EQUALLYWELL

Quality of Life - Equality in Life

2019 Symposium Book of Proceedings

28-29 March 2019, RMIT Melbourne

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Acknowledgement

Equally Well and Charles Sturt University acknowledge the Aboriginal and Torres Strait Islander peoples as traditional custodians of the land on which it operates.

We pay respect to Elders past, present and emerging, and value the rich history, unbroken culture and ongoing connection of Aboriginal and Torres Strait Islander people to country. Equally Well values inclusion and diversity and is committed to providing a safe, culturally appropriate, and inclusive service for all people, regardless of their ethnicity, faith, disability, sexuality, gender identity or health status.

Equally Well recognises the lived experience of people who have experienced emotional or mental distress and the variety of experiences those people have had in accessing mental health services. Lived experience is embedded in Equally Well and continues to drive and direct our purpose.

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Charles Sturt University

'Yindyamarra Winhanganha'
The wisdom of respectfully knowing how
to live well in a world worth living in

Contents summary

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E-MENTAL HEALTH IN PRACTICE

Contents detailed

* Peer-reviewed papers

Foreword

The physical health of people living with poor mental health is a major issue in Australia and internationally. People who use mental health services are dying younger and experiencing worse health than the general population.[1] This is not a new issue, as evidenced by thousands of research studies and hundreds of systematic reviews. [2] This disparity in health outcomes is an issue of basic human rights and Equally Well is working to fix it. [3]

What is Equally Well?

Equally Well is all of us! Equally Well comprises those who want to improve the physical health of people living with poor mental health. So far, every Australian government, 14 professional colleges/ societies, and almost 90 organisations have committed to Equally Well. Supporters of Equally Well work to improve the physical health of people who use mental health services by simply "doing what they can, where they can, when they can".

The Equally Well National Consensus Statement [4] lists 48 actions across six Essential Elements:

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

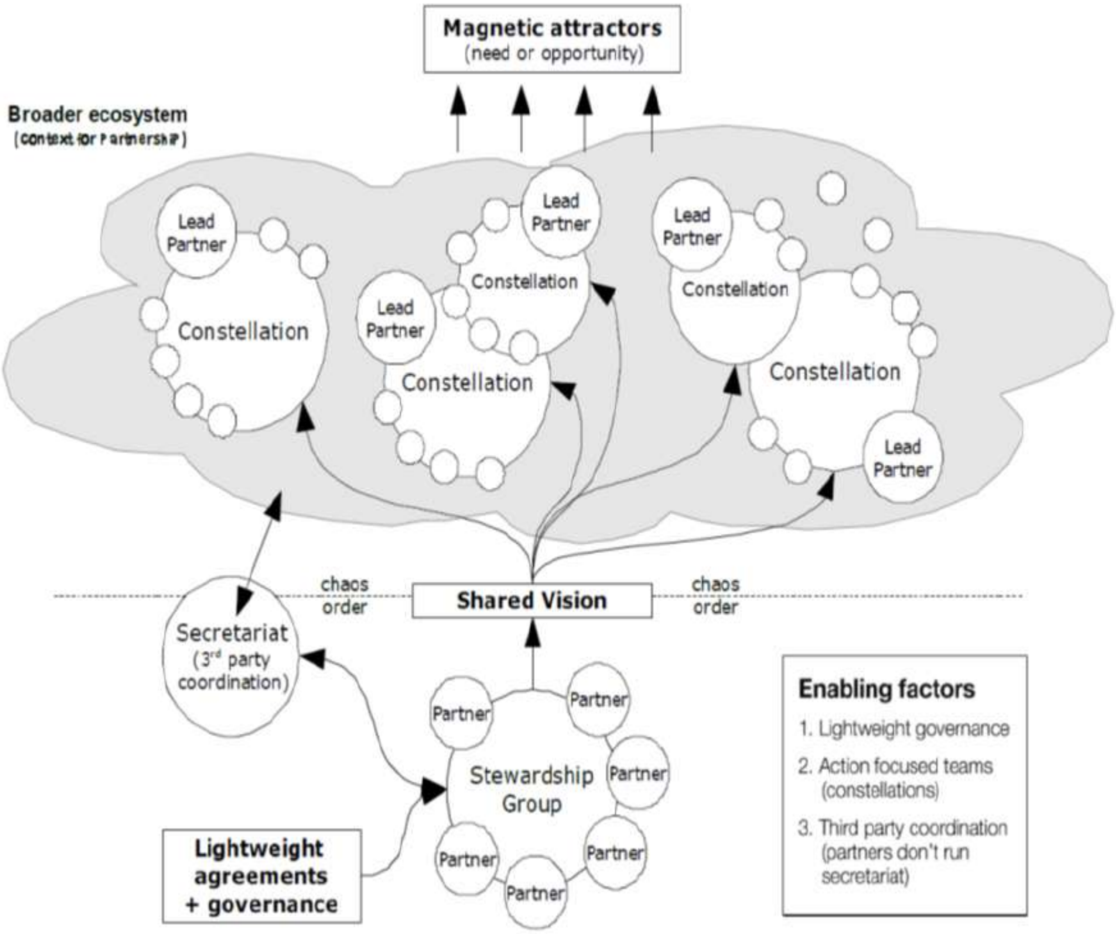

Figure 1. Constellation model of collective impact[10]

This is an international movement, with Equally Well also operating both New Zealand and the United Kingdom. Internationally, the actions to improve the physical health of people living with poor mental health are informed by the WHO guidelines for the management of physical health conditions,[5] the WHO multi-level intervention framework[6] and the Lancet Commission Blueprint for protecting the health of people with poor mental health[9].

In Australia, in addition to the Equally Well National Consensus Statement, the Fifth National Mental Health and Suicide Prevention Plan[7] and Joint Regional Planning Guidelines for Local Health Networks and Primary Health Networks[8] both prioritise the physical health of people living with poor mental health.

Equally Well Australia has adopted a Collective Impact Approach[3] to change and reform (see Figure 1).

This model assumes the case for change has been made and agencies are committed to action. It is also a *constellation model* of collective impact.[10] The Australian health and human services system has a number of sub-systems or constellations, such as consumer groups, carer groups, professional associations, non-government organisations, Primary Health Networks, local health services and various other communities of experience and practice. A collective impact approach works on the assumption we are more effective if we work together, sharing ideas, success and lessons learnt. This requires continuous communication across and within the key sub-systems. At its heart, Equally Well (and the Equally Well National Symposium) is a movement that facilitates this communication.

Mobilising action

The use of social media and electronic media is one mode of engaging and stimulating continuous cross-communication. We encourage readers to become part of this discourse by subscribing to Equally Well enquiries@equallywell.org.au or following, and sharing with us on social media.

The first **Equally Well National Symposium** comprises another important part of our collective impact strategy. It brought together partners from across Australia and across sectors to share learning and showcase innovation. This occured through the keynotes, the plenary panels and the concurrent sessions. It also happened between sessions and in the breaks where delegates exchanged contact details and made personal connections, which are so helpful in facilitating future contact.

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However, it was not possible for delegates to attend every session, or meet every presenter. As such, this book of proceedings has been compiled so the delegates, those who viewed the live video stream remotely, those who connected via social media and those not able to attend can also connect to the projects and presenters from the symposium.

Collective impact in action

The papers presented at the symposium highlight the diversity of approaches different stakeholders are taking. From around the world, particularly New Zealand and the United Kingdom, there is evidence of other Equally Well movements gaining traction and contributing to change in communities. Across Australia, Victoria is leading the way with its Equally Well policy framework and other jurisdictions are reorganising services to better respond to physical health needs for people in mental health services. A strong theme of maintaining human rights is evident, as is a loud consumer voice. Peer led and co-designed responses were showcased. Carers were also well represented, both in terms of the support they provide and in strategies to ensure their physical and mental health is not neglected.

From other presenters we saw work addressing issues of smoking and nutrition, with a good coverage across the lifespan, with young people and older people's mental and physical health also receiving attention. Cultural perspectives were also highlighted, including First nation narratives. This mix highlights the vitality of responses and the potential for change. The will to address this issue is clear.

Range of articles

The book of proceedings contains a range of articles and submission types.

- Full papers – peer-reviewed
- Full papers – not reviewed
- Written summaries of presentations
- Dot point precis of presentations.

For the purposes of focus and developing communities of interest, the papers are grouped by theme. To facilitate connection and collaboration, the presenter biographic and contact details are included with each paper. If a project is of interest to you, we encourage you to reach out and make contact with the authors and presenters in the spirit of a collective impact approach.

All the keynote presentations are available on the Equally Well website or our YouTube channel.

Together we can make a difference

A recent scan of activity against the six essential elements of Equally Well revealed 487 actions to progress Equally Well planned or underway. Some of the actions have been implemented across an entire state or territory, others involve one person in one small team. However, the impact is felt by every single person (and their carers and social networks) whose physical health improves and whose life is saved. We trust that the shared learning encapsulated in this book of proceedings will amplify this impact.

Viewed as a group, the papers in these proceedings show two things: that Equally Well is working and there is a great amount of work already going on, and that there is a huge amount of work left to do. Using the collective impact model, we can, and must, keep working until people who experience poor mental health are achieving the same physical health outcomes the rest of the population enjoys.

Symposium Co-Chairs

Chris Maylea, *RMIT University*

Russell Roberts, *Charles Sturt University*

Dave Peters, *NEAMI*

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Keynote summaries by Marie McInerney, Croakey News

Improving physical health for people living with mental illness

People living with mental illness experience much poorer physical health than others, for a range of reasons including their medications, silos between physical and mental health services, stigma and discrimination, and 'diagnostic overshadowing'. Journalist Marie McInerney covered the #EquallyWellAust symposium, which brought together more than 200 representatives of more than 80 agencies and organisations that have committed to the 2017 Equally Well Consensus Statement. The following is a summary of the program highlights.

IT'S NOT A KNOWLEDGE GAP, IT'S AN IMPLEMENTATION GAP

Mental health services need to provide interventions to improve the physical health of people who live with mental illness "as routine care", according to Equally Well exercise "ambassador" and keynote speaker Dr Simon Rosenbaum. Rosenbaum says only about one-third of all Australians are doing enough exercise "and that's without the additional barriers of living with a mental illness".

The challenge in mental health care is to create "the right culture, services and support", such as the South East Sydney Local Health District has done to support young people with psychosis. He said improved physical health of people with mental illness "really is an issue of equality and equity, making sure we meet the needs of people so we can support them to get active".

"We know what to do, we know how to do it, we just have to make sure we fund it, and actually do it," he said.

A PHN ASKS: HOW DO WE MAKE PHYSICAL HEALTH CHECKS ROUTINE IN MENTAL HEALTH?

In a vox pop interview ahead of the symposium, keynote speaker Libby Dunstan, from the Brisbane North Primary Health Network, and her colleagues Kasey McDonald and Cathy Faulkner, talk about why they were attending the inaugural event and what they hoped to take home from it.

A GLOBAL, URGENT MOVEMENT TO PREVENT TRAGIC DEATHS

In the opening address of the Equally Well symposium, National Mental Health Commission Advisory Board Chair, Lucy Brogden hailed the priority given to physical health in the special report released last year by The Lancet Commission on global mental health and sustainable development. Brogden later told Croakey: "The tragic headline is that today in Australia in 2019 someone with severe persistent mental illness has a life expectancy 24 years shorter than the rest of the population. That's just a tragedy by any strength of imagination. What makes it more tragic is these deaths are preventable." She said traditional siloed approaches to health care and training were barriers to addressing this profound inequity, and addressing the social determinants of health, including housing, gender equity, community services and urban design was also important to good care.

PIONEERING EQUALLY WELL – AND ADDRESSING CONSUMER CONCERNS IN AOTEAROA/NEW ZEALAND

Aotearoa/New Zealand pioneers Helen Lockett and Caro Swanson talk about the creation of Equally Well, which was founded in New Zealand in 2014, and the gains made and lessons learnt. They include addressing the concerns that people living with mental illness had in its early days that a new focus on their physical health might represent just another layer of scrutiny and stigma.

"We have a lot to learn about equity and experiences, that whenever there is a group that experiences disadvantage or a lack of power, it's too easy for the system to blame the person rather than to look at the system," Lockett said. They also discuss how they have built a diverse collaboration in New Zealand that is now beginning to produce strategic shifts in health policy and health care, such as having routine screening of people using mental health or addiction services as a priority area in New Zealand's National Diabetes Strategy.

EQUALLY WELL IN THE UK

In this six-minute video recorded for the symposium, Andy Bell, Deputy Chief Executive of the Centre for Mental Health in the UK, talks about how the Equally Well movement was formally begun in the UK last year, including through contact with Helen Lockett, one of the pioneers of Equally Well in New Zealand. Other major developments were the publication of a report – Improving the physical health of adults with severe mental illness: essential actions – by the Academy of Medical Royal Colleges and the implementation of the Mental Health Five Year Forward View by the NHS in England. Bell says Equally Well in the UK works on three core principles:

1. Improving physical health for people with mental illness requires collective action, "it has to be everyone's business";
2. The crucial answers are brought about by shared actions of people with professional expertise and those with expertise from lived experience;
3. We know what is needed and what works: "All of the solutions, we believe, are being done somewhere by someone" – the aim is to share ideas, insights and understandings to bring about the change.

MEDICATION/SIDE EFFECTS ARE PHYSICAL HEALTH PRIORITIES IN MENTAL ILLNESS

Maggie Toko, CEO of the Victorian Mental Illness Awareness Council (VMIAC), spoke about the development of Victoria's Equally Well Framework, which was launched at the symposium and is the first framework of its kind in the state. She said it had involved an "unprecedented" level of consultation with people using mental health services. She later talked to Croakey about the physical health priorities for mental health consumers, with over-medication of psychiatric drugs high on the agenda, including lack of consultation about the side effects of medications.

"When I started taking (psychiatric medication), I was 25 kilograms lighter, I didn't have type 2 diabetes, I didn't have chronic illnesses, all those things have come on board since I started taking medications," she said. "It's really hard to concentrate on losing weight when you are taking medications that make you eat…slow down your metabolism and slow you down so you are unable to be motivated to do anything, so all those things have to be taken into consideration."

WHAT SHOULD PSYCHIATRISTS DO TO IMPROVE PHYSICAL HEALTH?

Dr Kym Jenkins, President of the Royal Australian and New Zealand College of Psychiatrists (RANZCP), spoke to the symposium about what psychiatrists need to be doing to better address the physical health inequity experienced by their patients. She said: "I think we have a really important role in addressing stigma, monitoring side effects of all medications, not just antipsychotics, advocating and helping patients in lifestyle interventions. We need integration and communication with other health practitioners, I can't underscore that enough, and we need to advocate for systemic change." She talked to Croakey about several initiatives by the RANZCP to put physical health on the agenda in training, practice and prescribing, and about her own very personal lesson on 'diagnostic overshadowing'.

URGENT NEED FOR MEDICATION AND METABOLIC REVIEWS

Steven David, a Senior Clinical Pharmacist Mental Health for the Western NSW Local Health District in Orange, talks about a regional program that, in just six months, dramatically improved metabolic monitoring, medication reviews, and coordination among health services to improve the physical health of people with mental health issues. The project arose from a growing concern at the significant side effects of antipsychotic medications, notably obesity, diabetes and an increased risk of cardiovascular disease. "We're treating all these patients for their illnesses by reducing the psychotic symptoms but we're also killing them slowly through this emergence of these cardiovascular risk factors and diseases," David told Croakey.

SMOKING IS A SOCIAL JUSTICE ISSUE

Professor Lisa Brophy talks about the potential of involving mental health peer workers to help lift comparatively low rates of quit attempts and successes among smokers with severe mental illnesses. Brophy, who is Professor of Social Work and Social Policy at LaTrobe University in Melbourne and a Principal Research Fellow at Melbourne University, presented at the Equally Well Symposium with Mind Australia peer worker and researcher Nadine Cocks on the Quitlink: a peer supported smoking cessation research project. She later told Croakey that smoking should be seen as a social justice issue for marginalised groups, with a range of social and structural factors involved, including stigma and discrimination, and the costs of nicotine replacement therapy.

MAKING EQUALLY WELL HAPPEN, AND SOON

In this interview at the close of the event, social policy researcher Dave Peters, a keynote speaker, consumer representative and co-chair of the Equally Well Implementation Committee, wraps up #EquallyWellAust and the ongoing challenge for the 80-plus organisations and agencies that have signed up to the Equally Well Consensus Statement. “Everyone is really enthusiastic about the need for change but actually making it happen in a deliverable timeframe is the next challenge,” he told Croakey. “Part of it is the normalising of the issue and spreading the awareness that physical health outcomes are so bad for people with long-term mental illness – there are many people with mental illness who don’t know that.” He talked about the importance of bringing together people from across sectors, specialties and experiences of mental illness to discuss the issue, of the need to seriously address the impact of mental health medication and treatment on physical health, and of feeling “invigorated” about the possibility of better physical health outcomes for people living with mental illness.

Equally Well Victoria Launch

Physical health should be “routine care” in mental health

The National Mental Health Commission launched the Equally Well initiative in Australia in 2017 to improve the quality of life of people living with mental illness by providing equal access to quality health care. Equally Well aims to reduce the dramatic life expectancy gap between people living with a mental illness and the general population and where people with mental health issues often experience greater physical health challenges than the rest of the population but receive less care. Efforts in Australia, New Zealand, and the United Kingdom to bridge that gap were showcased at the Equally Well Symposium in Melbourne on 28-29 March 2019.

THE BENEFITS of physical activity for people with mental health issues are likely to be as apparent for traumatized Rohingya refugees in Bangladesh as they are in Australian services for people with mental health issues. Marie McInerney writes:

The world’s biggest refugee camp in Bangladesh may be the last place you would expect to find an Australian exercise scientist promoting sport. But Dr Simon Rosenbaum has been visiting the Kutupalong camp as part of research being done in partnership with the International Organisation of Migration. The focus is on exploring the use of physical activity programs like football, cricket and dance to help deeply traumatised Rohingya refugees.

