been experiencing auditory hallucinations. Remmy had a poor relationship with NWMH due to past traumatic experiences and gave very clear directions that they did not want this information to be shared with NWMH. There was nothing in their disclosure that indicated that Remmy wanted to harm themselves or another person. In clear violation of Remmy's wishes, the nurse alerted NWMH. Remmy felt betrayed. Their original distrust of healthcare professionals returned and, shortly after, Remmy disappeared. The team eventually managed to piece together that during an episode of psychosis, Remmy had been apprehended by police and taken back to NWMH. It was not clear how long they would be there. Their ICC file was closed and they lost their places on the multiple waitlists they had been patiently preparing for. Their NDIS application was never submitted.

The evaluation team considered how ICC might be located to overcome some of the issues identified, particularly regarding links to NWMH. A NWMH stakeholder indicated that the program would have been better placed in NWMH to address this. However Remmy's profile indicates some of the problems associated with that. One consumer also identified that moving away from NWMH was an important part of their recovery:

If I need anything, I know I can rely on her to help me, and it not always have to be [NWMH] that helps me, which is good. (cohealth Consumer 5)

Despite issues with integration discussed at 5.5.1, ICC should not only be available to users of the public mental health system but should also be accessible for people who do not, for whatever reason, want to use the public mental health system. For these reasons, the evaluation team recommend that future services of this nature be located in non-government organisations (Recommendation 10) but develop

more robust strategies, such as co-location, for ensuring access for public mental health service consumers (Recommendation 9). Location within primary care may be another effective alternative.³⁵

5.6.2 Duplications, redundancies and fragmentation

Both ICC programs were duplicating services that in an ideal healthcare system would be provided by another service. Duplication was consistently noted in relation to general practitioners, where ICC staff were assisting consumers to work with their general practitioner to undertake basic general practice work such as screening and referrals. In an ideal healthcare system people should not require assistance to engage with their general practitioner, and general practitioners should be trained, supported and funded to be able to engage with any consumer who requires their service (Recommendation 12).

Despite this duplication, external stakeholders indicated untapped demand for ICC, noting that no other services were available to replace it:

Evaluator: So if she's exited from this program, do you have other places where you can get those networks, or will you be stuck?
cohealth Stakeholder 1: I'd be stuck.

This reflects an almost artificial demand for ICC, where poorly funded, poorly functioning and discriminatory systems excluded people in the target cohort. This demand is not likely to be resolved by more care coordination unless that is also matched by an increase in service availability and a reduction in barriers to access.

Mental health service duplication was also noted, with some consumers having ICC, PSS, NDIS counselling and other mental health services all at the same time. These services provide different supports, but a service model that simply adds an additional coordinator may be less effective when other coordination and support services are already present. This was particularly evident with consumers who had mental health key clinicians (previously known as case managers) at NWMH. These clinicians are embedded into the tertiary healthcare system and yet do not appear to be coordinating physical health care in the way that they coordinate mental health care. The Commonwealth Productivity Commission into Mental Health has called for this to be addressed.³⁶

Fragmentation was also reflected in the data, with some consumers working with multiple general practitioners and a lack of communication between services that were not within cohealth or Neami. The file review indicates a lack of clarity regarding service roles and responsibilities. The evaluation team were also unable to assess the quality of the interprofessional communication between the various health care professionals supporting the person. This raises concerns about the sustainability of enhancements to care beyond the delivery of ICC. This also relates to the issues of integration discussed above at 5.5.1.

5.6.3 Future pilots

A number of findings and limitations emerged from the analysis which are salient for future pilots. Primarily, the small size of the pilot, spread across two organisations, meant that both programs were vulnerable to staff turnover. Neami, in particular, lost program continuity due to complete staff turnover. Funding uncertainty for short term projects contributed to this. This challenge is not unique to

³⁵ Fitzpatrick et al. (n 18).

³⁶ Productivity Commission (n 4).

this pilot. This is a common, persistent challenge. The Commonwealth Productivity Commission into Mental Health, a House of Representatives Select Committee, and two Senate Select Committees have recommended that the Australian Government fund PHNs and NGOs to fund mental health services on much longer-term contracts.³⁷ The findings from this evaluation support these recommendations (Recommendation 11).

Additionally, future pilots for peer work services should require the establishment and pilot of a model for peer work in physical *and* mental health care. In the case of ICC, both Neami and cohealth initiated the peer work elements of the program based on the very strong evidence base for peer work in mental health care. However more research is required to determine models of effective practice (Recommendations 6 and 7).