Hundreds of thousands of Rohingya are living in dire circumstances at the hastily assembled camp, in one of the world’s poorest nations, having fled escalating violence across the border in Myanmar. “It’s one of the most distressing, horrible situations I’ve ever seen in my life – a million refugees living in a tiny camp,” Rosenbaum told Croakey after his return from Bangladesh recently. “But even in that context of mass displacement and the horrendous situation they are in, people still turn to sport.”

Rosenbaum is a UNSW Scientia and National Health and Medical Research Council Research Fellow and a Director of Exercise & Sports Science Australia.

He says physical activity is a potential lifeline for the Rohingya and other refugees scattered in makeshift settlements across the globe, displaced and distressed, often experiencing idleness and boredom as well as post-traumatic stress disorder (PTSD).

As well, in these camps they end up eating higher levels of processed food, salt and sugar than their usual diets, which increases the risk of non-communicable diseases (NCDs), such as cardiovascular disease and strokes, as well as obesity and diabetes.

While their plight is extreme, it reflects a common story for people with mental health issues that Rosenbaum stumbled into after completing his degree in exercise physiology, when by chance he was offered work at a private psychiatric hospital in Sydney.

“I saw firsthand the benefits of activity for people with post-traumatic stress disorder (PTSD) and was frustrated they couldn’t get access to funding for exercise services because the response was that there was no evidence to support it,” he said.

In 2014, for his PhD, he led a 12-week clinical trial with 81 people, mostly former soldiers and police officers, in residential treatment at St John of God Hospital in Richmond in Sydney. Half the patients received usual care – a combination of group therapy, medication and psychotherapy. The others had a structured, individualised exercise program combining walking and strength-based exercises in addition to usual care.

The study found that those patients who received the exercise program showed greater improvements in symptoms of PTSD, depression, anxiety and stress compared to those who received usual care alone, and slept better. They also lost weight and reported significantly more time walking and less time sitting, ultimately reducing their overall risk of developing heart disease, he said.

Rosenbaum says there is "much overlap" between that study and his continuing work in mental health services in Australia and his experiences working in Bangladesh and with Syrian refugees in Turkey.

The benefits of physical activity for people with mental health issues are, he says, many and varied, including "the opportunity to build self-esteem, a sense of achievement, social interaction, an escape, optimism, hope, community and purpose, not to mention the physiological benefits as well for chronic mental and physical health".

"It's completely transcultural," he said. "It doesn't matter if it's a Rohingya refugee in a camp in Bangladesh or a person with psychosis in Sydney, they get the same benefits from exercise," he said.

One of our biggest public health challenges

Rosenbaum was a speaker at the Equally Well National Symposium in Melbourne to showcase efforts in Australia, New Zealand and the UK to improve the physical health of people living with mental illness. According to the National Mental Health Commission, the interaction of mental illness with other chronic diseases is one of Australia's biggest public health challenges.

A recent edition of the Mental Health Victoria and Community Mental Health Australia publication newparadigm was dedicated to the physical health concerns of people living with mental illness that "continue to go unrecognised, undiagnosed, and untreated".

It outlined the grim statistics: almost four in every five people living with mental illness have a coexisting mortality-related physical illness, and people living with severe mental health issues have higher mortality rates than the general population with a notable life expectancy gap of between 10 and 20 years.

"Some estimates suggest that the lives of both men and women with serious mental illness are up to 30 per cent shorter than those of the general population and Australian research indicates that the gap is increasing rather than diminishing," the Royal Australian and New Zealand College of Psychiatrists (RANZCP) says in a report on improving the physical health and life expectancy of people with serious mental illness.

The National Mental Health Commission has drawn up an Equally Well National Consensus Statement, which draws on an original Equally Well model from New Zealand. It has been backed by almost 90 groups across Australia, including health departments, state mental health commissions, medical colleges, carer and consumer organisations, Primary Health Networks (PHNs), peak bodies and community managed organisations.

The symposium sought to focus on the statement's six essential elements: equipping and engaging consumers, promotion and prevention, equity of access, providing quality care, care coordination, and measuring progress.

"Your biceps don't care about your diagnosis"

Rosenbaum explained the message of his presentation for mental health services and professionals will be similar to the one he brings from Bangladesh, where there is pitifully little space or equipment for sport: that often the people who stand to benefit most from physical activity are the least likely to be able to access it.

"A homeless person with schizophrenia is not going to join a gym but that person stands to benefit so much, both physically and mentally, from having access to exercise, so the question is how do we provide the systems and structures that support that?" he said.

The answer, he says, is for access to dietary advice and physical activity to be embedded in routine care, to have mental health practitioners trained in diet and lifestyle issues, including for themselves, and for exercise physiologists, dietitians and physical therapists to be trained in mental health at an undergraduate level.

“It’s about having (physical) interventions integrated as part of routine care,” he said. “It’s not treating it as an add-on, if you have time, or that’s someone else’s responsibility. If you’re a patient, just as you’d expect access to a psychiatrist or psychologist, likewise you could expect access to physical health interventions, whether that’s through referrals for private practice, for inpatient settings or community mental health settings.”

There have been strong moves towards that, including under Medicare’s enhanced primary care referral scheme, where GPs can refer patients with mental health issues to up to five sessions with a dietitian or physiologist. But Rosenbaum said the scheme is under-used, because of “lack of awareness, training, traditional silos (in health care), and ‘diagnostic overshadowing’,” where people with mental health issues experience delays in diagnosis and treatment of physical illness because their symptoms are seen as mental health issues.

He outlined work recently done in the South East Sydney Local Health District, to be reported in the near future, to develop individual exercise programs and sustainable diets with staff, giving them direct exposure to how interventions can work.

“It’s had a significant effect on the attitudes, confidence and knowledge of the mental health workforce towards exercise and dietary interventions,” he said. “More importantly, they’ve now embedded these interventions as part of routine care.”

And, he says, there’s nothing that needs to be specially invented or tailored to mental health issues, whether for patients in Sydney or the refugees in Bangladesh.

News from a growing global movement to improve physical health of people with mental illness

Marie McInerney writes:

A team of international health experts has nominated the physical health of people with serious mental health issues as one of the most important priorities for the global mental health agenda. National Mental Health Commission Advisory Board Chair Lucy Brogden has hailed the priority given to physical health in the special report released last year by The Lancet Commission on global mental health and sustainable development.

LUCY BROGDEN opened the first national symposium staged by the national Equally Well initiative, which was established under the leadership of the Commission in Australia in 2017 to improve the physical health toll experienced by people with mental illness.

She thanked New Zealand Equally Well leaders in the room for having launched the concept in 2014 and for working closely with Australia. "It truly is 'from little things big things grow'," she said yesterday. "We are really seeing a movement take hold in this space."

Brogden represented Australia on behalf of Health Minister Greg Hunt at the Global Mental Health Ministers forum last October in London, a high-powered event held to mark the release of The Lancet Commission report.

The Commission, which sought to capitalise on the Sustainable Development Goals to consider future directions for global mental health, proposed expanding the agenda from a focus on reducing the treatment gap to improving the mental health of whole populations and addressing gaps in prevention and quality of care.

Blueprint for action

The Commission outlines a blueprint for action to promote mental wellbeing, prevent mental health problems, and enable recovery from mental disorders. The report calls for a re-framed agenda in global mental health, saying that despite substantial research advances showing what can be done to prevent and treat mental illness and to promote mental health, translation into real-world effects "has been painfully slow".

Its verdict was: "The global burden of disease attributable to mental disorders has risen in all countries in the context of major demographic, environmental, and socio-political transitions."

In response, The Lancet Commission's first call for action is: "Mental health services should be scaled up as an essential component of universal health coverage and should be fully integrated into the global response to other health priorities, including non-communicable diseases, maternal and child health, and HIV/AIDS. Equally, the physical health of people with severe mental disorders should be emphasised in such integrated care."

Brogden told Croakey it had been exciting to have subsequent discussions with representatives of many other countries on the work being done on Equally Well.

It was already underway in the UK, and there was real appetite to take up similar work in Europe and particularly in Africa, and to work out how to leverage good existing physical health models to work with people with mental health issues as well.

"We can start to build an integrated model from scratch in some of these (developing) countries while we're catching up and designing a more integrated model ourselves," she said.

Symposium focus

The Equally Well Symposium brought together, for the first time, more than 200 people to look at how to implement the Equally Well Consensus Statement, and how to create a strong platform across the health sector and community to help the physical health outcomes for people with persistent and severe mental health conditions. Attending the event were clinicians, health service providers, researchers and people with lived experience from across Australia.

Brogden told Croakey the need for action was urgent: "The tragic headline is that today in Australia in 2019 someone with severe persistent illness has a life expectancy 24 years shorter than the rest of the population. What makes it more tragic is these deaths are preventable if we get in early on both the physical and mental illness. If we tackle them early, we can prevent these early deaths and the onset of more significant illness."

The "simple premise" for Equally Well is that a person living with severe mental illness should have the same right to physical health as anyone else.

Brogden said that when she says such things outside the health sector "they can't believe that in 2019 we have to make statements like this – but that is the reality".

The hope is that powerful reports like that of The Lancet Commission will help to put the issue of physical health outcomes high also on the agenda for the Productivity Commission inquiry into mental health, as well as the Royal Commission into Mental Health in Victoria.

"This is the number one global action for mental health and the governments at that forum all agreed to that," she said.

Brogden is looking to those inquiries to reveal problems with "culture" in health and mental health in the same way that Royal Commissions have done so into banking and aged care. In response to a question from a delegate, she said the Mental Health Commission also planned to make a submission to the proposed Royal Commission into abuse of people with disability.

She quoted management guru Peter Drucker as saying, "culture eats strategy for breakfast".

"We can have these beautiful documents, consensus statements that everyone puts their name to, but it's for naught if in our minds and behaviours we are still doing old practice, old ways, and not embracing a new mindset," she said.

Bust the silos

She nominated silos in health care as one of the biggest barriers to change and something she knows too well through personal experience, as the wife of former New South Wales Opposition Leader John Brogden. He experienced a mental health crisis in the full public glare and continues to work as an advocate for mental health and speak openly about the ongoing struggle he faces.

"I can tell you, nothing is more frustrating…(than when) I'm looking at my husband, working hard at recovery and now at risk of diabetes and heart disease, to be told (by a mental health specialist) that (his physical health) is someone else's problem," she said.

She later came close to tears when she told delegates that she wasn't able to stay for the full conference because Brogden was on Thursday turning 50. "For someone who lives with mental illness to get to any birthday is an achievement," she said. "But to get to 50 is a really big milestone which at times we didn't think we would get to."

Look for system change

In a wide-ranging address, Brogden said she tries to frame her work by the Justinian principle: "The wellbeing of the people is to be the highest law."

"What a great test to apply: (to ask ourselves) 'Am I enhancing, am I protecting, am I promoting the wellbeing of people or am I actually doing some harm?" That question was a big one at the symposium and explored particularly by people with lived experience who say a major contributor to their physical ill health is the use of isolation, restraint and over-medication in their treatments.

So too was concern that implementation of Equally Well strategies may be widely embraced by all those who sign up for it but not put into action.

Brogden finished her address with an appeal for delegates not to get tempted by the “low hanging fruit” but to look for system change. “We know what the problem is. Often I find in our sector, in our space, we like to keep talking about the problem, identifying the problem, quantifying the problem,” she said.

The symposium was, she said, “an exciting opportunity to move this all forward”.

Diverse collaboratives are driving efforts to improve the physical health of people with mental health conditions

In its early days, a movement in Aotearoa/New Zealand to address the poorer physical health of people with mental health conditions sparked some alarm bells among those with lived experience of mental illness. However, a national conference heard how these concerns were addressed, reports Marie McInerney, who was covering the Equally Well Symposium in Melbourne for the Croakey Conference News Service.

AS A PERSON with lived experience, Caro Swanson did not need to be convinced that people with mental health conditions suffered poorer physical health than the rest of the population. "Even when I started using mental health services 30 years ago, we all knew we popped off earlier than most people," the New Zealand mental health advocate said in a keynote address to the Equally Well Symposium.

On one hand, she welcomed moves that began about five years ago in the NZ mental health and addiction sectors to address the number of "untimely and unexpected deaths" occurring among people using their services. However, she was also uneasy about the development of what became the world's first Equally Well strategy and collaboration, which looked to address the inequitable physical health toll for people with mental health problems.

She said: "I had the scary feeling of stuff being done to and for us, without us. I was also worried that we are a group of people who are under intense scrutiny a lot of the time and 'now you're going to put the rest of our lives under scrutiny too!' Not only do we have to reveal our deepest, darkest (thoughts), not only do they get examined, talked about and judged by people we don't even know, but now you're going to start looking at our physical health and make judgements there as well."

Treatment side effects

Echoing the experience of many other people with lived experience who spoke at the symposium, Swanson said she had struggled with weight gain as a side effect of both mental health issues and the treatment for those issues, particularly anti-psychotic medication. "For me, having monthly girth measurements wasn't going to do anything for my mental health," she said.

Another concern was whether everyone with serious mental health issues actually wanted to be given an extra 20 years of life. "I was really concerned that no-one had asked us if we wanted to live the extra years because, to be honest, unless our lives are worth living why would you want that, and some of our decisions about how we live are made on that premise."

A further worry was what people with lived experience would feel when they heard the statistics: that people using mental health services have more than twice the mortality rate than the general population and that people with experiences labelled as psychosis have more than three times the overall risk of premature death. "I was really concerned about the impact when people with lived experience suddenly realised this was them, that these awful statistics belonged to them."

A champion

Five years on, Swanson is now the principal advisor, mental health and lived experience, at Te Pou o te Whakaaro, a national centre of evidence-based workforce development for the adult mental health, addiction and disability sectors in New Zealand. She has also been a lived experience champion of Equally Well in New Zealand since its formal inception in 2014. Her concerns were assuaged, she told the symposium, by what happened when she brought them up with Equally Well pioneer and strategic advisor Helen Lockett.

"Helen listened and took it seriously," Swanson said. "That's when I became a champion. The more we talked together, the more we realised how aligned we were, but also how we could trust each other to have, not quite difficult conversations, but really frank ones, and checks and balances with each other."

Swanson told Croakey she still holds the concerns to a degree, because there is always a tendency for people "with all the right intentions to patronisingly do the 'what's best for you' thing". But she said those concerns have led to a sensitivity about how people might work on Equally Well efforts with people with lived experience and how to send out messages in the right way.

Consensus statement

Swanson and Lockett jointly presented at the Equally Well Symposium, the first event in Australia to bring together people who have signed up to a Consensus Statement aimed at improving the physical health and wellbeing of people living with mental illness in Australia.

Lockett described how New Zealand has led the way on establishing an Equally Well collaborative, seeking to bring together disparate parts of the health sectors – "people effecting change at multiple places in multiple levels" – to work together on both systemic and program level change. She said the collaboration is now beginning to produce strategic shifts, such as having routine screening of people using mental health or addiction services as a priority area in New Zealand's National Diabetes Strategy.

Another has been having the Heart Foundation recommend cardiovascular screening from the age of 25 years for people with severe mental illness (schizophrenia, major depressive disorder, bipolar disorder, schizoaffective disorder). There will be a focus this year on oral health, on the needs of Maori and Pacifika communities, and on contributing to a high level review of New Zealand's health and disability system that is currently underway and to the national government's response to a major inquiry into mental health and addiction services.

"We've got a groundswell of people (taking action at the local level) but there are some things at a policy and funding level that can make things easier for us," said Lockett, who works at the not-for-profit Wise Group and is a senior advisor to the Organisation of Economic Cooperation and Development (OECD) and the New Zealand Government.

Beyond lifestyle drivers

Lockett and Swanson say an important step in addressing concerns of people with lived experience has been to ensure that Equally Well has not focused on so-called "lifestyle factors" as the drivers of inequity. Lockett admitted she initially had wanted to include lifestyle issues, given that they were "all over the literature". But for Swanson, this focus was part of the stigma, the "patient blaming" that leads to stereotypes in and out of mental health services.

Swanson said: "What we showed was, yes, lifestyle choices are part of it, but we all have those and we don't all make good ones. But there are all these other things that affect (people with lived experience) as well. It took the blame off the person and put it where it (belongs), with some of our systems that don't work well together and with things that were unnoticed before all this."

Lockett gave as an example the separation of mental health and drug and alcohol addiction services from mainstream health, geographically as well as in funding. She said: "That makes it incredibly difficult, for example, to get early intervention for diabetes if you're in a mental health or addictions hospital. We have a lot to learn about equity and experiences, that whenever there is a group that experiences disadvantage or a lack of power, it's too easy for the system to blame the person rather than to look at the system."

So-called 'diagnostic overshadowing', where health professionals see all physical health issues through a mental illness lens, is also a big issue to address, as are the social determinants of health, "people living in poorer quality homes, not having a job, not having a high enough income".

Diverse collaboratives needed

The breadth of the contributing factors requires response from a "diverse collaborative" of people across services – from pharmacists and dentists to exercise specialists, cardiovascular specialists and psychiatrists, Lockett and Swanson said.

They offered some tips for building and sustaining such a collaboration:

1. Create a sense of urgency
2. Involve the people affected from the outset
3. Help individuals and organisations see how they can contribute
4. Build a virtual community
5. Develop distributed leadership
6. Work with diversity, respect difference
7. Build understanding and bridges across different sectors.

Why the physical health of people with mental illness is a critical human rights issue

The harmful effects of mental health treatments – especially medication but also seclusion and restraint – were much-discussed at a recent symposium seeking to address health inequalities experienced by people with mental health conditions. Efforts to improve the physical health of people with mental illness must start with changed prescribing practices and ensuring that mental health services comply with international human rights obligations, the Equally Well Symposium was told. The two-day symposium came ahead of a report released in Victoria that urged the state's Royal Commission into Mental Health to investigate rising rates and duration of seclusion in mental health facilities and a lack of transparent data about how and why seclusion is used at individual facilities across Victoria. Marie McInerney writes:

"DO YOU PLAN ON BEING OLD?" the former New South Wales Mental Health Deputy Commissioner, Fay Jackson, bluntly asked delegates at the Equally Well Symposium in Melbourne. "I don't," she said. "It's highly unlikely I'll make it."

Jackson, who was diagnosed with depression and hearing voices as a teenager and later with bipolar disorder, asked those in the room aged 57 and over to stand up. "That's the age that most of us die at," she said. "If you are people with diagnoses like schizophrenia and bipolar, you probably don't have much time left."

Jackson told the symposium that when she first went onto antipsychotic medications, she gained 22 kilograms in two months. "It wasn't about diet, it wasn't about eating and drinking too much. It was about nothing other than the medication – that's what caused it," she said.

It was an overriding message from many people with lived experience of mental health at the symposium – that they face worse physical health and earlier death not because of their mental health, but due to a range of other factors, including some mental health medications and the discrimination they face in health services and health care.

"I've stopped calling it stigma," Jackson said of how people with mental illness are treated in the health system. "It's discrimination."

Leading Victorian mental health advocate Indigo Daya, human rights advisor at the Victorian Mental Illness Awareness Council (VMIAC), echoed Jackson's concerns. She told delegates that she had felt uncomfortable, working previously in the public service, when a bunch of colleagues were talking about what they would do when they retired.

She realised it was because she did not expect to live to retirement age. It was a shocking revelation, "but I know the statistics, the risks for someone like me who has lived for years with antipsychotics, the weight gain associated with that".

A lot of that reflected the treatment she was given, she said, describing how a psychiatrist had "lied to me by omission" when she was first prescribed antipsychotic medication. She said: "The only thing I was told about side effects was 'you might gain a bit of weight'. I don't know about you, but gaining 50 kilograms in one year is not what I would call 'a bit'. This is not okay."

A shared commitment

The symposium brought together, for the first time, organisations and agencies across Australia that have signed up to the Equally Well Consensus Statement, a commitment to improve the physical health of people with mental illness. Delegates included people with lived experience, clinicians, pharmacists, researchers and service providers.

The statement was initiated in 2017 by the National Mental Health Commission out of a growing concern that people living with mental illness have poorer physical health yet receive less and lower quality health care than the rest of the population – and die younger. People with psychosis die 14-23 years earlier than the general population.

Many contributing factors were raised at the symposium, including silos between mental and physical health services, diagnostic overshadowing, ‘lifestyle’ issues like smoking, and socio economic factors such as poverty and precarious housing. But many speakers with lived experience also highlighted poor mental health treatment and practice as a powerful contributor and breach of human rights.

“Too many of us are disabled when we needn’t be,” said VMIAC CEO Maggie Toko. She urged clinicians and services to cut back prescriptions of multiple antipsychotics at once, to consider lower doses, safer treatment options like therapy, and to start being honest with consumers about side effects and health risks of the treatments they prescribe.

Toko said: “Consumers are very clear that the biggest priority are the health problems that are caused by psychiatric treatment, the health problems we wouldn’t have if we hadn’t been to your services, like obesity, diabetes, cardiovascular disease, movement disorders and too much more. We have the right to know if a treatment will shorten our lives, even if you force us to take it. Leaving us in the dark means that too many people never get the chance to try and improve their health. If we are ever going to make a difference in the physical health of consumers, it starts with the prescribing practices of psychiatrists.”

Rights and violations

Article 25 of the UN Convention on the Rights of Persons with Disabilities (CRPD) makes it clear what health services should provide to people with mental illness and other disability. It includes requiring health professionals to “provide care of the same quality” to people with mental illness as to others, including on the basis of free and informed consent.

Co-presenting with Daya at a plenary session on ‘Physical health as a human rights issue’, RMIT mental health law academic Dr Chris Maylea urged mental health services and professionals to adopt “a rights-based approach and critique underpinning the work we do”.

He showed a slide comparing the quality of care offered to patients at Melbourne’s Peter MacCallum Cancer Centre, where there was even hairdressing and manicure services, versus the basic services available at most in-patient psychiatric services.

He said: “We can talk about resource issues but when you deny someone a level of service please look them in the eye and say, ‘because of resource issues I’m violating your human rights’.”

Daya has long been outspoken about the human rights breaches and risks to health of compulsory treatment orders and of the use of seclusion and restraint in mental health care, including she says as punishment, for example for smoking in in-patient services.

She led recent VMIAC research on the use of seclusion in mental health facilities in Victoria, which highlights significantly different rates in services across the state and calls for more transparency and an end to the practice. As well as causing significant psychological harm and breaching human rights, the report says seclusion can lead to serious physical harm as was seen in the tragic death of Miriam Merten at the Lismore Base Hospital in northern New South Wales.

Speaking on ABC radio after the release of the seclusion report, Daya blamed “poor culture and a lack of skills” in the mental health sector for high rates of seclusion. “We see an alarming lack of counselling and therapeutic skills in the mental health workforce at the moment; they don’t always know what to do when someone is in serious distress, so they just lock them up,” she said.

Daya challenged the mental health mantra that compulsory treatment "is done in our best interests". "If you think someone lacks the capacity to make their own decision, the answer is not coercion to make decisions on our behalf, the answer is supported decision making," she said. "It's finding (out) what is that support we need to make our own decisions, not to substitute your decisions for ours."

Maylea said services that fail to recognise the importance of agency and autonomy will continue to struggle in other efforts to improve the physical health of people with mental illness. "There is no way someone is going to quit smoking if they don't feel they have autonomy in their own life. There is no way that someone is going to go to the gym or engage with other health professionals if they don't feel they are getting dignity from mental health services. Human rights aren't something you can bolt on. If you are doing mental health service provision and you are not maintaining human rights, not upholding dignity and autonomy, you are not doing mental health work."

Raw honesty

Presenting the closing keynote address to the symposium, Jackson spoke with raw honesty about her experiences in health services. She talked about the trouble she has to go through to convince each new doctor or specialty to take her physical health seriously, once she has to list her conditions: not just significant mental illness and cancer, but also serious side effects of medication, including often disabling shaking. "I have so many chronic illnesses that it seems like I'm a hypochondriac," she said.

She said it was not just her own health that was at risk from poor attitudes to mental health, but that of her family as well. She talked about desperately taking a sick child several times over some days to a doctor who dismissed her concerns as delusional. It was only when her husband convinced another doctor to act – "Fay is a bit unwell at the moment but she knows our kids" – that their child was admitted to hospital and diagnosed with gangrenous appendicitis.

Jackson urged mental health professionals and policy-makers at the symposium to go away and "actually make a difference" as a result of the things they had learnt. "This isn't about your ego or even about your research or about your clinical work, this is about making a difference, a positive difference," she said.

Supporting healthy decision-making

The symposium also heard about a Health Talk Australia project where researchers spoke to 29 people across Victoria from a range of backgrounds who have received various psychiatric diagnoses including psychosis, schizophrenia, bipolar disorder, and depression. In the videos, interviewees talk about their experiences of diagnosis, medication, hospitalisation, experiences with health professionals, discrimination, personal recovery, and their views about how they could best be supported by health professionals in making decisions about treatments and other aspects of their lives.

Profiling diverse efforts to improve the physical health of people with mental illness

Eighty key health agencies and organisations have signed the Equally Well Consensus Statement, formally pledging to improve inequalities that lead to poor physical health outcomes for people with mental illness. These supporters include all jurisdictional health departments, state mental health commissions, medical and nursing colleges, carer and consumer organisations, Primary Health Networks (PHNs), peak bodies and community managed organisations. The recent #EquallyWellAust symposium in Melbourne sought to highlight efforts to put those commitments into action and find ways to build momentum. Marie McInerney writes:

STRONG EFFORTS are being made around Australia to improve the physical health of people with mental illness, through changes in clinical practice, policy and education. Some efforts were showcased at the recent #EquallyWellAust symposium in Melbourne, the first time that agencies and organisations signed up to the 2017 Equally Well Consensus Statement have come together to discuss that commitment.

The event brought together policy-makers, academics, clinicians, service practitioners and people with lived experience of mental illness to showcase success and try to identify and address barriers to implementation of Equally Well priorities. Together they highlighted the need to break down silos between physical and mental health care, to address the stigma that many health professionals still have about mental illness, and to tackle 'diagnostic overshadowing', where health professionals see physical health issues only through a mental health lens.

The forum also heard that targeted lifestyle interventions can work for mental health clients and staff but that a focus on weight alone does not work and is also not fair for so many people with mental illness whose medications promote significant weight gain.

In an interview at the end of the event, Dave Peters, consumer representative and co-chair of the Equally Well Implementation Committee, told Croakey that the forum was an important step in itself, in providing a platform to "normalise" the issue.

But acting on those concerns raised was the critical next step, especially given that Equally Well has just a few paid support staff and is led by people with other day jobs. "Everyone is really enthusiastic about the need for change but actually making it happen in a deliverable timeframe is the next challenge," he said.

Metabolic and medication reviews

In just six months, a project in regional New South Wales has dramatically increased the number of people in community mental health settings who are having regular metabolic and medication reviews. The proportion of patients having these reviews, which check for adverse reactions to medications and treatment, jumped from less than 10% to nearly 70%.

The project was part of a multidisciplinary effort by the Western NSW Local Health District in Orange to better manage the physical health of patients in the community and avoid acute hospital admissions through better integration of care. Steven David, the area's Senior Clinical Pharmacist Mental Health – one of a handful of specialist mental health pharmacists in NSW – said the project arose from a growing concern at the significant side effects of antipsychotic medications, notably obesity, diabetes and increased risk of cardiovascular disease.

"We're treating all these patients for their illnesses by reducing the psychotic symptoms but we're also killing them slowly through this emergence of these cardiovascular risk factors and diseases," David told Croakey at the symposium.

Baseline studies found that less than 8% of community mental health clients had an accurate medication history and less than 5% were documented to have recently had cardiometabolic screening to look for a cluster of risk factors associated with the development of cardiovascular disease, including diabetes, raised cholesterol and high blood pressure. This was despite strong evidence that people with psychosis face a reduced life expectancy of up to 20 years compared with the general population.

David told the symposium that the project, Integrative multidisciplinary services: key towards improvement in mental health delivery, brought him together with nurses, social workers, GPs, dietitians, and psychiatrists to try to address gaps in medication and metabolic reviews and between hospital, community mental health and local GP services.

For the 80 clients involved over the six-month project, metabolic and medication reviews rose to 67%, and the project identified 13 medication-related errors and six incidents of adverse drug reactions.

David told of one patient who was being managed on a mood stabiliser and reported in multiple health interactions that she was experiencing worsening myopia. She had changed her prescription glasses about six times in two years but nothing had been done to investigate why she needed so many replacements – until the project team reviewed her care, highlighted the problem, and gave her different medication "and better quality of life".

David told Croakey that pharmacists could play a critical role in improving the physical health care of people with mental illness, given their frontline role in taking a history of medications and previous adverse events. But he said most community pharmacists need more training to be able to identify issues and to address stigma that made many uncomfortable or fearful dealing with people with mental illness.

Psychiatrists as advocates

Psychiatrist Dr Kym Jenkins told the symposium she had received a personal and powerful lesson some years ago on the risks of 'diagnostic overshadowing' – where a person with a mental illness receives inadequate or delayed treatment for physical health issues because a health professional attributes their physical symptoms to their mental illness.

Jenkins, president of the Royal Australian and New Zealand College of Psychiatrists (RANZCP), said her mother experienced various mental health issues throughout her life. She said: "Shortly after my father died her moods seemed to be very flat. She wasn't able to enjoy anything, she wasn't smiling when the rest of the family were laughing. We put it all down to grief and her dipping back down into another episode of depression, until I took her to a GP who, as soon as we walked into the room, said, 'But your mum's got Parkinson's disease!'"

It was, Jenkins said, a huge wake up call. "Here am I, as a psychiatrist, seeing it through my lens of depression and mental illness, completely missing the fact that my own mum had Parkinson's disease. What a huge bit of diagnostic overshadowing that was."

Jenkins said the RANZCP realised about five years ago that it needed to play a much larger role in mental health advocacy and one of its first campaigns was about the physical health of people with serious mental illness. It sought to draw the attention of governments and policy-makers to the reduced life expectancy of most people with serious mental health issues, and to work with its own committee and members to drive change in practice, she said.

"I think we have a really important role in addressing stigma, monitoring side effects of all medications, not just antipsychotics, advocating and helping patients in lifestyle interventions," she said. "We need integration and communication with other health practitioners. I can't underscore that enough, and we need to advocate for systemic change."

To that end, the college published four reports that documented the issues and economic cost of serious mental illness in physical health terms. It has also published an expert consensus statement for the treatment, management and monitoring of people with serious mental health illness, and included physical health in new clinical practice guidelines and at Your Health In Mind.

But she agreed with audience members that there was a continuing need for system change, including where most public hospital psychiatric appointments last for only 15 minutes. Similar time and funding pressures and a relative lack of evidence base meant that important 'talk therapy', like cognitive behaviour therapy, also did not get prescribed as easily as medication, she said.

Speaking to Croakey, Jenkins acknowledged grave concerns expressed at the symposium by people with lived experience of mental illness about the impact of mental health medications and treatments on their physical health, and stressed the importance of supported decision-making.

She said: "Whenever considering medication it's got to be as far as possible a joint decision. With any intervention in medicine, particularly medication, the patient needs to be fully informed and aware of the pros and cons and benefits and side effects and balancing up the right thing for that person at the right time. And (of) being given options and choices."

Recruiting nurses to the cause

AUSTRALIA'S 410,000 nurses and midwives should be a priority focus in improving the physical health of people with serious mental health issues, according to Adjunct Associate Professor Kim Ryan, CEO of the Australian College of Mental Health Nurses (ACMHN).

Ryan told the Equally Well Symposium nurses and midwives are often the first point of contact for many people with mental health concerns in the health system but are not necessarily alert or skilled to help manage mental health issues.

Ryan is hopeful the current review of registered nurse accreditation standards will strengthen the mental health component of undergraduate studies "so we'll have all nurses coming out of uni with a better understanding of mental health and the intersection (with physical health for people with serious mental health issues)".

The ACMHN has also developed a mental health scope of practice for general practice nurses, and introduced five online modules, starting with 'mental health first aid 1.01', to help them be more alert to the issues.

"For example, we do know that men over 45 who have a heart attack are going to have an increased risk of suicide that stays high for 12 months," she said. "If their GP and practice nurses who are checking their blood pressure don't know to ask about depression, that's going to get missed, so it's really important we get general practice nurses to know about the incidences and be confident to ask the questions and do something with it."

Since the modules were introduced in July 2018, they have been viewed by more than 4,100 people, enrolled in by 2,000 people and completed by 1,500. The College has also developed a physical health care check reminder card to go with the ACMHN's popular Mental Status Examination (MSE) cards that are attached to ID lanyards and used by mental health nurses, primary care nurses, student nurses and others in their daily practice. More than 5,000 cards have been distributed since October 2018.

A Victorian first

VICTORIA'S EQUALLY Well Framework, the first of its kind in the state, was also launched at the symposium, and lauded for the "unprecedented" level of consultation by government with people using mental health services and their carers.

It includes introductions from the peak mental health consumer and carer groups, the Victorian Mental Illness Awareness Council (VMIAC) and Tandem.

VMIAC CEO Maggie Toko told the symposium: "We often get to comment on documents like this, and sometimes, our feedback is acted on, (though) often it is not. We never think that's okay because, after all, these documents are about our lives. But this is the first time we've been asked to write our own section of a formal framework. I think that's very significant (but) more so because we were never asked to change anything that we wrote. Our contribution was included word for word."

Launching the framework, Chief Mental Health Nurse Anna Love said it describes a range of initiatives for organisations and clinicians to work in partnership with consumers and carers to discuss physical health in the context of a mental health recovery plan.

Lifestyle interventions

THE SYMPOSIUM also heard about a lifestyle intervention program run by the South Eastern Sydney Local Health District (SESLHD) that has reported significant and long-term physical health gains.

Andrew Watkins, co-developer and clinical lead of the Keeping the Body in Mind (KBIM) program, said it emerged out of a concern among staff that young people with early psychosis experienced significant weight gain after beginning treatment. "We were seeing their body shapes changing in a matter of weeks or months," he said.

Watkins' first response was to bring in a soccer ball from home and to go down to the local park for a kick with some of the young people, but the program grew. It added first a cooking club, converted a room into a gym, and then developed into a 12-week KBIM program run by a team of four – a clinical nurse consultant, exercise physiologist, dietitian and a peer support worker – which built in evaluation and achieved impressive results.

Where the average weight gain in the first two years of mental health treatment for young people with early psychosis is 12 kilograms, young people in the KBIM program were "weight neutral", or had no change to their waist circumference, after two years – exceeding the expectations of the team.

"Instead of setting up people at the start of mental health treatment for a lifetime of physical poor health, we were actually setting them up for lifetime of healthy living," Watkins said, noting that the first three months of treatment was the critical time.

He said his hope is that mental health services around the world will sign up to the Healthy Active Lives (HeAL) international declaration, aiming for health care professionals and their organisations to work together to protect and maintain the physical health of young people experiencing psychosis.

But while there is growing evidence of the benefits of programs like KBIM, which is now run by four teams and for adults at the SESLHD, Watkins said traditional "silo" thinking between physical and mental health practice remains a barrier for many services.

To address that, the KBIM team did a staff intervention, called Keeping Our Staff in Mind (KOSIM). It delivered a mini five-week version of the intervention, to try to shift the culture among staff, to give them the confidence to know they could and should intervene on some physical health issues – like a patient drinking two litres of Coke a day – without leaving it to a dietitian or other specialist.