5.6.4 Systemic change

The nurse booked Samir an appointment with a new GP who specialised in chronic pain, but they required a \$40 deposit just for the first consult. This made Samir feel frustrated because he simply couldn't afford these services.

The evaluation identified many barriers to accessing services and to good physical and mental health. Ultimately, the key finding from this evaluation is that no amount of care coordination can address the current gaps in the mental and physical healthcare systems, or at least not the gaps that are present for the target cohort during coronavirus restrictions. Given the limited resources available in the pilot, it may be appropriate that ICC did not work with those who are most at risk of early death, as it is likely that it could have provided little other than the care and compassion which was so highly valued for consumers they did see.

The experiences of many consumers are so complex that healthcare coordination alone is insufficient. Olivia's profile highlights this, where barriers in housing, family violence support and legal systems all needed to be resolved before healthcare coordination could be useful:

Olivia is a 36-year-old female and a single mother to two young children, aged 6 and 8. They are currently homeless and living in a hotel in Sunshine. Olivia was diagnosed with Crohn's Disease several years ago and sometimes gets migraines. Olivia and the kids fled their family home over a year ago due to escalating family violence. Since then, they have moved between various women's refuges and hotels waiting for public housing. Olivia is in the process of taking out an IVO against her ex-partner but is struggling to navigate the court system and all its requirements. Both Olivia's children are autistic, and her GP said they might be eligible for NDIS.

The consumer profile analysis suggests that ICC is most effective when working with people who are able to be supported to self-manage their physical health, rather than with those who require intensive

³⁷ House of Representatives Select Committee on Mental Health and Suicide Prevention (n 17); Productivity Commission (n 4).

and consistent support. Systemic change is required to adapt the service system to be suitable for people requiring this more intensive support.

ICC is not well-positioned to advocate for this systemic change, but it is a good source of evidence for where the gaps are, and for priority setting as to which gaps should be addressed first. Hopefully, the implementation of the recommendations of the Commonwealth Productivity Commission, the Royal Commission into Victoria's Mental Health System, and the Victorian Government's Equally Well Framework will lead to the change that is required. Neami, cohealth, and NWMPHN should continue to contribute to this system change (Recommendation 12).

The work with the physio helped briefly, but he could only afford two sessions. Struggling with his pain management, financial hardship and social isolation, Samir's mental health deteriorated. He disengaged completely from ICC, telling them he no longer wanted to be contacted. Respecting his wishes, they closed his file and stopped following up. Things continued to get worse for Samir, and he eventually ended up in prison. Now, a few months after his release, he is living with a friend in temporary accommodation. He doesn't know where he will go next. His situation is, for all intents and purposes, the same as before he encountered ICC.

6 Recommendations

These recommendations have been developed with a view to future program development but are also relevant to ongoing ICC service delivery. These recommendations reflect the final outcome of the analysis process conducted by the evaluation team.

Physical health screening

1. Ensure screening is conducted, documented and followed up in accordance with clinical best practice, particularly:
 - a. Family medical history
 - b. Age-appropriate screening tools

Equity of access

2. Develop strategies to ensure equity of access, particularly for:
 - a. People of all genders
 - b. People from culturally and linguistically diverse communities
 - c. People using public mental health services

Care coordination

3. Care coordinators should have expertise in both physical and mental healthcare or expertise that reflects the gaps in the teams in which they are based

Peer work

4. Peer workers in programs without established models for conducting peer work should be sufficiently experienced and supported to develop ways of doing peer work in these contexts
5. Peer workers should be able to intentionally reflect on and share their own experiences of both mental and physical health challenges
6. Develop a clear model for peer work for mental and physical health
7. Evaluate the implementation of a consistently applied model of peer work for mental and physical health

Service integration

8. Service integration should be underpinned by a consistent approach with clear lines of responsibility and accountability for all parties
9. Co-location should be used to increase service integration

Future program development

10. Care coordination services should be located with NGO or primary care services rather than public mental health services
11. Future pilots should be of sufficient size and timeframe to minimise staff turnover and to meet potential demand

Systemic change

12. NWMPHN, cohealth and Neami should continue to advocate for and support meaningful systemic change to allow care coordination to be successful

Appendix 1. Consumer profiles

Consumer profile 1 – Leila

Leila is 41 years old. She is female and lives in Footscray with her partner. Leila was engaged with a community mental health service for support with generalised anxiety disorder. They referred her to a local health clinic for general physical health support. The Primary Health nurse at the clinic then made an internal referral to the ICC program for care coordination. She initially engaged with the ICC nurse and peer worker through health screenings and regular phone calls, and was then invited to join their 12-week group program. Leila was hesitant about this. Her fluctuating anxiety sometimes made it difficult for her to leave the house and she was also dealing with physical health problems due to long-term smoking and weight gain from antidepressants. She had gained 45 kilos since starting Lexapro six months ago. Leila felt like the extra weight dragged her down, making everything she did feel like more effort.