Watkins said staff members' health improved, and they gained confidence and knowledge about clients' physical health issues. He said: "Most important was these staff members now feel this is an important area (of their work). Culture change is perhaps the hardest part of service delivery. Staff are working in a system where they already feel burdened, so to come in and say 'we want you to do physical health care as well' is a massive challenge."

Equally Well 2019 Symposium papers

Theme: Lifestyle and physical activity

Redefining routine mental health treatment to include exercise and diet

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Simon Rosenbaum[1,2] and Grace McKeon[1]
[1]School of Psychiatry, UNSW Sydney, [2]Black Dog Institute, Sydney

Presentation Links

Slides Video

Presenter:

DR SIMON ROSENBAUM

Simon is a Senior Research Fellow in the School of Psychiatry, UNSW Sydney and the Black Dog Institute. He currently holds an NHMRC Early Career Fellowship and is also an inaugural UNSW Scientia Fellow. Simon conducted the first clinical trial of exercise for inpatients with post-traumatic stress disorder and has published over 130 peer-reviewed publications and co-edited the first textbook on the role of exercise in the treatment of mental illness.

Simon has worked with a variety of groups including inpatients, emergency service workers, contemporary veterans and refugees, both in Australia and overseas. Simon serves as an elected national director of Exercise and Sports Science Australia and is a passionate advocate for the integration of exercise as a component of treatment for people living with mental illness.

Abstract:

People living with mental illness are at high risk of experiencing poor physical health, including diabetes and cardiovascular disease. Modifiable risk factors including smoking, physical inactivity and poor nutrition contribute to the burden of poor physical and mental health in this group. Targeted lifestyle interventions that provide adequate support, are tailored to the individual and delivered by qualified professionals can be efficacious in improving both physical and mental health outcomes.
This talk outlines the evidence for and components of effective lifestyle interventions for people living with mental illness.

Paper:

People living with mental illness die on average 15 years younger than the general population,[1] primarily due to premature and preventable cardiovascular disease.[2 3] This inequality has been described as both a 'scandal', and an international public health priority.

Recently, more than 30 international experts from around the world co-authored a Lancet Commission titled, A blueprint on protecting the physical health of people living with mental illness.[2] Among the Commission's recommendations was the importance of embedding evidence-based exercise interventions as a routine component of mental health care, including a focus on early-intervention and prevention.

The Commission highlights the high rates of modifiable risk factors contributing to the disparity in physical health outcomes for people living with mental illness, including low levels of physical activity, high levels of sedentary behaviour,[4 5] poor nutrition and high rates of smoking.

Importantly, the Commission outlines practical steps that can be taken to protect physical health, with an emphasis on prevention and early intervention, arguing that all people living with mental illness should expect to have their physical health prioritised alongside their mental health from first contact with a mental health service. This includes redefining what ‘standard’ mental health treatment involves and expanding this to include non-traditional allied health practitioners, such as exercise physiologists and dietitians to deliver evidence-based, individualised and tailored lifestyle interventions across the lifespan.

There is strong evidence to show that physical activity can help prevent the emergence of mental illness[6 7] while being a powerful strategy to maintain and improve physical health.[8 9] For people living with mental illness, exercise interventions are well accepted, destigmatising and can be delivered without significant side effects. Exercise has repeatedly been shown to help reduce symptoms of a range of mental disorders including depression, anxiety, post-traumatic stress and schizophrenia when added alongside usual care.[8] As part of a multi-disciplinary approach, exercise can improve cardiometabolic markers such as blood pressure and blood sugar levels and if adopted as part of an early intervention framework, can help to prevent medication induced weight gain.[10]

Despite the clear benefits, physical activity and exercise programs are not routinely offered as part of mental health care. Unfortunately, the very people who stand to benefit the most are typically the least likely to have access to the critical support and resources needed to help them participate in appropriate interventions. People living with severe mental illness may be unaware of how to access the physical healthcare they need and experience unjust health inequalities.

While everyone experiences barriers to getting active, those living with a mental illness face additional challenges, including low mood and side-effects of prescribed medication.[11] Therefore, we need to provide the right support to motivate and help people to get active, which may include the help of a dedicated allied health clinician such as an exercise physiologist. Research shows there is no one-size-fits all prescription for physical activity and that one type of exercise is not superior to another. The benefits of exercise also occur regardless of the type or intensity. Finding something people enjoy is therefore most important for increasing adherence and maximising the long-term benefits.

We need to facilitate access and provide the right support to help people living with a mental illness engage in healthy lifestyle behaviours. While physical activity and lifestyle programs are not a cure, they are vital to protecting the physical health of everyone, including those living with mental illness.

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Theme: Equally Well New Zealand

Together we are making a difference: Lessons from the Aotearoa New Zealand Equally Well collaborative

Caro Swanson and Helen Lockett
Te Pou o te Whakaaro Nui (Te Pou)

Presentation Links

Slides Video

Presenters:

CARO SWANSON

Caro is Principal Advisor Mental Health and Service User Lead for Te Pou o te Whakaaro Nui, national centre of evidence-based workforce development for the adult mental health, addiction and disability sectors in New Zealand.

Caro has worked in mental health in a variety of lived experience roles for more than 20 years. Currently, she leads the national peer workforce development suite of projects and co-leads the national least restrictive practice suite of projects for Te Pou. As a champion of Equally Well, New Zealand for many years, Caro vigorously highlights the importance of lived experience leadership, participation and co-production as essential in seeking effective solutions and better futures for people and their families.

In 2018 Caro nearly became an Equally Well statistic when she unexpectedly had to undergo open heart surgery from undiagnosed cardiovascular disease. This highlighted for her the urgent need to un-silo physical health, mental health and addiction services and meet the needs of people earlier and more holistically.

HELEN LOCKETT

Helen is an experienced researcher, innovator and critical thinker. She is the strategic policy advisor for the Wise Group, a non-government organisation in New Zealand and also works as a senior advisor to the OECD and the New Zealand Government.

The focus of Helen's work is on how to influence and bring together policy, research and practice to address inequities and to improve outcomes for individuals and families/whanau.

Helen has a national leadership role for Equally Well New Zealand, an award-winning collaboration of people and organisations committed to taking action to improve physical health outcomes for people who experience mental health conditions and addiction. Since 2014, Helen has been on Pegasus Health's Community Board, and now sits on the Pegasus Population Health Advisory Board. Prior to emigrating to NZ in 2010, Helen was director of programmes at the UK's Centre for Mental Health.

Abstract:

Caro Swanson and Helen Lockett have both been instrumental in the development and continued expansion of the Equally Well movement in Aotearoa/New Zealand. The Equally Well collaborative is underpinned by evidence, both in terms of understanding the issues and in designing the solutions. It is also underpinned by principles, most importantly the principle of co-design with people with lived experience. In this presentation, Caro and Helen will take us through how the Aotearoa New Zealand Equally Well collaborative began, and some of the highlights from their five-year journey. They will also share some of their reflections on lessons learnt. As they

share their experiences, they hope to inspire Equally Well Australian champions, outlining what make up the key ingredients of an 'Equally Well action or set of actions' and explaining the underpinning mechanisms and success factors which support the continued growth of this diverse and impactful collaborative.

Paper:

Background and context

Caro Swanson and Helen Lockett, along with many other Equally Well champions in Aotearoa, have been instrumental in the development and continued expansion of the Equally Well movement. The Equally Well collaborative is underpinned by evidence, both in terms of understanding the issues and designing the solutions. It is also underpinned by a set of principles, most importantly the principle of co-design with people with lived experience.

This presentation details how the Aotearoa New Zealand Equally Well collaborative began and some of the highlights from the program's five-year journey. There are reflections on some of the lessons learnt and crucial ingredients of the Equally Well collaborative in Aotearoa. The presentation aims to inspire Equally Well Australian champions by highlighting key ingredients of an 'Equally Well action or set of actions' and explaining the underpinning mechanisms and success factors which support the continued growth of this diverse and impactful collaborative.

The main points:

1. Equally well is underpinned by evidence both in terms of the inequities that are present, the contributors to those inequities and the process by which we are creating a movement for change to address these inequities.
2. Co-design is crucial and needs to be there from the start. It is imperative that Equally Well addresses discrimination and leads by example in its approach.
3. It is crucial that information on these health disparities is communicated in a sensitive and safe way at the same time as conveying the seriousness and unacceptable nature of the issues. The information being communicated is shocking and scary for the people and families affected – so Equally Well partners need to be careful and kind in their delivery.
4. In Aotearoa New Zealand we were intentional and targeted with the stakeholders we contacted (e.g., primary care, Heart Foundation, Diabetes NZ … but we also went where the energy was, with the willing).
5. Model strengths-based language while also recognising that different groups use different language.
6. The backbone team also aims to model authenticity and take a non-blame approach in our leadership.
7. Trust and mutual respect is essential.

Overview of Equally Well Aotearoa New Zealand

1. Equally Well Aotearoa New Zealand began when NGO leaders from the mental health and addictions sector, led by Platform Trust, were discussing the number of untimely and unexpected deaths of people connected with their services. They agreed this was not acceptable and they needed to take action.
2. Platform Trust partnered with Te Pou o te Whakaaro Nui, one of the national workforce and information centres, to conduct an evidence review. This first literature review asked:
    - What is the mortality and morbidity gap?
    - What's contributing to it?
    - What can be done to improve physical health outcomes and reduce the disparity?

   The review also called for evidence from people already taking action across the country, and included these in the review.
3. The 2014 evidence review informed the development of the Equally Well consensus position paper, calling for urgent action and that people with mental health and addiction issues should:

- Be identified as a **priority group** at a national policy level based on significant health risks and relatively poor physical health outcomes.
- Have access to the **same quality of care and treatment for physical illnesses** as everybody else, and in particular to have a right to assessment, screening and monitoring for physical illnesses.
- Be **offered support** and **guidance** on personal goals and changes to enhance their physical wellbeing.

The evidence review and consensus position paper helped build awareness of the issues and the contributing factors and encouraged people and organisations to take action in their spheres of influence. Recognising that no one organisation can fix this in isolation — change is needed at multiple levels in multiple places.

4. Equally Well Aotearoa New Zealand was launched at a summit in November 2014. From the initial eight endorsing organisations Equally Well Aotearoa has more than 120 endorsing partners and has sparked a global Equally Well movement.

Lessons for the future

Be intentional about building and sustaining a collaboration.

- Create a sense of urgency
- Involve the people affected from the outset
- Help individuals and organisations see how they can contribute
- Build a virtual community
- Develop distributed leadership
- Work with diversity, respect difference
- Build understanding and bridges across different sectors

If people can see their part of the picture/puzzle they are happy to be responsible for that bit. Having a wide conversation through multiple lens offers more solutions. Diversity matters! Good ideas travel fast.

Theme: System level reform / coordinated care

Equally Well in Victoria – physical health framework for specialist mental health services 2019

Anna Love
Department of Health and Human Services Victoria

Presentation Links

Slides Video

Presenter:

ANNA LOVE
Anna commenced her career in Scotland in the early 80's and moved to Australia in 1989. She worked in both Inpatient and Community settings as a clinician and as a manager and as a Director of Nursing both in Mental Health and Drug and Alcohol services. During the early 90's Anna was involved in the decommissioning of the North Eastern Metropolitan Psychiatric Services (NEMPS) which gave Anna her first experience of managing service change and reform and it has been an area of interest since. Anna's vision is to ensure we have a skilled Mental Health Nursing workforce for the future which is flexible, responsive and works collaboratively with consumers and carers encouraging self-determination and self-management of mental health and wellbeing.

Abstract:

Each time a consumer engages with a clinical mental health service provides an opportunity to explore physical health issues, consider how they might impact on recovery goals and offer help.

The Physical health framework for specialist mental health services is the first of its kind in Victoria. It describes a range of initiatives for organisations and clinicians to work in partnership with consumers and carers to discuss physical health in the context of a recovery plan. This framework provides information to help mental health services and clinicians to think about how to tailor treatment and strategies to the realities of the daily lives of consumers.

Under the leadership of Victoria's Chief Mental Health Nurse, Chief Psychiatrist, in partnership with peak organisations Victorian Mental Illness Awareness Council and Tandem, the framework was developed as Victoria's response to the Equally Well National Consensus Statement. The framework describes consumer, carer and clinician's perspectives on how physical health issues can be worked on by mental health services.

An Expert Reference Group comprised of mental health consumers and carers, experts from mental health, general practice, community health and peak health organisations guided the approach and content of this document.

Five interconnected domains support physical health care in Victorian specialist mental health services.
They are:

- Consumer physical health needs
- Collaborative planning and therapeutic interventions
- Healthcare setting
- Workforce considerations
- Supporting safety

The framework describes the necessary elements at the organisation and clinical practice levels to guide implementation of physical health in a consistent way across Victoria. It asks services and clinicians to use a recovery approach to physical health, and offer help to consumers that extends beyond biomedical screening, diagnosis and treatment. It asks clinicians to work in an interprofessional manner to understand each person's recovery journey and using collaborative recovery plans to enquire about the person's physical health, appreciating the complex interplay with mental illness and how this operates in the context of the person's life.

The framework is an important first step for Victorian mental health services. Presented by Victoria's Department of Health and Human Services Chief Mental Health Nurse, Senior Consumer Advisor and Senior Carer Advisor, this presentation will describe the framework in detail, as well as implementation plan for Victoria over the coming years.

Paper:

Overview

Every time a consumer engages with a mental health service it provides an opportunity for clinicians to work together to understand physical health issues and how they impact on recovery goals and to offer help and support to address them.

This includes working with the consumer's family, carers and support community to better understand their health needs and goals, and this applies across service settings (inpatient and community).

Equally well in Victoria – physical health framework for specialist mental health services is the first policy of its kind in Victoria. The framework was developed in partnership with an Expert Reference Group comprised of mental health consumers and carers, experts from mental health, general practice, community health and peak health organisations. The purpose of the framework includes:

- To support mental health services to make decisions about developing, implementing and reviewing policies, procedures and programs that help consumers to make decisions about addressing physical health issues.
- To enable services to provide a positive experience of care and improve outcomes for consumers, with the support of families and carers.
- To create a consistent approach to physical health care in Victorian specialist mental health services. We acknowledge that many Victorian mental health services are already working in this area and have established a range of initiatives to improve their response to the physical health needs of consumers.

It describes a range of initiatives for organisations and clinicians to work in partnership with consumers and carers to discuss physical health in the context of a recovery plan. This framework provides information to help mental health services and clinicians to think about how to tailor treatment and strategies to the realities of the daily lives of consumers.

This framework will assist services to continue to improve their response to this challenge and establish a baseline to monitor our progress in this area.

We can do more to provide holistic and personalised care. And the help extends beyond biomedical screening, diagnosis and treatment. It is about each person's recovery journey and using collaborative recovery plans to enquire about the person's physical health, appreciating the complex interplay with mental illness and how this operates in the context of the person's life.

Consumers, families and supporters have the right to be informed and helped to take responsibility for treatment decisions affecting their physical health. The Office of the Chief Psychiatrist and Office of the Chief Mental Health Nurse are committed to working in partnership with Victorian services, consumers and carers to do better in this area. A significant first step is the creation of this framework.

Next steps

Similar to the approach to the production of the framework, the Office of the Chief Mental Health Nurse is working in partnership with mental health services, consumers and carers to design and deliver an implementation plan. The vision is to support Victorian specialist mental health services to develop service models that integrate mental health and physical health treatment and service coordination in a sustainable manner at the acute, subacute and community mental health service settings.

For more information go to Equally Well Victoria.

Theme: Supporting healthy lifestyles - smoking

Physical health and mental health – Multi-site clinical practice improvement

Peer-reviewed paper

Sally Plever[1], Irene McCarthy[1], Brett Emmerson[1], Melissa Anzolin[1], John Allan[2]
1. The Qld Mental Health Clinical Collaborative, Metro North Mental Health, Brisbane, Australia.
2. Mental Health Alcohol and Other Drug Branch, Queensland Health, Brisbane, Australia.

Presentation Links

Slides

Presenter:

SALLY PLEVER

Sally Plever job-shares the position of manager of the Mental Health Clinical Collaborative (MHCC) for Queensland Health. The MHCC is a state-wide initiative that uses the collaborative methodology to drive service improvement using a clinician-driven approach to identify topics for improvement.

Sally is a Psychologist who has worked in both a clinical and project management capacity across community, in-patient and forensic services in adult mental health. Sally has been managing the MHCC since its inception in 2000.

Abstract:

Aims: Despite well-documented poor physical health outcomes for mental health consumers the provision of routine physical health assessment and smoking care is not the norm in mental health facilities. The following outlines a service improvement initiative applied across Queensland public mental health facilities to introduce routine six-monthly physical health assessment for people with Schizophrenia and universal screening of smoking with delivery of a brief smoking cessation intervention to identified smokers.

Methods: Over a five-year period, sixteen adult mental services across Queensland voluntarily participated in the statewide Queensland Mental Health Clinical Collaborative (Qld MHCC) to improve clinical practice in physical health. In 2012 services prioritised six-monthly routine physical health assessment for people with a diagnosis of Schizophrenia in community mental health services. Then in 2015 the provision of smoking care in inpatient services was introduced with universal smoking screening and delivery of clinical pathway brief intervention for identified smokers. In 2017 routine smoking care was extended to community mental health services. Services were supported to implement local clinical practice changes by the Qld MHCC through development of clinical indicators to monitor progress and promote benchmarking and in the delivery of six-monthly statewide forums to share experiences, hear from experts and set service-specific goals.

Results: Improvements across all three areas were seen during the staggered implementation of practice change. The MHCC physical health assessment indicator demonstrated a significant statewide improvement over a five-year period from 12% to 65%. The delivery of smoking cessation in inpatient services also demonstrated significant statewide improvement over a two-year period moving from 38% to 73% and early results from the community implementation of routine smoking care delivery indicate promising improvements.

Conclusions: The improvements seen support the application of a service improvement collaborative approach to achieving widespread clinical practice change across multiple services. Given the dire physical health outcomes for people with a serious mental illness, mental health services need to implement approaches that can support policy and demonstrate real-world changes. The next step will be to determine whether the clinical practice change translates to improved physical health outcomes for consumers.

Paper:

Introduction

In 2012, the Australian National Mental Health Commission identified the poor physical health of people with mental health problems, in particular those with a serious mental illness (SMI), as a "national disgrace" that should be a "major public health concern".[1] Research has clearly demonstrated that people with an SMI have a reduced life expectancy of between 10 to 25 years when compared with the general population. This is primarily due to poor physical health, including cardiovascular disease and other chronic and preventable physical illnesses.[2-3] People with SMI are at even greater risk of developing metabolic syndrome because of known metabolic side effects from antipsychotic medications.[4] Compounding these problems is the unacceptably high smoking rate in mental health populations. It is well known that tobacco related conditions are the biggest contributor to premature death for people with an SMI.[5] While smoking rates in the general population have demonstrated a steady decline in recent years, this trend has not been seen in people with an SMI who continue to have unacceptably high smoking rates.

Despite these alarming statistics, physical health has not been considered a priority in mental health services with many consumers having their physical health needs overlooked and rarely monitored.[6] Moreover, a permissive smoking culture has been evident in many mental health services with staff not considering smoking a health issue for people with a SMI.[7-11] This has meant that the prevalence of smoking in mental health inpatient units is high with more patients identifying as smokers than non-smokers.[12]

The implementation of quality improvement programs has been shown to improve both physical health screening and assessment practices in mental health services.[13-17] Similarly, these approaches have also demonstrated effectiveness in improving the detection and provision of tobacco dependence treatment in general[18] and psychiatric inpatient settings.[19-21] With this in mind, in 2012 the Queensland Health Adult Mental Health Clinical Collaborative (MHCC) undertook to support public mental health services across Queensland to implement clinical practice changes to improve the prioritisation of physical health in mental health services. Initially, this task focused on the provision of routine six-monthly assessments of physical health for adults of community mental health consumers with schizophrenia. However, the increase in awareness of the poor physical health of consumers and the introduction of statewide smoke-free legislation prohibiting smoking at all public and private Queensland hospitals and facilities, resulted in the extension of the topic in 2015 to address smoking care in inpatient acute units. In 2017, community mental health services were brought on board to ensure smoking cessation was addressed across the continuum of care.

The MHCC applies a clinical improvement network approach to bring diverse mental health services together to work on a shared problem and improve clinical practice.[22] As part of this approach, each individual service joins the collaborative and commits to engaging in service improvement activities in their local area. The MHCC works to bring services together through six-monthly statewide forums in which staff share their experiences, review statewide and service data, and hear from experts in the focus areas. As part of the process, a statewide multi-disciplinary Steering Committee oversees the direction of the initiative with a clinical chair leading the team. Over a five-year period, all Queensland

Health adult mental health services voluntarily participated in this statewide initiative with additional rural services coming on board during the extension of the topic area to include smoking cessation. The following provides a review of the outcomes of this approach to driving clinical practice change in the six-monthly assessment of physical health and provision of smoking care in multiple adult mental health services located in geographically diverse sites in Queensland.

Method

In 2012, 16 adult mental services across Queensland voluntarily worked together to improve the delivery of six-monthly routine physical health assessments to people with an ICD-10 diagnosis of schizophrenia being treated in community mental health services and aged between 18-65 years. The MHCC developed a statewide clinical indicator based on information sourced from the Consumer Integrated Mental Health Application (CIMHA), a statewide information system for Queensland Health mental health services. Staff were asked to complete either a Metabolic Monitoring Form (MMF) and/or record a physical health assessment in CIMHA during the reference period of six-months.

In 2015, the physical health topic was extended to include the delivery of smoking cessation to acute inpatient mental health services. This included broadening the population group for this initiative to all consumers over the age of 18 years. This was achieved by encouraging the identification of smokers and use of an evidence-based brief intervention Smoking Cessation Clinical Pathway (SCCP)[23] for identified smokers. This process was already widely used across Queensland Health acute services as part of a larger drive to promote smoking cessation. However, until this time mental health services were disengaged with units continuing to permit smoking in designated areas and few implementing any smoking screening or cessation support. Encouragingly, with MHCC support, all services across the state voluntarily joined the initiative to improve the delivery of smoking care. Clinicians were then asked to determine, for every admission to the inpatient ward, if eligible consumers were smokers. A smoker was defined as a consumer who self-identified as having smoked tobacco in the past 30 days or asked for support to quit smoking. For consumers identified as a smoker, the SCCP was completed and filed in the medical record, with a minimum number of fields required to be considered completed. The SCCP is an evidence-based decision support tool for clinicians to use at point of care that enables assessment of nicotine dependence, nicotine replacement therapy (NRT) prescription and follow-up. All services were provided with monthly updates on smoking status identification and delivery of SCCPs to identified smokers.

In 2017, this approach was extended to smoking care in community mental health services and an additional four rural and remote services joined the initiative. The implementation of smoking care in community services required a change to the statewide mental health clinical information system to include a Smoking Status Tab for the identification of smokers. Prior to this, there was no systematic way of identifying consumers who smoked. The SCCP was reviewed for use in the community and implemented in community mental health services. This initiative was further supported by the introduction of a $1 million Queensland Health Quality Improvement Payment (QIP) for smoking cessation in community mental health services. This has meant that services achieving set targets every six months for smoking status identification and provision of SCCPs (to identified smokers) received a monetary reward to put toward smoking cessation initiatives in their mental health service.

All data used for reporting and analysis was extracted from existing Queensland Health information systems that are routinely used in order to minimise additional burden on clinicians. Throughout the initiative, services were supported to implement local clinical practice changes through the development of clinical indicators to monitor progress. This was complemented by six-monthly statewide forums in which staff determined statewide targets, reviewed results, shared implementation experiences and heard from experts in the area.

Results

Physical Health

Six, six-monthly reference periods were analysed from January 2012 to December 2014 to determine any significant trend in the proportion of physical health assessments conducted for community consumers between the ages of 18-64 years with a diagnosis of schizophrenia spectrum disorder across the 16 sites. The results demonstrated that over a three-year period statistically significant improvement was demonstrated in all mental health services with a statewide improvement from 12% to 58% in the provision of six-monthly physical health assessments. These results have been reported in detail elsewhere.[24]

Inpatient mental health smoking

Monthly data from October 2015 to September 2017 was analysed to determine any significant trend in the proportion of inpatient mental health separations where a consumer had a smoking status recorded and proportion of mental health separations where an identified smoker had a completed SCCP. These results indicate statistically significant improvement in the reporting of smoking status 88% to 97% and in the provision of a brief smoking cessation intervention (SCCP) 38% to 73% in acute inpatient mental health consumers across Queensland (publication pending).

Community mental health smoking

The community mental health smoking initiative began in July 2017 and analysis of the results of this initiative are ongoing. Preliminary review of progress indicates improvement in the number of community consumers with a smoking status identified and in the proportion of identified smokers receiving a brief smoking cessation intervention (SCCP).

Discussion

The MHCC model aims to support multiple mental health services across the state to work together to improve clinical practice. Since 2012 mental health clinicians participating in the MHCC have identified physical health as the highest priority problem able to be influenced by clinical practice change. Under the banner of physical health, mental health services have strived to implement six-monthly physical health assessments to community consumers with schizophrenia and universal identification and delivery of brief smoking cessation interventions to all smokers in acute and community mental health services. To assist services to advance change, the MHCC developed and reported on clinical indicators to provide feedback on performance and hosted six-monthly forums to enable networking, benchmarking and learning.

Analyses conducted to date indicate that the initiative has supported a statewide increase in the number of six-monthly physical health assessments conducted in community mental health services. It has also improved the detection and recording of smokers and subsequent delivery of a smoking cessation brief intervention to consumers in acute mental health units. Furthermore, initial review of progress in extending this smoking cessation approach to community mental health services indicates similar positive results for recording of smokers and provision of smoking care.

The demonstration of improvement across physical health assessment and smoking cessation statewide, and within each individual mental health service, lends support to the value of the MHCC service improvement model for changing clinical practice. As discussed above the physical health of mental health consumers should be a priority for all mental health services. However, despite a plethora of literature and national and state policies intended to improve this situation, practice change in mental health services has been slow to follow. We believe that the MHCC approach to statewide improvement provides a mechanism for translating policy into practice. Moreover, it delivers an effective way to help services to prioritise endorsed areas for change and quarantine clinician time to plan and implement service-wide practice changes without the additional burden of collecting data. The statewide backing provided by the MHCC influences all levels of mental health services. It provides a mandate for executive leaders to promote clinical practice change but also supports clinicians working on the ground to be able to focus on managing local issues and draw upon the collective to address commonly experienced problems. The next step in this process is to evaluate the long-term sustainability of the changes in services and most importantly whether this positively affects the physical health outcomes for consumers.

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Theme: Supporting healthy lifestyles - smoking

Tackling Tobacco in mental health services - translating evidence into practice

Rachel Whiffen[1], Lorena Chapman[1], Marty Pritchard[1], Suzanne Turner[2], Fiona Connally[2], Niki Fourniotis[2], Shane Sweeney[2], Enrico Cementon[3]
[1] Quit Victoria, [2] North Western Mental health, [3] Orygen Youth Health

Presentation Links

Slides

Presenter:

RACHEL WHIFFEN

Rachel Whiffen is the Manager, Communities and Program at Quit Victoria. Rachel joined Quit in November 2017 after six years coordinating Cancer Council Victoria's Clinical Network program. During this time Rachel oversaw the program's policy and advocacy in cancer care portfolio.

With Quit, Rachel leads a dedicated team who work with communities and support organisations, where rates of tobacco use are high, to co-develop initiatives that enable all Victorians the opportunity to become smokefree and reduce the health, financial and social disadvantage that is directly impacted by tobacco use. Priority populations include people living with a mental illness, Aboriginal and Torres Strait Islander people, people upon release from prison and the LGBTI community. Rachel holds a Masters in Public Health and degrees in Exercise Science and Psychology.

Abstract:

Recognising the significant impact that smoking has on the health of mental health consumers, Quit Victoria, NorthWestern Mental Health partnered in 2016 to embed evidence based smoking cessation into routine care. The pilot sites chosen work with more than 1,000 consumers annually and employ approximately 280 staff.

The Tackling Tobacco Framework1 was used to address challenges identified during initial consultations with consumers and staff and identify best-practice smoking cessation strategies. In 2017-2018, strategies implemented included:

- Establishment of executive leadership group
- Revision of smoke free policies and the development of smoking cessation clinical pathways
- Delivery of staff training using the Ask, Advice, Help model, pharmacotherapies and behavioural support
- Implementation of a range of consistent quit supports including smoking cessation peer support worker, tailored stop smoking resources for consumers and carers, and skilling of Quitline Specialists
- Focused efforts to record consumer smoking status through a new smokefree screening and assessment tool.

Midpoint learnings based on analysis of 130 staff surveys, 180 training evaluation forms, key informant interviews, and 165 file audits indicate:

- Staff knowledge and confidence in providing smoking cessation increased by 34%
- 60% of staff now rate their service's capability to provide cessation support as extremely or very capable

- Staff members are more actively supporting consumers to quit with an increase in referrals made to Quitline.
- The smoking cessation peer support worker is a key role to support consumers to quit.
- Appropriate resources are important. To date, a total of 23,000 hard copies of the ten new Tackling Tobacco resources have been disseminated.
- The collection of consumer's smoking status has increased
- That the TT Framework is adaptable across a range of service types.

The presentation will detail implementation activities and evaluation findings to date.

Paper:

Supporting consumers to be smoke-free – embedding smoking cessation care into mental health services in Victoria

Introduction

Smoking significantly impacts the health, social and financial wellbeing of people living with a mental illness. People living with mental illness who smoke experience a reduced life expectancy of between 10-20 years [1], with the main cause of early death being chronic disease, of which smoking is a significant contributor. Most current national data indicates that people living with mental illness are more than twice as likely to smoke than the general population, with smoking rates in people living with complex mental health illness more than triple the general population [2]. The financial impact of smoking is also considerable. Recent data indicates that an individual who smokes 20 cigarettes a day can save around $9,855 a year upon quitting [3]. People living with severe mental illness smoke on average 21 cigarettes per day [4].

Despite indisputable evidence that smoking drives significant biopsychosocial inequalities and that people living with mental illness are just as motivated to quit smoking as the general population [5], best practice smoking cessation is not routinely provided by mental health services [6]. The most effective way to stop smoking, for people living with mental illness and for those who are not, is through a combination of behavioural support and pharmacotherapy [7]. Brief advice is the intervention through which health professionals communicate this information and also encourage a quit attempt, thereby increasing the rates of successful quitting [7-8.]

Overview of the initiative

NorthWestern Mental Health (NWMH) is a public mental health service, providing hospital-based, specialist and community mental health services in the north western metropolitan region of Melbourne. The 32 NWMH sites service a region of eight local government areas, with a population of approximately 1.2 million people.

An unpublished review of NWMH consumer mortality data, between 2012-2018, indicated that the average age of death for consumers dying of natural causes was 48.7 years. This is over 33 years less than the average life expectancy, with most causes due to chronic disease such as stroke, heart disease, pulmonary disease, diabetes complications and cancer–smoking is a significant contributor for each of these chronic diseases. This alarming evidence, alongside the higher smoking rates for people living with mental illness and an acknowledgment of the lack of access to best practice smoking cessation support prompted NWMH and Orygen Youth Health (OYH) to take action. In 2016, NWMH, Orygen Youth Health (OYH), and Quit ("the partners") established a collaboration to improve access to smoking cessation support.

The goal of the initiative is to increase access to best practice smoking cessation care across three NWMH adult sites (one short-term, one long-residential unit and one community-based mental health service), and OYH (both inpatient and community services).

In 2017, staff consultations and mapping of current smoking cessation care at participating sites, informed the development of the project objectives. Based on the findings, the project objectives were to:

- Increase staff knowledge, skills and confidence to address smoking with consumers

- Increase access to, and use of, best practice smoking cessation information and interventions for consumers, carers, and staff
- Create a smoke-free mental health service environment that encourages and supports smoking cessation, manages nicotine withdrawal and reduces the exposure of consumers, staff and visitors to second-hand smoke
- Test the feasibility of the Tackling Tobacco Framework for organisational change to guide the implementation of best practice smoking cessation care in a Victorian setting.

Comprehensive implementation strategies

The Tackling Tobacco Framework, which was developed by the Cancer Council NSW, has demonstrated effectiveness in embedding smoking cessation in social and community services [9]. This framework was used to systematically identify gaps and opportunities for smoking cessation support. Using the six pillars of the framework to identify strategies and ensure a comprehensive approach, the partners co-designed workplans across participating sites that included inpatient, residential and community services for adults and young people.

In 2016-2018, the following strategies were implemented, as per the six pillars of the framework:

Committed leadership: An executive leadership group and site project steering committees were established to drive and deliver practice change. Members included executive, managers, team leaders, clinical leaders and staff, peer and family support workers, and Quit staff. A NWMH staff member at each site took on the smoking cessation portfolio to coordinate and drive strategies, and a NWMH project lead undertook overall coordination of the project across the four participating sites.

Comprehensive smoke-free policies: Smoke-free policies and procedures were reviewed and redeveloped to align with best practice, with updates communicated to staff via a range of mechanisms, such as staff emails and meetings.

Staff training and follow-up: A pre-training survey was disseminated to staff at participating services to explore existing knowledge, attitudes, current practice, and enablers and barriers to the provision of smoking cessation support to consumers. A total of 135 staff completed surveys (a 48.2% response rate).

On average across the participating sites, 77% of staff had never received training in smoking cessation care.

Based on the staff survey results and integration of best practice smoking cessation care within the context of the mental health setting, training was co-developed by NWMH, OYH and Quit, and delivered by Quit. The aim of the training was to build staff skills and knowledge to deliver evidence-based brief advice (using the Ask, Advise, Help model), including referral to Quitline and provision of pharmacotherapies. The training also focused on debunking myths about smoking and mental health.

Training was delivered face-to-face, at each site, and online training was available to staff who were not able to attend in person. Two staff workshops have also been conducted (June 2017 and September 2018), with 160 staff attending these workshops to date.

Consistent support to quit: Co-designed smoking cessation resources, in the form of brochures, posters and postcards, were developed. Resource topics included an overview of best practice smoking cessation support, an overview of Nicotine Replacement Therapy (NRT) options, financial benefits of quitting, a quit plan for consumers, stress cycle of smoking, and a carer resource. Resources were co-developed with consumers, carers and staff.

Three part-time smoking cessation peer support workers, who shared the mental health lived experience, were employed to provide brief advice and smoking cessation support across all sites. Peer support workers facilitate access to smoking cessation care, such as referral to Quitline and arranging NRT from the appropriate clinician. Quitline specialists also received refresher training on mental illness and smoking, and the Quitline protocol for people living with mental illness was reviewed and updated.

Care pathways were also developed at each pilot site to guide staff delivery of smoking cessation support, including when and how smoking status is assessed, the provision of NRT and referral to Quitline for behavioural intervention.

Smoking has also been included in physical health clinical review meetings, where treating teams review smoking status and how consumers may be progressing with a smoking cessation attempt.

Monitoring and data collection: A new smoke-free screening and assessment tool was developed to record smoking status, as well as the offer and uptake of smoking cessation care, and to enable ongoing follow up to provide support.

Supportive systems: Supportive systems include changes to the physical and cultural environments as well as processes that support change. Many physical changes had already occurred when NWMH and OYH went smoke-free in 2009, such as smoking being banned in courtyards. Smoke-free signage was, however, updated across all participating sites, to reflect a more positive message about the benefits of being smoke-free, rather than conforming to policies. Cultural changes included the changes in language from ‘smoke leave’ to ‘ground leave’. Process changes included smoking being integrated into physical health clinical review meetings, standing agenda items on staff meetings, regular feature articles and project updates in staff communications such as staff newsletters and the intranet.