However, Leila had had positive experiences with a peer worker at a different service and knowing that there would be a peer worker at the group programs ultimately convinced her to attend.

To her surprise, Leila found the group sessions both enjoyable and helpful. She appreciated the opportunity to share her experiences and find solidarity with the other group members. The content was useful too, providing information on diet, exercise, the benefits of meditation and mindfulness, and how to access NDIS and other support services. After group sessions, the peer worker would check-in with her and Leila appreciated these conversations. The peer worker showed a genuine care for Leila's interests, values and priorities, and took the time to explore her world view and personal history. Leila always felt supported and respected, and that she was in the driver's seat when it came to making decisions about her medication and healthcare. The peer worker also supported Leila to reflect on her goals around education, employment and social connections, facilitating a holistic approach to her health and wellbeing.

Meanwhile, the ICC nurse used brokerage funding to buy Leila a gym membership and some new runners. A physiotherapist organised by ICC accompanied Leila to the gym on several occasions, showing her how to use the equipment and designing an exercise regime together. After starting the exercise regime, and a couple of consultations with a dietician organised by ICC, Leila found her mood improving and her energy increasing. For the first time in a long time, Leila felt optimistic about her future, and more comfortable in her weight. Her engagement with the peer worker had been particularly transformative, and she decided she wanted to support others the same way. After she exited from the ICC program, Leila enrolled in a Certificate IV in Mental Health Peer Work and is now working towards becoming a qualified peer support worker.

Consumer profile 2 – Remmy

Remmy is 34. They are non-binary and live alone in Coburg. Remmy has been engaged with psychiatric services since they were a teenager and has been admitted twice to a NorthWestern Mental Health (NWMH) inpatient unit. Despite repeated requests, Remmy's GP didn't use their preferred pronouns. Already deeply distrustful of health professionals, Remmy disengaged from the GP's clinic. Remmy mentioned this to their private psychiatrist, who then referred them to PSS. PSS then referred Remmy to ICC for support engaging with a new GP.

The nurse and peer worker at ICC worked with Remmy to determine their priorities and connect them with an appropriate GP. This was difficult at times, because Remmy could be hard to contact and often missed appointments. One day Remmy mentioned that they found phone calls anxiety-provoking and preferred text messages. The ICC team noted this in their file, and started using text messages as the main communication method with Remmy. From that

Appendix 1 - Consumer profiles

point onwards, communication between Remmy and the ICC team was much easier. The nurse identified that Remmy was pre-diabetic and put them on a waitlist to see a low-cost diabetes educator. They also went on a waitlist for free dental treatment. Remy needed a number of dental fillings due to a combination of poor diet and dry mouth, a common side effect of antipsychotic medication. Remmy was also completing an NDIS application with the peer worker's support.

The ICC nurse managed to find a suitable GP and organised regular case conferences over Zoom for everyone to meet and discuss Remmy's goals and care plan. Halfway through the first meeting, Remmy burst into tears. Alarmed, everyone stopped to console them and find out what was wrong. Wiping away tears, Remmy said "I've never felt this cared for in my life." Slowly, through these meetings, Remmy began to trust that the GP had their best interests at heart and became more receptive to the GP's suggestions. The GP, on the other hand, developed new skills as a result of working with the ICC team, including how to talk to and be more collaborative with consumers regarding their healthcare. Remmy was making good progress and slowly moving up the waitlists for dental and diabetes care. Their NDIS application was almost complete.