Systems and practice change – mid-point evaluation

Based on the measures, the initiative has reached more than 250 staff and 1000 mental health consumers, across the participating sites.

The following measures have been used to evaluate the project’s implementation to date:

- Staff surveys measuring changes in knowledge, attitudes and behaviour pre-implementation (as noted above), and at 14 months post-implementation (another survey at 24 months post-implementation will be undertaken in June/July 2019)
- Staff workshop training feedback and evaluation surveys
- Monitoring the number of referrals to Quitline
- Clinical file audits examining the use of the NWMH smoke-free screening and assessment tool
- Focus groups with staff at pilot sites to identify challenges, learnings and opportunities for continued work to embed smoking cessation into usual care
- Semi-structured surveys with key project champions and leaders
- Monitoring the number of consumer and carer resources downloaded and ordered.

Staff knowledge and skills

Staff knowledge in providing best practice smoking cessation care to consumers increased, with 61.6% of staff rating their knowledge to address smoking as high/very high in 2018, compared to 35% in 2016. Confidence in providing brief advice increased to 62.4% in 2018 from 28.6% in 2016. Nearly 88% of staff also strongly agree/agree that they have the support of their organisation to provide smoking cessation care compared to 66% in 2016.

Staff focus groups and surveys indicate that cultural change is occurring. For example, staff are now actively supporting consumers to quit, via brief advice and providing offers of support. These conversations are not necessarily being documented in consumers’ files.

In the 12 months prior to implementation, there had been no referrals to Quitline from participating NWMH and OYH sites. As of April 2019, staff had referred 86 consumers to Quitline.

Increased access to, and use of, best practice smoking cessation care

Prescribing of nicotine replacement therapies to manage nicotine withdrawal has increased at inpatient settings, with one site dispensing almost double their NRT prescriptions.

The newly developed resources are being provided by staff to consumers and their families and carers.

To date, there has been a total of 23,000 hard copies of the 10 new smoking cessation resources ordered from Quit, with the carers' resource downloaded 81 times in one week.

Implementation of the new smoke-free screening and assessment form has had mixed results. A random audit of 165 files at NWMH and OYH revealed that 42% of the files had the form included, however, only 28% had been fully completed. Discussions with sites identified that introducing a new care pathway document into a busy mental health service is challenging. Sites are subsequently refining the form to enable higher compliance. The file audit will be repeated in June 2019.

The role of the peer support workers has been central to facilitating consumer discussions and referring consumers to best practice smoking cessation care.

For example, John, a mental health consumer, who lives with severe anxiety and depression, recently quit with support of the peer support worker. He had been wanting to quit smoking for a long time but had only been given general advice in the past such as, "just distract yourself" or "just go cold turkey".

"The peer support worker came out with a quit pack," recalls John. "I had a browse through it and thought ok, this is how you do it."

Creating a smoke-free mental health service environment

As well as policies and procedures relating to smoke-free settings at NWMH and OYH being reviewed and updated, consumers have also taken action in supporting opportunities to become smoke free. At one participating site, a long-term residential inpatient service, the consumers suggested having smoke-free outings. The team leaders observed: "Sadly many of our clients are very fixated on smoking when they are out and about, so this is huge for them to initiate this."

Staff indicate that smoke-free policies provide a clear health message and are important and supportive of consumers trying to quit, and the role of staff in assisting quitting.

The role of peer support workers and the physical health nurses has been identified by staff as highly valuable in not only supporting consumers but building the capacity of other staff to support consumers.

Executive management endorsement was rated highly by staff (staff surveys, focus groups and key informant interviews) in creating the enabling environment for system and practice change. The role of the lead worker at each of the sites has also been central to maintaining drive and delivering strategies.

NWMH amended its policy to include clearer guidance on the use of evidence-based cessation care, including NRT, and updated its signage as mentioned.

Key lessons to date

Challenges to embedding best practice smoking cessation into usual care have been identified at both the staff level and system level. Staff consistently identify lack of time to provide brief advice and support as a barrier, in a busy mental health service, when staff are often supporting consumers experiencing crisis and are therefore addressing other competing priorities. Staff identify that the peer support workers and the physical health nurses are key roles to support people after initial admission to a service.

Access to regular training opportunities to capture new staff and refresher training for existing staff has been identified as a barrier. In response, NWMH is developing compulsory online training for staff to complete annually. Quit is also developing more in-depth online training for the mental health workforce.

Inconsistencies in communicating smoke-free polices exist between staff shifts within the same service. To ensure consumers and staff receive consistent messages, opportunities for more regular staff training and site leadership to facilitate a supportive environment for staff to enact and support smoke-free policies has been identified.

At the systems level, as noted previously, the introduction of a new form can be challenging. Subsequently, the smoking status form has been revised and will be re-introduced into services. Access and affordability of NRT has also been identified as a barrier for consumers. Access to NRT can be dependent on already limited pharmacy budgets available at inpatient participating sites and in the community setting. Consumers can access NRT at much lower costs via a script for NRT products listed on the Pharmaceutical Benefits Scheme, although this, in turn, identifies the need for better training by general practitioners in terms of supporting this client group.

Sustainability and future work

The mid-point evaluation has identified enablers and barriers to embedding smoking cessation into usual care at four busy mental health services. Compulsory online raining for staff will improve access to regular training opportunities, and changes to monitoring systems intend to ensure data relating to smoking status and the provision of brief advice are collected to inform ongoing care. There have been significant changes in systems and practice, such as discussion of smoking cessation in regular clinical review meetings and physical health assessments. These changes have resulted in smoking cessation being integrated into routine care. The role of the peer support worker has been integral to ensuring ongoing discussions with consumers and linking into best practice interventions. All of these elements ensure multiple points for care that enhance access to pharmacotherapies and behavioural intervention via Quitline.

The impact of the smoking cessation initiative beyond the primary participating sites is notable. At the beginning of 2019, NWMH committed to extending the initiative to all 32 sites.

The initiative demonstrates that providing ongoing best practice smoking cessation care as part of routine practice is achievable within a comprehensive mental health service.

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Theme: Carers and supporters

Someone has to do it! Carers' experiences of physical health care for consumers of mental health services

Brenda Happell
University of Newcastle

Presentation Links

Slides

Presenter:

BRENDA HAPPELL

Professor Brenda Happell, University of Newcastle, is a registered nurse with specialist qualifications in mental health nursing. She has 29 years' experience in academia in Victoria, Queensland, New South Wales and the ACT.

Throughout her career she has been a passionate and unrelenting advocate for Mental Health Nursing. Brenda was the inaugural Director of the Centre for Psychiatric Nursing at the University of Melbourne, former Director of the Institute for Health and Social Science Research at Central Queensland University and Professor of Nursing and Executive Director of Synergy, Nursing and Midwifery Research Centre at University of Canberra and ACT Health.

Brenda is a Fellow and Board Director of the Australian College of Mental Health Nurses, and former Editor of the International Journal of Mental Health Nursing. Her research interests include: consumer participation in mental health services, physical health of people experiencing mental illness, and mental health nursing education.

Brenda is the lead investigator of a NHMRC grant: Improving the cardiometabolic health of people with psychosis: The Physical Health Nurse Consultant service, a nurse-led initiative. She was the proud recipient of the inaugural VMIAC lifetime ally award in 2018.

Abstract:

People diagnosed with mental illness have increased risks of physical illness and earlier death, problems able to be addressed through better physical health services. Carers of people with mental illness play a significant role in the mental health care system yet research examining their views is lacking. A qualitative exploratory study involving in-depth interviews with 13 mental health carers about their views and experiences pertaining to the physical health and availability of physical health care for the people they care for.

Analysis of carer responses identified two important themes: responsiveness and access, and a shortage of care coordination. Carers felt alienated from physical health care providers and were compelled to fill gaps in available care through persistence in ensuring access to physical health care services. The findings identify carers as key stakeholders in the physical health care of the people they care for. Their involvement in accessing and coordinating care provides vital perspective on health service capacity, which requires further consideration in the practice and research domains.

Paper:

Introduction

The essential contribution carers make to the mental health system is widely acknowledged in Australian mental health policy and other relevant government documents. To date most discussion on this topic relates to the role carers play in supporting the mental health needs of the people they care for. Given the increasing focus on the neglected physical health of people diagnosed with mental illness, it is important to understand the issues and impediments from the perspective of carers. Reviewing the literature was not helpful. Until a few years ago there was almost no research literature pertaining to the role of carers in the physical health of consumers.

Method

A qualitative research project was undertaken in collaboration with Carers ACT. Focus groups were conducted and jointly facilitated by a carer researcher and nurse academic. Carers were asked to describe their experiences and observations in relation to physical health assessment, care and treatment for the people they cared for. Rich, in-depth information was collected and subsequently analysed to identify major themes.

Results

The carers described significant barriers to accessing quality physical health care for the people they care for. Participants described being ignored and dismissed by health professionals when seeking physical health services for consumers. They perceived health providers frequently dismissed physical complaints as not serious, or as symptomatic of mental illness.

Effectively these barriers meant carers were often left to 'fill the gap' by dogged persistence until the services were provided. Furthermore, they described lack of coordination and integration preventing optimal physical health care within the mental health system. As a result, they had no choice but to take on this role to meet physical health needs. Carers took on the coordination role reluctantly as they did not perceive they had the skills and knowledge to effectively execute this role. They did so because they believed that anything was better than the current fragmented and unresponsive health system. Carer participants were particularly concerned that consumers who did not have a strong support network would have little chance of accessing services (Happell, Wilson, Platania-Phung, & Stanton, 2017a).

Understandably the co-ordination role took its toll and carers described the negative impact on their own physical health, and generally did not receive any support from health care providers (Happell, Wilson, Platania-Phung, & Stanton, 2017b). When presented with the idea of a physical health nurse specialist role in physical health care, the carers responded enthusiastically. They felt the nurse could facilitate access to, and provide much needed coordination of, physical health care. Carers gave a note of caution and stressed the need for this role to be consistent and ongoing. They did not want to experience once again a strategy that was implemented and later withdrawn because of insufficient funds. They also emphasised the importance the role be individually focused on the specific needs of individual consumers rather than a one size fits all approach (Happell, Wilson, Platania-Phung, & Stanton, 2016).

Discussion

This research highlights the difficulties carers experience in supporting people they care for in accessing quality services. The role and expertise carers bring in relation to physical health care must be acknowledged, and therefore carers must be included as key stakeholders for the identification, implementation and evaluation of all initiatives designed to improve physical health for people accessing mental health services.

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Theme: Carers and supporters

The ‘C’ word: why carers matter

Debbie Childs
HelpingMinds

Presentation Links

Slides

Presenter:

DEBBIE CHILDS
Debbie is CEO of HelpingMinds, a West Australian based Mental Health and Carer Support organisation. Debbie leads a team of over 90 to deliver quality support services to people experiencing mental ill health and their families.

With lived experience as a Mental Health Carer, Debbie is a passionate advocate within the sector. She currently holds seats on several committees and groups. In addition to this, over the last four years, Debbie has been an active member of the steering committee developing the new national guide: “A Practical Guide for working with Carers of People with a Mental Illness”.

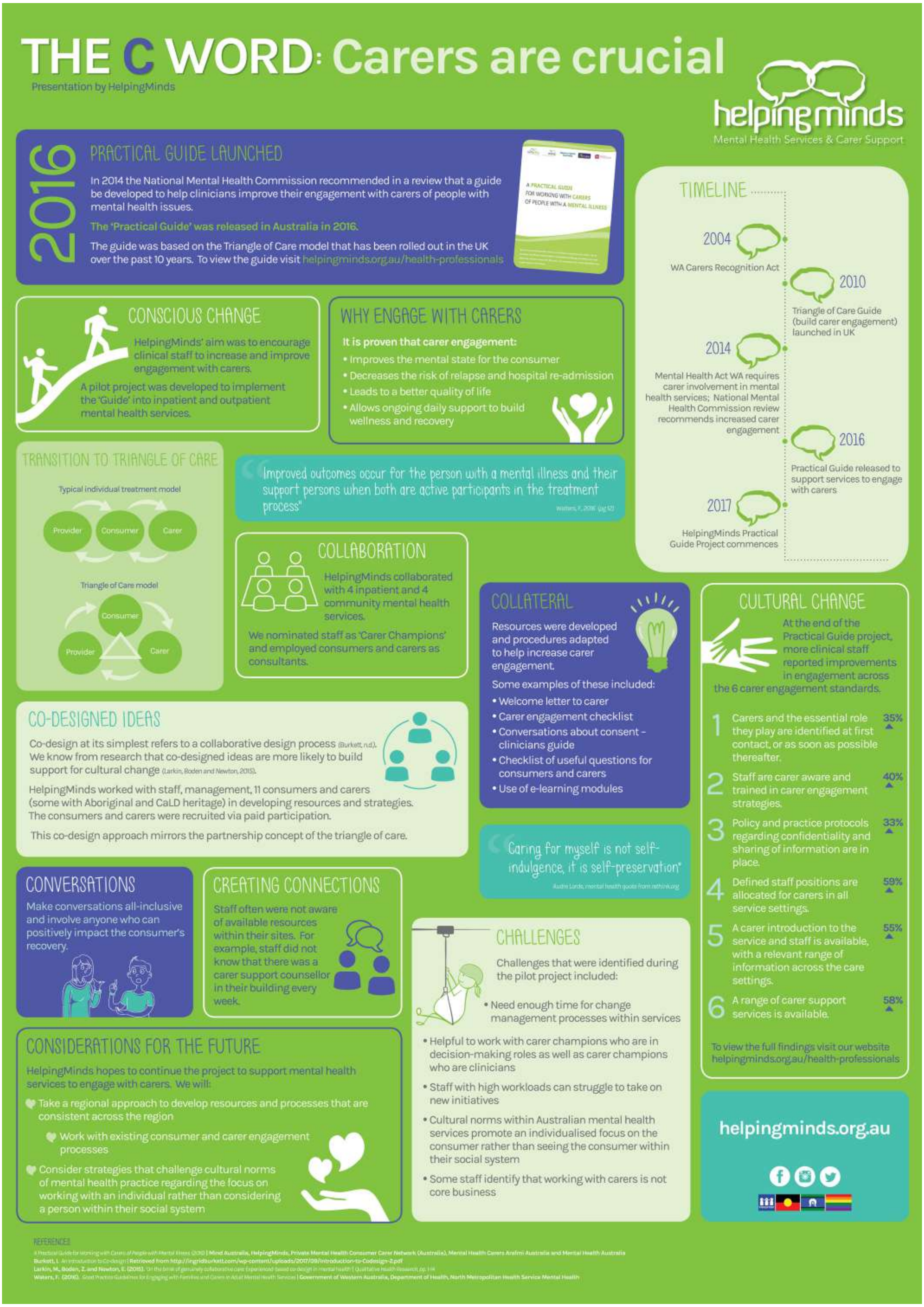
Debbie brings a wealth of experience both in the leadership of smaller ventures and larger corporate enterprises as well as extensive experience as a Board Director with both not for profit and commercial businesses.

Abstract:

Better outcomes for people who are using mental health service can be achieved when staff are able to engage with the service user’s supportive family members or friends. However, it can be challenging to do so in busy work settings.

With the support of the WA Mental Health Commission and the North, South and East Metropolitan Health Services, HelpingMinds is working with clinical staff in mental health services to co-design resources and solutions that support greater engagement between staff and the family or friends identified as the service user’s supporters. This project is built on a nationally co-designed resource – A Practical Guide to Working with Carers of People with Mental Illness. The Guide was developed by people with lived experience of mental health issues, either as consumers or carers, and staff.

This national level collaboration has generated state-based pilot projects to test the usefulness of the Guide. In WA, a co-design approach has been adopted. A diverse team of paid consumer and carer consultants have been employed to guide the project. The staff in mental health services are partners in identifying and implementing practical strategies. Co-designed resources have been collated into a tool kit to assist staff in their engagement with family members and friends. If you are involved in cultural change processes in the mental health sector or looking to identify new ways of working with the family and friends of people using mental health services, this session outlines a straightforward yet very rewarding process of co-designing site-specific solutions.



THE C WORD: Carers are crucial

Presentation by HelpingMinds

helpingminds
Mental Health Services & Carer Support

2016 PRACTICAL GUIDE LAUNCHED

In 2014 the National Mental Health Commission recommended in a review that a guide be developed to help clinicians improve their engagement with carers of people with mental health issues.

The 'Practical Guide' was released in Australia in 2016.

The guide was based on the Triangle of Care model that has been rolled out in the UK over the past 10 years. To view the guide visit helpingminds.org.au/health-professionals

CONSCIOUS CHANGE

HelpingMinds' aim was to encourage clinical staff to increase and improve engagement with carers.

A pilot project was developed to implement the 'Guide' into inpatient and outpatient mental health services.

WHY ENGAGE WITH CARERS

It is proven that carer engagement:

- Improves the mental state for the consumer
- Decreases the risk of relapse and hospital re-admission
- Leads to a better quality of life
- Allows ongoing daily support to build wellness and recovery

TRANSITION TO TRIANGLE OF CARE

Typical individual treatment model

Triangle of Care model

> "Improved outcomes occur for the person with a mental illness and their support persons when both are active participants in the treatment process"
>
> Waters, F., 2016 (pg 12)

COLLABORATION

HelpingMinds collaborated with 4 inpatient and 4 community mental health services.

We nominated staff as 'Carer Champions' and employed consumers and carers as consultants.

CO-DESIGNED IDEAS

Co-design at its simplest refers to a collaborative design process (Burkett, n.d.). We know from research that co-designed ideas are more likely to build support for cultural change (Larkin, Boden and Newton, 2015).