During a meeting with the ICC nurse, Remmy disclosed that they had been experiencing auditory hallucinations. Remmy had a poor relationship with the local NWMH due to past traumatic experiences and gave very clear directions that they did not want this information to be shared with NWMH. There was nothing in their disclosure that indicated that Remmy wanted to harm themselves or another person. In clear violation of Remmy's wishes, the nurse alerted NWMH. Remmy felt betrayed. Their original distrust of healthcare professionals returned and, shortly after, Remmy disappeared. The team eventually managed to piece together that during an episode of psychosis, Remmy had been apprehended by police and taken back to NWMH. It was not clear how long they would be there. Remmy's ICC file was closed and they lost their places on the multiple waitlists they had been patiently preparing for. Their NDIS application was never submitted.

Consumer profile 3 – Natalie

Natalie is 55 years old. She is female and lives with her adult son in a small unit in Broadmeadows. Natalie was diagnosed with multiple sclerosis (MS) in her late 30s and experiences chronic pain in her back and legs. During the 2021 COVID lockdown, Natalie's pain was exacerbated because she couldn't do her usual exercises like pool and gym therapy that helped manage the symptoms. Natalie began feeling deeply depressed. One day she called Beyond Blue for support, and they gave her the contact number for her local PSS. From there, Natalie was connected with the ICC team for support to manage her mental and physical health. A member of the ICC team called Natalie once a week, alternating between the nurse and the peer worker. Even before the COVID lockdown, Natalie felt socially isolated, so she found these phone calls comforting, knowing that every week on a Wednesday at 4pm she would hear from someone. The nurse and peer worker sent Natalie many online resources, like links to Ted Talks about managing chronic pain, YouTube exercise tutorials, and websites with information on portion size and nutrition.

Natalie desperately wanted to see a dentist because of pain and bleeding in her gums. The nurse set up an appointment, but it was continually delayed due to COVID restrictions. It wasn't until November, several months after engaging with ICC, that Natalie was able to get her gums examined and attend the ICC office to have an in-person health check-up. Once there, the ICC nurse was finally able to discuss other preventative health screenings relevant to Natalie's demographic, like breast, bowel and cervical cancer, bone density, heart health, and diabetes. Not all of these screenings were conducted, however Natalie had the information she needed to make decisions about which screenings to prioritise.

Appendix 1 - Consumer profiles

Natalie had a lot of anxiety around getting the COVID-19 vaccine. She had seen confusing and conflicting information online and was worried it would make her MS symptoms worse. Natalie talked through these concerns with the nurse, who provided calm and clear advice around the vaccine and its benefits. Once Natalie was ready, the nurse facilitated both her and her son's vaccination appointments. Now out of lockdown, Natalie is slowly getting back to her previous pool and gym exercises. She is on a waitlist for a bulk-billing psychologist but has been warned that, because of the COVID backlog, it could be months before she's able to see someone. In the interim, she speaks to the ICC peer worker on a semi-regular basis. Previously Natalie didn't know what a peer worker is, but now she feels grateful to know that this kind of support is available to her.

Consumer profile 4 – Olivia

Olivia is a 36-year-old female and a single mother to two young children, aged 6 and 8. They are currently homeless and living in a hotel in Sunshine. Olivia was diagnosed with Crohn's Disease several years ago and sometimes gets migraines. Olivia and the kids fled their family home over a year ago due to escalating family violence. Since then, they have moved between various women's refuges and hotels waiting for public housing. Olivia is in the process of taking out an IVO against her ex-partner but is struggling to navigate the court system and all its requirements. Both Olivia's children are autistic, and her GP said they might be eligible for NDIS. The GP referred Olivia to a local NDIS access worker. Once the access worker learnt a bit more about Olivia's situation, they thought she might be an appropriate candidate for the ICC program.

By this point, Olivia had been a mental and physical healthcare consumer for many years. She had a high level of health literacy and, for the most part, self-managed her and her family's healthcare. However, working with ICC, the PSS and now NDIS for her two children, she began to feel overwhelmed by the number of people and appointments she had to keep track of. Sometimes she wasn't even sure what the difference was between ICC and the PSS, as they seemed to do similar things. At one point, Olivia was liaising between the nurse at ICC, her social worker at Anglicare, the Autism Services team for her children and the Brotherhood of St Laurence for NDIS support coordination. She was also in regular contact with a family violence worker, lawyers at a community legal centre and Child Protection. It was a never-ending, exhausting whirlwind of phone calls, filling in forms and travelling to and from appointments. While she appreciated the support, she didn't know how she was going to sustain this level of engagement with so many services.

Olivia always prioritised her children and, at the very least, was grateful to have the ICC nurse remind her not to neglect her own needs. The nurse also ran tests to check her blood sugar, cholesterol, iron levels, and her kidney, liver and thyroid health. Olivia spoke on the phone a few times to the peer worker, but really felt that it would be better to have those conversations in person. After six months of working with ICC, Olivia exited from the program. This decision was made in consultation with the nurse, and Olivia was confident that she had enough supports in place going forward.

Consumer profile 5 – Samir

Samir is a 60-year-old male and lives in Deer Park. He came to Australia as a refugee 5 years ago. Shortly after arriving, Samir got his license and began working as a taxi driver. Things were going well for him until he was in a car accident and badly injured his back. Samir got compensation from TAC and started receiving Centrelink, but his Centrelink payments were reduced after he gambled using his TAC funds. Samir was stuck. He couldn't work due to his chronic back pain, and he couldn't afford the pain medication he needed because of his low-income. After the accident he wasn't able to drive any more, which made it difficult for him to get to appointments. His English was limited, and he began to feel increasingly isolated. One day Samir self-harmed and was taken to hospital. When he was discharged, he spoke to his GP about the issues he was having, and the GP referred him to ICC.

Appendix 1 - Consumer profiles

Samir began working with the ICC nurse. She arranged interpreting services and assisted him with a range of practical things, like calling his utility services and advocating on his behalf to have a payment plan. She even brought food to his house when he had run out of money to purchase food. The nurse organised transportation to and from appointments.

The ICC nurse managed to connect Samir with a physiotherapist who spoke Arabic, which made a huge difference because Samir could accurately explain his symptoms. She suggested other things that could potentially help, like a gym membership and seeing a dietitian, but wasn't able to offer funding. The nurse booked Samir an appointment with a new GP who specialised in chronic pain, but they required a \$40 deposit just for the first consult. This made Samir feel frustrated because he simply couldn't afford these services. Samir was grateful for the phone check-ins and the practical support, but he sometimes got the sense that the program was a one-size-fits-all blueprint, and that if he didn't fit the mould then the nurse's ability to help him was limited. During his time with ICC, he did not have any engagement with the peer worker.

The work with the physio helped briefly, but he could only afford two sessions. Struggling with his pain management, financial hardship and social isolation, Samir's mental health deteriorated. He disengaged completely from ICC, telling them he no longer wanted to be contacted. Respecting his wishes, they closed his file and stopped following up. Things continued to get worse for Samir, and he eventually ended up in prison. Now, a few months after his release, he is living with a friend in temporary accommodation. He doesn't know where he will go next. His situation is, for all intents and purposes, the same as before he encountered ICC.

Appendix 2. File review template

FILES FOR REVIEW

Example of evaluation questions potentially relevant to file reviews:

- How have these programs contributed to the improvement of the physical and mental health of people who used them?
- What was the experience of people who used the programs?
- To what extent did the services identify and meet the physical and mental health needs of consumers, including practical support where needed?
- To what extent did consumers develop skills for self-management of physical health? What factors were critical in the development of self-management skills?

The file reviews will document diagnoses, comorbid medical conditions, blood pressure, body mass index, family history, parameters required to calculate cardiovascular risk and diabetes risk, diet, exercise, smoking and drug and alcohol use. This information will be assessed against relevant best practice guidelines including:

- The *Australian College of Mental Health Nurses* “Standards of Practice in Mental Health Nursing” and “Mental Health Practice Standards for Nurses in Australian General Practice”
- The *Royal Australian College of General Practitioners* “Guidelines for preventive activities in general practice” and “Principles for collaboration, communication and cooperation between mental health service providers”
- The *Victorian Office of the Chief Psychiatrist* “Equally well in Victoria: Physical health framework for specialist mental health services”
- The *Royal Australian and New Zealand College of Psychiatrists* Keeping “Body and Mind Together: Improving the physical health and life expectancy of people with serious mental illness”

These guidelines will inform the file review process while acknowledging the specific and unique nature of the ICC programs.