HelpingMinds worked with staff, management, 11 consumers and carers (some with Aboriginal and CaLD heritage) in developing resources and strategies. The consumers and carers were recruited via paid participation.

This co-design approach mirrors the partnership concept of the triangle of care.

COLLATERAL

Resources were developed and procedures adapted to help increase carer engagement.

Some examples of these included:

- Welcome letter to carer
- Carer engagement checklist
- Conversations about consent – clinicians guide
- Checklist of useful questions for consumers and carers
- Use of e-learning modules

> "Caring for myself is not self-indulgence, it is self-preservation"
>
> Audre Lorde, mental health quote from rethink.org

TIMELINE

2004
WA Carers Recognition Act

2010
Triangle of Care Guide (build carer engagement) launched in UK

2014
Mental Health Act WA requires carer involvement in mental health services; National Mental Health Commission review recommends increased carer engagement

2016
Practical Guide released to support services to engage with carers

2017
HelpingMinds Practical Guide Project commences

CULTURAL CHANGE

At the end of the Practical Guide project, more clinical staff reported improvements in engagement across the 6 carer engagement standards.

1	Carers and the essential role they play are identified at first contact, or as soon as possible thereafter.	35% ▲
2	Staff are carer aware and trained in carer engagement strategies.	40% ▲
3	Policy and practice protocols regarding confidentiality and sharing of information are in place.	33% ▲
4	Defined staff positions are allocated for carers in all service settings.	59% ▲
5	A carer introduction to the service and staff is available, with a relevant range of information across the care settings.	55% ▲
6	A range of carer support services is available.	58% ▲

To view the full findings visit our website helpingminds.org.au/health-professionals

CONVERSATIONS

Make conversations all-inclusive and involve anyone who can positively impact the consumer's recovery.

CREATING CONNECTIONS

Staff often were not aware of available resources within their sites. For example, staff did not know that there was a carer support counsellor in their building every week.

CHALLENGES

Challenges that were identified during the pilot project included:

- Need enough time for change management processes within services
- Helpful to work with carer champions who are in decision-making roles as well as carer champions who are clinicians
- Staff with high workloads can struggle to take on new initiatives
- Cultural norms within Australian mental health services promote an individualised focus on the consumer rather than seeing the consumer within their social system
- Some staff identify that working with carers is not core business

CONSIDERATIONS FOR THE FUTURE

HelpingMinds hopes to continue the project to support mental health services to engage with carers. We will:

- Take a regional approach to develop resources and processes that are consistent across the region
    - Work with existing consumer and carer engagement processes
- Consider strategies that challenge cultural norms of mental health practice regarding the focus on working with an individual rather than considering a person within their social system

helpingminds.org.au

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Theme: Carers and supporters

Counting past one: the physical and mental health and wellbeing of Australia's carers

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Anne Muldowney
Carers Victoria

Presentation Links

Slides

Presenter:

ANNE MULDOWNEY

Anne Muldowney joined Carers Victoria's policy and research team in 2010 and is senior policy advisor in health and aged care. She holds a Bachelor of Science (Psychology), and a Master of Social Policy and has more than 25 years' experience working with and on behalf of people in care relationships.

Anne is a member of several Victorian government advisory groups and represents Carers Australia at National aged care reform advisory groups. She is dedicated to addressing the challenges of the three-way relationship between consumers, carers and professionals.

Abstract:

While the psychological and physical impacts of caring have been extensively documented for many years, addressing carer's physical health has received significantly less attention in both research and practice than interventions targeted at psychological health.

More than a third of Australia's 2.7 million carers live with chronic illness and disability and many spend more than 10 hours a day on health-related activity, caring for both others and themselves.

While research demonstrates physical activity has psychological benefits for people of all ages, the benefits may be less certain for people caring for a relative or friend with an illness or disability, given the time-consuming and often stressful nature of the caring role.

Significant change in Commonwealth carer support services is scheduled for 2019, promising to deliver a range of low-cost, effective, preventative services with a proven ability to improve carer quality of life.

This presentation will include an overview of the limited evidence on the effectiveness of interventions to address carer physical health needs, including low intensity interventions with carers and people receiving care. There is emergent evidence that carer supports should include physical health promotion, such as offering opportunities for physical activity, nutrition and preventive health care visits. These may potentially also offer more cost-effective options to improve carer psychological health than more intensive mental health interventions. Emergent and promising practice examples of low-cost carer physical activity interventions will also be featured.

Emphasis will be given to the importance of recognising carers as health consumers, as well as partners in care. While implications for health professional practice in working with consumers and carers will be discussed, further research is required to address the personal and systemic barriers to carer participation in health promotion activities.

Paper:

- Equally Well acknowledges people living with mental illness need health care that counts past one (condition)
- Carers need health care that counts past one (consumer)
- Mental and physical impacts of caring have been extensively documented for many years
- Addressing a carer's physical health has received significantly less attention in both research and practice than interventions targeted at their mental health

Carer mental health

- Carers and their families experience high rates of mental health problems
- Carers have significantly worse mental health and vitality and higher rates of depression than the general population
- Depression and anxiety can be due to:
    - The stress of caring
    - Social isolation and loneliness
    - Relationship changes
    - Loss and grief
    - The worsening health of cared for person
    - A loss of paid work

Carer physical health

- Almost twice as many carers report poor physical health than the general population
- Elevated rates of poor physical health were not the result of carers being older than the general population
- Female carers had poorer physical health than females in the general population for all age categories, except 65 years and over

The double burden of disease

- Carers compared with non-carers are more likely to report living with asthma, diabetes, COPD, arthritis, mental health conditions and CVD
- Many older carers spend more than 10 hours a day on health-related activity, caring for both others and themselves

Carers are consumers too

- More than a third of Australia's 2.7 million carers live with mental or chronic illness or disability

Barriers to carer self-care

- Lack of recognition of impacts of caring
- Time and resource constraints
- Guilt, duty, obligation
- Family, cultural and community expectations
- Carer's own beliefs and values
- Loss and grief
- Balancing other responsibilities
- Lack of insight/resistance of person receiving care

Assessing and helping carers

- Health professionals can help legitimise the carer role and signpost them to support
- Working in a team-based approach to care that includes and supports carers, involves:
    - Recognising the importance of organised and structured care planning involving carers and other family members as part of the multi-disciplinary team
    - Considering how the consumer's illness may be affecting his or her carer's health (from a medical, social and financial perspective)
    - Identifying the implications for carers of any changes made to the consumer's management plans

Carers and physical activity

- Research demonstrates physical activity has psychological benefits for people of all ages
- The benefits may be less certain for carers, given the time-consuming and often stressful nature of the caring role

- Limited evidence on the effectiveness of interventions to address carer physical health needs, including low intensity interventions with carers and people receiving care
- Emergent evidence that carer supports should include physical health promotion, such as offering opportunities for physical activity, nutrition and preventive health care visits
- These may potentially also offer more cost-effective options to improve carer mental health than more intensive mental health interventions

Recommendations for policy and health service delivery

- Recognition of the double burden of disease
- Routine assessment of carer needs
- MBS item for carer health assessments
- Targeted support to high intensity carers living with chronic illness
- Additional investment in formal care, including respite care to free up carers for self-care activities
- Measurement of quality of life and health outcomes of carers
- Further research on effectiveness of carer health interventions

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Theme: Peer work and co-design

Re-focusing weight-related public health initiatives to promote mental and physical health

Peer-reviewed paper

Natalie Jovanovski[1] and Carolynne White[2]
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Presentation Links

Slides

Presenter:

CAROLYNNE WHITE

Dr Carolynne White is a registered occupational therapist and lecturer in health promotion at Swinburne University of Technology. Carolynne is interested in person-centred health care and empowering all people to participate in activities that benefit their health and well-being. Carolynne has worked extensively in health promotion and occupational therapy with adults in mental health (community and forensic), community health, and research settings. Carolynne values equity in health and uses collaborative, strength-based approaches to address health inequalities.

NATALIE JOVANOVSKI

Dr Natalie Jovanovski is a sociologist and research fellow at Swinburne University of Technology. Dr Jovanovski's research focusses specifically on women's relationships with food and eating. In 2014, Dr Jovanovski completed her PhD, which examined body-policing attitudes in popular discourses on food and eating. Dr Jovanovski translated the findings from this research for a wider audience in her publication, "Digesting Femininities". As a post-doctoral fellow, Dr Jovanovski has conducted research with low-income single mothers in receipt of welfare benefits and investigated how socio-economic status affects women's relationships with food, eating and mental and physical health.

Abstract:

Public health initiatives designed to promote the physical health of the general population rarely consider their impact on a person's mental health. "Obesity prevention" initiatives provide one such example. "Obesity" has become the target of public health campaigns as it a risk factor associated with chronic diseases, including cardiovascular disease and diabetes.

Currently, discourses about the relationships between body weight and health are framed in a way that shame people for their weight, size or shape, or their lifestyles, contributing to weight stigma. Research indicates that weight stigma has negative consequences, especially for women, and is associated with anxiety, depression, and body dissatisfaction, which is an established risk factor for eating disorders. Such evidence emphasises the need for public health initiatives that promote both physical and mental health.

In May 2018, Swinburne University of Technology and Women's Health Victoria co-hosted a symposium with 38 key stakeholders and professionals from across public health, community, and government sectors to critique

and challenge current discourses around women, food, and their bodies. The symposium showcased evidence from policy, research, and practice and identified innovative new directions for public health initiatives that are both holistic and empowering.

This paper will highlight the findings from the symposium, which has been a catalyst for action, including a submission to the Senate Select Committee into the Obesity Epidemic in Australia. This submission was one of few that considered the impact of obesity policy on people's mental health, and resulted in two recommendations to address weight stigma in public health and clinical practice.

Mental health advocates are well positioned to address the health inequalities faced by people living with mental illness by challenging weight stigma and helping shift the focus of public health discourse and clinical practice from weight to wellbeing.

Paper:

In Western societies, having a smaller body confers privileges that are denied to people with larger bodies. Compared to the general population, people with a diagnosed mental illness are more likely to have a body mass index (BMI) in the 'obese' category (BMI> 35)[1], with weight gain being a common and distressing side effect of psychiatric medication [2]. Weight stigma, or discriminating against somebody on the basis of their weight, shape and size, is a social justice issue [3] that may compound the distress and stigma experienced by people living with a mental illness [4]. In this paper, we discuss our work challenging the cultural normalisation of weight stigma with health professionals from across Victoria, Australia. In doing so, we highlight the urgent need to re-focus weight-related public health messages and challenge the stigma associated with body weight, shape and size [5].

Influences on mental health care

Over the past 25 years, there have been two major influences on mental health care: the recovery model and trauma-informed care. The recovery model emphasises the personal process whereby people can learn to live with, or without, ongoing symptoms of mental illness and lead meaningful and contributing lives [6]. Trauma-informed care recognises that trauma, particularly in early life, is a risk factor for developing a mental illness later in life, and that services need to provide a safe environment that minimises the risk of re-traumatisation [7].

One principle that is common to both of these influences is that of empowerment. Empowerment involves emphasising people's strengths, focusing on wellness rather than illness, and developing coping strategies to have some control over one's life [6, 7.] In this paper, we use the notion of empowerment to challenge weight stigmatising messages in public health campaigns.

'Obesity' and public health

'Obesity' has become the target of many public health campaigns as it a risk factor associated with chronic diseases, including cardiovascular disease, diabetes and cancer [8]. Despite media reports that Australians are getting heavier, the National Health Survey shows that the proportion of adults with a high BMI has levelled off in recent years [9]. Although commonly used in the media, public health and medical care, the term 'obesity' carries negative connotations [10]. Discussions of 'obesity' tend to frame body size as a disease, thus contributing to weight-related stigma. As such, we avoid using the term 'obesity' and only use it when it has been used in the cited sources.

While public health initiatives designed to promote the physical health of the general population tend to focus on preventing weight gain, they rarely consider the impact of their messages on a person's mental health. This point is made abundantly clear in photographs used to accompany media articles about the so-called 'obesity epidemic'. Fat studies scholar, Dr Charlotte Cooper, calls these photos 'headless fatties', and points out that such photos are often taken without the person's consent and are both objectifying and dehumanising [11].

One of the problems associated with public health, as in other fields, is the lack of representation by people with lived experience in policymaking and research. This can often lead to simplistic messages like 'energy in and energy out', that ignore the complexity of people's situations, such as people who gain weight due to psychiatric medications, and may cause psychosocial harm [12]. For example, mandatory kilojoule labelling is meant to be empowering by giving people information but may be triggering for a person with an eating disorder and hinder their recovery.

Weight-focused clinical care

In Australia, 'obesity' has been named as a health priority and receives significant public funding for research, receiving more National Health and Medical Research Council (NMHRC) funding than primary health care or drug addiction [13]. To address high rates of 'overweight' and 'obesity' in the general population, and improve the physical health of people with mental illness, a number of guidelines have been published to guide clinical practice. These include the NHMRC Guidelines [14], the Royal Australian and New Zealand College of Psychiatrists' consensus statement [15], and the Positive Cardiometabolic Health algorithm [16]. Each of these guidelines incorporate weight and other anthropometric measurements and the provision of lifestyle and more intensive interventions to reduce or manage weight. Indeed, the Equally Well Consensus Statement identifies weight management as a strategy to prevent the onset of chronic disease [17].

While body weight is a key focus of health care for the general population and for people with mental illness, its specific effects on health are more complex. Tomiyama and colleagues [18] analysed general population data from the National Health and Nutrition Examination Survey in the United States to examine and quantify the extent to which cardiometabolic health is misclassified when using established BMI categories. They measured metabolic health across a range of systems including blood pressure, triglycerides, cholesterol, blood glucose, insulin resistance, and c-reactive protein. People with 0-1 metabolic abnormalities they were considered healthy and two or more abnormalities were deemed unhealthy. They found that the BMI was not a very reliable measure of metabolic health, misclassifying 1 in every 3 people [18]. Similarly, using data from the Survey of High Impact Psychosis, Foley and colleagues [19] found that BMI and waist circumference could not explain all of the observed differences in blood pressure, cholesterol or triglycerides between the psychosis and general populations.

Is weight loss necessary for health?

An extensive body of literature has shown that while weight loss is achievable, maintaining lost weight is incredibly difficult; the majority of people who lose weight will regain it over time. A review conducted to inform the NHMRC clinical guidelines showed that weight-loss using lifestyle interventions is maximal at 6 to 12 months, with weight regain occurring within 2 to 5 years [14]. Another study conducted in the United Kingdom reviewed medical records in general practice and primary care. Fildes and colleagues [20] found that the annual probability for a 5% weight reduction is 1 in 8 for men and 1 in 9 for women. They also showed the outcomes for changes in BMI for people who initially lost weight and found that a minority of people went on to lose further weight, the majority of people regained more weight than they lost and their BMI increased.

While bariatric surgery is often recommended for people who are unable to maintain weight loss through lifestyle or pharmacological interventions, people tend to regain weight over a 10-year period as the human body adapts to changes in its circumstances [14]. When this occurs, many individuals blame themselves and internalise a sense of failure and hopelessness. Indeed, rates of self-harm and suicide following bariatric surgery are high [21]. In light of these findings, health professionals and public health practitioners must ask themselves: is weight loss a realistic goal?

The harms of disempowerment

When focusing on weight as an indicator of health, research shows that we are not only disempowering people, but we may in fact be causing harm. Currently, discourses about the relationships between body weight and health are framed in a way that shame people for their weight, size or shape, or their lifestyles. Among people with mental illness, medication-induced weight gain occurs under the backdrop of a weight stigmatising culture, both of which are associated with the avoidance of health care [1, 22].

Weight stigma is a chronic stressor, which is independently associated with increased risk of cardiovascular disease and diabetes [23]. It can result in engagement in weight-loss dieting and extreme exercise practices that are unsustainable in the long-term and contribute to weight cycling, which can have metabolic consequences that drive weight gain over time [24].

In addition, research indicates that weight stigma has negative psychological consequences, especially for women, and is associated with anxiety, depression, and body dissatisfaction, which is an established risk factor for eating disorders [25, 26]. Eating disorders are a leading cause of disability among young women and have the highest mortality rate of any mental illness [27, 28].

Weight-focused health policies emphasise weight as an individual, personal responsibility, leading to negative stereotypes of people of higher weight, such as being lazy or lacking willpower [29]. This assumption that weight is manageable, combined with negative representations in the media, leads to teasing, bullying and harassment. People also report weight bias, stigma and discrimination in education and employment and in their relationships with family, friends, and intimate partners [25]. For people with a mental illness, weight stigma may compound the stigma, marginalisation and exclusion many already experience due to their mental illness [30].

To support the physical health of people with mental illness, it is important to health professionals to acknowledge the implications of cultural discourses about weight and health and develop public health initiatives that promote physical and mental health simultaneously.

There is more to health than weight

In the framework for the determinants of health presented in the Australia's Health 2018 report [31], 'weight' is positioned as one of many determinants of health, including social inclusion, education, employment, housing, and stress. Low income and food insecurity are additional determinants faced by many people [32]. Although these determinants are recognised, weight is often framed as a primary focus of public health initiatives, despite evidence that weight is not necessarily modifiable in the long-term [14, 20]. Thus, it is important to consider other determinants that are relevant to people with mental illnesses, and within their ability to control or influence.

A study by Matheson and colleagues [33] investigated the relationship between health behaviours and mortality. They found that people with a BMI over 25 who engaged in all four habits under investigation (i.e. consuming more than five fruits and vegetables a day, not smoking, engaging in physical activity, and drinking alcohol in moderation) had a similar mortality risk as people who had a BMI between 18.5 and 24.9. This study suggests that health behaviours, rather than weight itself, have a stronger association with mortality risk and may be a more appropriate focus for public health and clinical care.