The file reviews will also look for any demonstration of Intentional Peer Support principles:

- Connection
- mutuality (breaking down power, not positioning as expert)
- exploring worldview (understand based on person’s own experience)
- moving toward (exploring values, making choices based on those things)

| FILE TYPE | Deidentified ID | HEALTH AREA | Prompt/potential issue | Current status/diagnosis at intake. | QUESTION/best practice | Action taken |
|-----------|-----------------|-------------|------------------------------|-------------------------------------|------------------------|--------------|
| | | Dates | Referral date | | | |
| | | | Health screening intake date | | | |

Appendix 2 - File review template

| | | | | | | |
|--|--|--|---|--|--|--|
| | | | Consumer risk assessment date | | | |
| | | | Discharged from service | | | |
| | | | Assessments/referrals | | | |
| | | Demographics | Age: | | | |
| | | | Gender: | | | |
| | | | Interpreter required: | | | |
| | | | Country of Birth | | | |
| | | | Culturally and Linguistically diverse | | | |
| | | | Marital status: | | | |
| | | | Aboriginal and/or torres straight islander. | | | |
| | | | Family history: | | | |
| | | | Medications: | | | |
| | | | Height | | | |
| | | | Weight/ BMI | | | |
| | | | Reason for referral | | | |
| | | | | | | |
| | | Income | Main source of income | | | |
| | | NDIS care package insitu | | | | |
| | | Social | Education | | | |
| | | | Occupation | | | |
| | | | Homeless? | | | |
| | | | Lives with | | | |
| | | | Dependents | | | |
| | | | Feels has a safe contact? | | | |
| | | | Social issues /Hx of trauma | | | |
| | | | Risks at home? | | | |
| | | Regular GP | Identified a regular GP? | | | |
| | | | Has a psychiatrist | | | |
| | | Preexisting physical medical hx | | | | |

Appendix 2 - File review template

| | | | | | | |
|--|--|-------------------------------------|---|--|--|--|
| | | Preexisting mental health hx | | | | |
| | | Health aids insitu | Glasses Walking frames Walking sticks Motorized wheelchair | | | |
| | | Cardiovascular | Blood pressure | | | |
| | | | Cholesterol check | | | |
| | | | Smoker | | | |
| | | | | | | |
| | | Respiratory | Spirometry (if smoker or cough) | | | |
| | | | | | | |
| | | Dental | Dental checkups | | | |
| | | Endocrine | Blood sugar levels | | | |
| | | Gastrointestinal | Bowel issues | | | |
| | | | Reflux issues | | | |
| | | Renal | Bladder issues | | | |
| | | | | | | |
| | | Neurological | | | | |
| | | Integumentary | Skin cancer screening | | | |
| | | | Feet free from sores/blisters/ swelling | | | |
| | | | | | | |
| | | Musculoskeletal | Pain | | | |

Appendix 2 - File review template

| | | | | | | |
|--|--|-------------------------|------------------------------------|--|--|--|
| | | | Movement issues | | | |
| | | PAIN | Chronic pain | | | |
| | | Hematological | | | | |
| | | | | | | |
| | | | | | | |
| | | Immune | Flu vaccine | | | |
| | | | Other vaccines including covid | | | |
| | | | | | | |
| | | Sexual health | Regular Sexual health contact | | | |
| | | | Cervical screening | | | |
| | | | Menopause issues | | | |
| | | | Additional risks for sexual health | | | |
| | | Activity level | | | | |
| | | Nutrition | Diet (fruit intake) | | | |
| | | | Diet (vegetable intake) | | | |
| | | | Water consumption | | | |
| | | | | | | |
| | | Substance use | Alcohol | | | |
| | | | Smoking | | | |
| | | | Drugs | | | |
| | | | Other | | | |
| | | Cancer screening | Skin cancer | | | |
| | | | Bowel cancer | | | |
| | | | Prostate cancer | | | |
| | | | Pap smears/ cervical cancer. | | | |
| | | | Breast cancer | | | |
| | | | Mammogram | | | |
| | | Balance | Balance issues/recent falls | | | |
| | | | Recent falls | | | |

Appendix 2 - File review template

| | | | | | | |
|--|--|---------------------------------|---|--|--|--|
| | | Vision | Regular eye check Vision | | | |
| | | | Vision issues | | | |
| | | Sleep | quality of sleep | | | |
| | | Comprehension | Auditory issues. | | | |
| | | | Issues with understanding health information | | | |
| | | | Do they feel they have enough information about your medications? Medication side effects Autonomy in conversation re medications and other aspects of care | | | |
| | | | | | | |
| | | GOAL SETTING | | | | |
| | | FOLLOW UP | | | | |
| | | IMPACT OF COVID | | | | |
| | | INTENTIONAL PEER SUPPORT | Connection | | | |
| | | | Mutuality | | | |
| | | | Exploring worldview | | | |
| | | | Moving toward | | | |

Notes for review of Consumer X

Appendix 3 - cohealth Program Logic

Appendix 3. cohealth Program Logic

| <p>People experiencing serious mental illness</p> <p>have high rates of chronic disease compared to the general population. This has significant impacts on morbidity and mortality, as well as community participation. Population data shows that mental illness in the Brimbank and Maribyrnong LGAs is growing. People experiencing serious mental illness face significant barriers to achieving optimal physical health including medication side effects, psychiatric symptoms and access to services. There are evidence based interventions which have been shown to improve the health and wellbeing of this group. It is cohealth's experience that consumers even when linked to mental health services, are not well linked to physical health services which meet their needs.</p> | <p>Funding – Integrated Chronic Care program plus in-kind contributions from existing services.</p> <p>Partnerships with GP's, Area Mental Health, Mental Health nurses, counsellors, psychologists and psychiatrists and hospitals.</p> <p>Collaboration with cohealth ATSI & Refugee Health teams.</p> <p>Care Coordination space, desks, telephone (landline and mobile), computers and group materials.</p> <p>Group venues (cohealth and community).</p> <p>Client management system.</p> <p>Qualified and accredited staff.</p> | <p>Provide care coordination to clients of the target group to develop care plans, liaise with care partners, coordinate case conferences and supported on referral.</p> <p>Develop a three-tiered support program for consumers with varying support needs.</p> <p>Deliver individual care coordination to clients in the catchment. Develop care plans, provide health information, referral and liaison with other health professionals involved in the care.</p> <p>Establish and maintain referral pathways inclusive of physical and mental health and which promote community participation.</p> <p>Using codesign principles provide two dedicated exercise group sessions per week and one group session with a dietitian a fortnight.</p> | <p>12-180 clients to have their care coordinated per year.</p> <p>It is proposed up to 12 clients a year may access the comprehensive package of care, 35 to access the moderate package of care and between 90-180 may access the brief level of care.</p> <p>All clients to have a goal directed care plan.</p> <p>Deliver 80 group exercise sessions per year and 20 sessions with a dietitian per year.</p> <p>Referral into the program is streamlined.</p> | <p>Short term</p> <p>For consumers to have improved skill and confidence in managing their chronic disease.</p> <p>Access to physical health services is improved.</p> <p>Group health education and exercise programs</p> <p>are developed which meet the needs of the target group.</p> <p>Long term</p> <p>To improve the physical health of people experiencing severe and persistent mental illness living in Brimbank and Maribyrnong.</p> <p>The cost from developing and worsening of chronic disease is reduced.</p> <p>Quality of life of participants is improved.</p> <p>Clients linked into longer term supports where necessary (i.e. NDIS).</p> | <p>Referrals made to other services.</p> <p>Relevant changes to consumer circumstances of physical health, mental health, personal safety, community networks, family functioning, money, employment and housing.</p> <p>Progress with achieving goals including: Changes in knowledge, skills, behaviours, change in confidence and / or engagement with service.</p> <p>Client satisfaction with service.</p> <p>Client demographic information including age, gender, location.</p> <p>Number of consumers in receipt of services, length of care episode, hours of service and level of support provided.</p> <p>Linkages and referral pathways developed.</p> <p>Brokerage use.</p> |
|--|---|---|--|--|--|

Appendix 4. Neami Service model

Aims of the Service:

“Integrated Chronic Care is a pilot program created with the intention that individuals experiencing severe and persistent mental illnesses who can be or are being appropriately managed in a primary care setting:

- *Are supported to achieve improved outcomes, including better self-management, for their chronic conditions.*
- *Are offered access to physical and mental health services and supports.”*

Neami ICC’s aim is to make it easier for individuals to connect with, access and maintain the services they need to enhance their physical health.

We work together with primary health, mental health, and other community services to ensure the effective delivery and coordination of high-quality integrated care.

We also support the active engagement of carers, healthcare teams, family members and friends.

We use an evidence-informed, mental health understanding to support an individual’s physical health. Our approach emphasises the importance of individuals increasing understanding and confidence to manage their own health.

Principles guiding Integrated Chronic Care

All Neami programs are guided by the principles of the Collaborative Recovery Model (CRM). Central to all recovery paradigms are the principles of hope, self-determination, self-management, empowerment, and advocacy. Also essential is a person’s right to full inclusion, and to meaningful life of their own choosing, free of stigma and discrimination.

Furthermore, the ICC understands that people experiencing Serious Mental Illness face significant barriers to achieving physical health outcomes that must be considered and addressed.

Service Model

ICC provides short-term, moderate and comprehensive support to manage physical health. Ranging from six-weeks to 12-months, the support is flexible and can change to meet an individual’s needs.

During sessions with our Registered Nurse, or Peer Support worker, individuals develop ways to improve their health management. This includes:

Integrated Health Goal Planning

- Ensure that participants are included in the decisions of the treating practitioners and teams and stay well informed
- Support participants to become a more active in their own care planning
- Health Coaching and advice

Physical Health Screening and Assessment

- Provide thorough screening and assessment of participants physical health needs

Appendix 4 - Neami Service model

Care Co-ordination Based in the Community

- Provide tailored services and support participants to actively manage their physical Health
- Support referral and access to physical health services including GPs and Community Health
- Ensure care and treatment plans are communicated across providers, including GPs, to support integrated person-centred care
- Deliver care coordination that is based in the community to facilitate access to services and supports that are based in the community
- Deliver care coordination that is flexible to participants' needs, delivering care when and where is appropriate
- Provide consultation to care teams to improve physical health supports for people experiencing mental health issues

Eligibility

The Preventative Health Initiative is available to people aged 16-65 who:

- Are experiencing a mental health condition (a formal clinical diagnosis is not required, this can be discussed during intake).
- Are at risk of a Chronic Health condition and would benefit from short-term, targeted physical health support.
- Live, work or study in the Hume, Moonee Valley and Moreland LGAs

Referral

Anyone can make a referral for Integrated

Chronic Care, including:

- Individuals
- Doctors or General Practitioners
- A family member or friend
- Other mental health or health services.

To make a referral call Neami on 1300 160 335. A referral form can also be downloaded at neaminational.org.au/ICC or mailed on request
Call 1300 160 33

Fax 03 9309 4843

ICC@neaminational.org.au

Staffing

Registered Nurse

The ICC Registered Nurse is responsible for delivering an integrated approach to supporting an individual's mental health and physical health needs. The position requires current registration with AHPRA.

Appendix 4 - Neami Service model

Peer Support Worker

Peer Support Workers (PSW) are integral members of the team and draw on their lived experience of recovery from mental illness, to instil confidence and hope in others about the journey of recovery. Peer Support Workers purposefully use their own story to help staff and consumers further their own recovery and achieve better physical health outcomes.

Interventions

| Staff Member | Intervention |
|---------------------|---|
| Registered Nurse | <ul style="list-style-type: none">• Physical Health Screening and assessment• Care Co-ordination, advocacy and referral support• Motivational Interviewing/Health Coaching• Health Goal Planning• Health education and advice• Secondary consultation• Mental health support/case management where there are clear indirect benefits for a consumer's physical health and no other services are available |
| Peer Support Worker | <ul style="list-style-type: none">• Health Goal Planning• Peer Coaching• Care Co-ordination and peer advocacy• Group Facilitation• Self-disclosure and strategic storytelling |

Modality

Members of the Integrated Chronic Care team provide supports in the manner which best suits the consumer, this could occur via:

- Face to face meetings in the community
- Meetings at an office or centre
- Telehealth appointments
- Support groups

Exit

Exit planning from the Integrated Chronic Care Service is expected for all consumers and includes review at the time of exit.

- When the consumer comes to the end of their care, and exit is being considered, plans should be put in place in consultation with the consumer and their family/carers as appropriate.

Appendix 4 - Neami Service model

- Where a consumer is being exited from the service when it is not meeting their needs, or the consumer is unable to be contacted, this is to be communicated as much as is practical with the consumer and relevant parties, such as other care team members.

Upon exit, all members of the care team are to be involved in, or informed of, the completion of care. A summary regarding rationale and ongoing care arrangements is to be circulated to appropriate parties.

The consumer and their remaining supports should be made aware of ways in which they can return to the service, should circumstances warrant, and what alternatives are available.

The Service Provider will ensure that consumers exiting the service have an opportunity to complete an exit/feedback form and/or participate in other feedback mechanisms (e.g., a meeting).

Assessments

- Health Prompt (At assessment, interim and service closure)
- Risk Assessment (At assessment, complete within four weeks)
- Goal Directed Care Plan (within four weeks)
- YES Survey (Upon exit of service)

KPIs

- Minimum of 60 clients to have their care coordinated per year
- Maintain an active consumer level of no less than 24 eligible consumers

Integrated Chronic Care - Consumer Journey