Empowering people using weight-inclusive approaches

Weight-inclusive approaches to health care are a positive way to promote health and prevent chronic disease without placing any focus or emphasis on the weight, shape or size of a person [5]. The Health at Every Size®, or HAES®, approach is one weight-inclusive approach that is gaining traction, both in Australia and internationally. The principles of the HAES® approach, as outlined by the Association for Size Diversity and Health [34], include:

Weight inclusivity: accepting and respecting the inherent diversity of body shapes and sizes;

Health enhancement: supporting health policies that improve and equalise access to information and services, and personal practices that improve human wellbeing;

Respectful care: acknowledging our biases and working to end weight discrimination, weight stigma, or weight bias;

Eating for wellbeing: promoting flexible, individualised eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on weight control; and

Life-enhancing movement: supporting physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement to the degree that they choose.

Weight-inclusive and HAES® approaches have been supported increasingly in international studies. In a systematic review of non-diet approaches on attitudes, behaviours and health outcomes, Clifford and colleagues [35] found that non-diet approaches improved people's disordered eating patterns and depression. Two studies showed improvements in biochemical measures for people using a non-diet approach, however, blood pressure, blood glucose and cholesterol levels remained unchanged. The researchers argued that non-diet approaches offer a promising way forward for clinical care and public health.

Similarly, in a 2019 study, Begin and colleagues [36] tested a Health at Every Size® intervention with a sample of 216 women and compared their findings with a control group of 110 women. Women attended an average of 14 weekly meetings provided by health professionals focusing on HAES® principles, such as intuitive eating and self-acceptance. Results showed that the HAES® intervention improved eating-, weight-, and psychological-related variables in women struggling with their weight and body image.

Tackling weight stigma: A Victorian example

While weight-inclusive interventions have been mostly tested in clinical settings [35], there is still the need to challenge weight stigma in health care settings and public health initiatives [5]. In May 2018, we co-organised the 'We need to talk: How public health discourses about obesity impact women's health' symposium and workshop with Women's Health Victoria. The symposium aimed to: (a) critique current public health discourse about women, food and bodies, and (b) identify opportunities to improve structures, strategies and practice.

We invited 38 key stakeholders in mental and physical health, as well as the community sectors, to talk about women's diverse experiences with weight stigma, as weight stigma disproportionately affects women. Our speakers came from a range of disciplinary backgrounds to talk about weight stigma and its negative effects on women's mental and physical health. They focused on the key determinants of health, including gender, biology, socioeconomic status and culture, as well as healthcare delivery.

Following the symposium, we ran a gender-sensitive workshop to talk about how services could improve their health promotion messages about weight and health while thinking about the mental and physical health of girls and women. Feedback from the symposium and workshop was overwhelmingly positive, with participants showing a desire to raise awareness about weight stigma and to work together on projects to achieve more integrated public health messages that promoted physical and mental health, while recognising women's social circumstances.

Our initial collaboration resulted in writing a submission to, and giving evidence at, the Senate Select Committee into the Obesity Epidemic in Australia. The submission raised awareness of the negative impacts of weight stigma on children's mental health and how health professionals can unintentionally reinforce weight stigma by focusing clinical care on children's weight, shape or size. Our suggestions resulted in the first two recommendations of the final report asking for greater awareness about weight stigma and its consequences, especially among health professionals [37].

Our recommendation: Focus on health and wellbeing, not weight

To achieve this recommendation, health professionals and the public require a deeper understanding of the complex relationships between weight, health and wellbeing, and that improving people's health and wellbeing does not rely on changing their body weight. In this paper we have argued that focusing on weight as a means of improving physical health is disempowering and may lead to the development of maladaptive weight-loss behaviours. Rather, a broader focus on encouraging positive health behaviours, addressing upstream determinants of health, and eradicating weight stigma are necessary to address the physical health inequities of people living with mental illness and prevent eating disorders.

Weight-inclusive approaches to health and wellbeing

[3] offer an empowering and effective alternative to weight-focused health care and public health policy that supports people's long-term physical and mental health, without contributing to stigma. Such approaches have received high-level support in recent position statements from the Royal Australian College of Physicians [38] and the Royal Australian College of General Practitioners [39] that call for ending weight bias and stigmatisation and focusing health messages on optimising health at any weight. Mental health advocates are well positioned to address the health inequities faced by people living with mental illness by challenging weight stigma and helping shift the focus of public health discourse and clinical practice from weight to wellbeing.

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Theme: Peer work and co-design

Pictorial physical health prompt: A co-design process

Whitney Lee and Vicki Langan
Neami National

Presentation Links

Slides

Presenter:

WHITNEY LEE

Whitney completed a Bachelor of Psychology and began her career working at a non-government mental health organisation, Neami National. It was here, that as a support worker, she witnessed the gap in physical health for people living with a mental illness. As she has always taken an interest in physical health and is passionate about leading a healthy lifestyle, she undertook a Master of Public Health (Health Promotion), to be able to work in the space to prevent poor health and promote physically healthy lifestyles for people living with a mental illness. Her role as Health and Wellbeing Officer at Neami National allows her to tie in both her passions to promote physical health for people living with a mental illness. She works closely with mental health consumers to co-design strength-based initiatives to improve physical health opportunities, access and health literacy for people living with a mental illness

VICKI LANGAN

Vicki began her career working in Juvenile Justice and AOD services. With a background in Sports Science, she worked with the Irish Sports Council concentrating her efforts developing strategies in disadvantaged communities engaging young people in physical activity/sport. With a lived experience and qualifications in Addiction Studies, Vicki clearly saw the link between poor mental health and the impact on physical health. In 2012, Vicki began working as a frontline mental health outreach worker the Aboriginal homelessness service within Neami, moving into the NSW Health Promotion Officer position and then to her current position as the Health and Wellbeing Manager for NSW. Vicki has contributed to the development of several physical health programs/initiatives and research projects with UWO, Neami's Health Literacy Project and Oral Health E-Learning with University of Melbourne. Vicki is dedicated to improving the physical health of people living with mental illness through innovation and collaboration..

Abstract:

The Physical Health Prompt (PHP) is a tool consisting of 28 strengths based close-ended (yes or no) questions developed primarily to guide conversations between staff and consumers to address health care needs. The PHP adheres to the National Health guidelines and was written through a co-design process in response to the poor physical health needs of individuals accessing Neami services. The PHP is intended to facilitate conversations where physical health concerns can be identified and then addressed through improving health literacy and engagement with primary health care providers, GPs, allied health professionals, alternative practitioners or relevant services.

Following the introduction of the original PHP in a boarding house program, staff discovered approximately 65% of residents identified as illiterate. In response, a co-design process was implemented involving mental health consumers and staff to develop an innovative version of the PHP tool to cater for different learning styles. The

outcome was a Pictorial Physical Health Prompt (PPHP) designed specifically by consumers for consumers in community mental health setting using images to support the comprehension of each written question.

There is a growing awareness of the need to identify successful models of co-design in mental health services and useful strategies to support consumer participation in developing services and practice tools. The PPHP demonstrates how consumer participation can result in a collaborative and dynamic partnership to create meaningful outcomes. This presentation explores the learnings from the co-design process to develop the PPHP including benefits, challenges and mitigating strategies used during the process. This contributes to the growing body of knowledge around methods to implement consumer participation when developing resources for people living with a mental illness.

Paper:

In response to the significant link between mental health and physical health, supported by overwhelming international evidence, initial discussions regarding the development of a physical health prompt began at Neami National in 2010. Neami is a national, not-for-profit organisation providing services to improve mental health and wellbeing in local communities. The Health Prompt sits in line with the Australian Government's Fifth National Mental Health and Suicide Prevention Plan, with Priority Area 5: Improving the physical health of people living with mental illness and reducing early mortality.

After researching current physical health check tools being used internationally, Neami designed a Physical Health Prompt specifically for Neami consumers that:

- reflected a holistic approach to health care
- promoted a sense of empowerment among consumers
- reflected a strengths-based and recovery-orientated approach
- reflected international standards
- aimed to promote and support discussions about physical health and further referrals onto health services

The Health Prompt includes 28 questions, addressing a set of diverse age and gender-related issues. A positive answer to the questions requires a tick in the 'yes' box, reflecting the strengths-based approach, while a 'no' indicates that follow up is required.

To increase accessibility of the Health Prompt, Neami has developed several versions of the Health Prompt, including an electronic version and has translated versions into Somali, Mandarin and Auslan. Neami seeks to identify needs of the consumers and to generate further opportunities to improve accessibility and health literacy through the Health Prompt.

Pictorial health prompt

The need for the Pictorial Health Prompt (PHP) was identified in the Elpis Project, which had a boarding house setting. As a direct result of face-to-face interaction with consumers, an emerging need was identified relating to building capacity to manage physical health. Within the boarding house setting, 65% of residents expressed having literacy issues and were not receiving what they required from the standard Health Prompt questionnaire. The Neami NSW Health and Wellbeing team, the Elpis team and boarding house residents collaborated to develop an appropriate method of communicating messages about physical health, resulting in the development of the Pictorial Health Prompt. Due to needs and the time restraints of the Elpis project, the initial Pictorial Health Prompt was produced quite quickly. The Health and Wellbeing team later revisited the Pictorial Health Prompt to focus on a comprehensive consumer co-design process.

Co-design and the pictorial health prompt

Governments are increasingly recognising the value and importance of consumer participation in governing bodies that oversee activities concerning people living with a mental illness. This can be seen in the Australian Government's governance commitments for the Fifth National Mental Health and Suicide Prevention Plan, and the subsequent NSW Health Strategic Framework and

Workforce Plan for Mental Health 2018-2022, which outlines Enabler 5: improving service delivery and partnerships through consumer participation and co-design.

In line with the government's commitment to collaborative partnerships with consumers, Neami National has consumer participation practises embedded into its design and planning, supported by paid consumer involvement activities. Neami National was established through grassroots approaches more than 30 years ago, and involved consumer participation in its foundations, through different stages of planning, delivering and evaluating the services used. Consumer advisory groups were fundamental in this work and played a vital role in the implementation of the Consumer Participation Framework in 2014, which aimed to embed consumer engagement at the individual, service, organisational, sector and community levels. Within the framework are guidelines and procedures to ensure best practise in the recruitment and payment of consumers during their involvement.

The Pictorial Health Prompt followed the stringent co-design process within Neami National's consumer participation framework. Consumers were recruited through an appropriate low-literacy approach to the expression of interest process, and strategies were put into place to cater for different needs of participants, to reduce barriers to attendance.

Participants reviewed the design of the previous health prompt – focusing on whether the existing pictures reflected the questions being asked. The participants proceeded to design the Pictorial Health Prompt which included drawing, painting, taking photos, editing the questions and designing the resource to include elements to make it more practical. The process also included a review by the consumer participants to view the final product and provide any further feedback. The result was a Pictorial Health Prompt, which featured photos, drawings and designs by people living with a mental illness, to be used with people living with a mental illness.

Learnings from co-designing the pictorial health prompt

The consumer participation process is not without its barriers and challenges. Below are the practical learnings of the co-design process and applied strategies that can be used to improve and embed consumer participation into organisational core practice.

Risk versus benefit

There needs to be consideration of risk versus benefits to consumer participation. It is important to have consumer participation; however, consumers can be vulnerable, and care needs to be taken to not put them at risk or incite feelings of being taken advantage of. The risks to consumers need to be explored fully to determine whether harm may result from participation and how to implement mitigating strategies. It is not just the overall resource that needs to be considered, but the safety of those contributing. Benefits of consumer participation need to outweigh the risks.

- Communicate upfront about the expectations of participants. Provide all information possible to ensure consumers can make an informed decision about participating. Inform them of how they can contribute, how many people to expect in the group, the staff to consumer ratio and the focus topic. Consumer participants need to be made aware of the risks, for example, the group will be discussing physical health issues, and this could potentially be challenging to hear.
- Communicate clearly about the payment process. Different organisations will have different payment processes and finance departments may need following up to pay consumers. Consumers need to be made aware of the process, such as money may not be paid directly into their accounts that day and that their payments may be delayed by processes or pay cycles. Past experiences reveal that some consumers spend the money before payment, as they expect the payment immediately, which results in them being left short of money and financially vulnerable. Additionally, this risk potentially affects relationships between the organisation and consumers, who understandably can become upset about delayed payments or a lack of communication about the process.

Skilled workforce

Attitudes, understanding and competency among staff impact greatly on the effectiveness of consumer participation and whether it is even considered in developmental reform.

- Appropriate training needs to be provided so that staff have a comprehensive understanding of the consumer participation process and to improve confidence in facilitating this process.
- Staff attitude when approaching the consumer participation process needs to view all participants as equal.
- Adequacy of consumer representation is likely to impact on effective participation and the achievement of anticipated goals. An EOI process in addition to screening phone calls, helps participants' capacity in making an informed choice about participation and helps guide adequacy of consumer representation.
- A consumer participation toolkit should be made available to staff to help them with practical strategies relating to consumer participation processes.

Poor communication and non-collegial approaches

Barriers to effective consumer participation can include poor communication between staff and consumers, as well as approaches that are not collaborative. This includes power imbalances that can affect outcomes and engagement. Lack of clarity on the type and purpose of participation presents a needless barrier to a consumer participant who is considering the opportunity.

- Communicate the expectations of what the consumer participation process is. An easily avoidable barrier is the misunderstanding of what consumer participation is and what is expected of all stakeholders. It is important to be transparent about the expectations of consumer participants and ensure this is communicated effectively.
- Ensure participants have all the information required beforehand. To ensure a fair process and reduce barriers to attending consumer participation opportunities, it is critical that all information is provided to participants prior to attending their work. This includes phone conversations to discuss the opportunity; sending out relevant paperwork to read through beforehand and paying participants for their time.
- Consider group dynamics. It can be challenging to ensure equal participation in a context where staff are accustomed to taking the initiative and managing the process, while consumers and carers often take the role of being more passive 'receivers' of care. A ratio of no more than an equal amount of staff to consumers within the group is desirable. It is best practise to have more consumers than staff.
- Staff members' roles in the group need to be clear. Often the staff members' presence is not to participate, but rather to be a support for the consumer participants.
- Having a consumer participant as co-facilitator is an effective way to reduce imbalanced power dynamics and give control to the consumer participants.

Mental health or cognitive issues

The nature of consumer participation is that lived experience is valued and is fundamentally needed to guide service and resource development. With this comes challenges regarding mental health or cognitive issues. For example, an individual's mental health may affect their ability to attend the consumer participation opportunity or affect someone cognitively, such as their ability to retain information. The complexities of mental health affecting an individual's ability to contribute should not be a deterrent, but rather a learning opportunity towards effective practice.

Strategies to mitigate these barriers include:

- Be flexible because sometimes an individual cannot face a group on that day and perhaps if there is capacity, meet that individual separately on an alternative day.
- Provide alternatives as one option will not suit all. Provide different structured, collaborative approaches which cater to different learning styles.

- Medication affects ability to participate, therefore be aware of the side effects of medication and discuss with consumer participants their needs in relation to this.
- Encourage a carer or support worker to attend; the purpose of the support worker is not to participate actively in the group, but to be a support to the consumer.
- Ensure comprehension by taking the time to check in with participants.
- Give space as needed which may mean more breaks than planned.
- Literacy issues or the dislike of paperwork can be a barrier to effective participation – too much writing may act as a deterrent.

Ensuring diversity and cultural sensitivity

The underlying concepts and language we use are becoming more inclusive as we provide a wider range of services to different sections of society across the country. Participants are not a homogenous group and include people from different educational, cultural and employment backgrounds, gender and different mental health needs. These differences need to be considered when organisations incorporate consumer participation. More specifically, some people or groups may require extra effort to engage, due to a range of barriers, including a history of discrimination.

- Be aware of specific barriers or historical disadvantage that the group may have experienced and adapt accordingly.
- Be aware of appropriate use of language.
- Acknowledge that consumer participants are the experts and take the cue from the group. Be open and transparent, allowing for the opportunity to learn from participants and not assuming facilitators bring in the expert knowledge

Meaningful conversation

Fundamentally, consumer participation is the use of lived experience towards reform. It is only natural that passionate conversation can occur as it is a topic close to the participant, therefore strategies need to be considered to keep the conversation meaningful and on track.

- Consider own skills in reconciling challenges of constructive conversation while acknowledging consumer participants' experiences.
- Safe disclosure should be discussed within all group agreements to maintain participant safety and ensure that sharing is purposeful.

Socialisation

Often the participants who attend consumer participation opportunities may have experienced isolation for a variety of reasons. Lived experience such as this is critical to the development of mental health reform but also presents a significant barrier to consumer participation processes. Participants may find it difficult to face a group situation which prevents them from participating, or may not have the skills to socialise in groups.

- Ensuring space for equal participation is important, especially if the working group includes staff or other stakeholders, who may overshadow consumer voices. Check in with all participants to allow opportunities for all opinions. Consider other options for providing feedback, such as checking in with participants after the session, should they express not feeling comfortable speaking up in the group or encouraging them to write notes in lieu of speaking.
- Strategies such as a group agreement are useful to establish the tone for the day and can be referred to throughout the session. Important cues to consider within the group agreement include not speaking over others, being respectful of different opinions, being mindful that this is not a group therapy session and safe disclosure.

Accessibility for consumers

Consumers may have support requirements that, if not supported, may prevent participation. To ensure equity and access to participation, it is important to consider barriers and reduce the burden on consumers. Often these are practical barriers, which can be overcome simply through problem solving with consumers. It may be challenging enough to attend the group, therefore guaranteeing that consumers have complete accessibility is paramount.

- Consider what is convenient for consumers, not what is convenient for staff. The location of the consumer participation opportunity should be accessible and close to the participant, not where it is easiest for staff.
- The location of the consumer participation opportunity needs to be an appropriate setting for the group. For example, when running a focus group to develop an Aboriginal and Torres Strait Islander resource, only one participant attended at an office. After discussion and review, the participant suggested a setting that encouraged cultural connection. All five participants attended the second focus group, which was held outdoors in a setting of cultural significance for the Aboriginal culture.
- Accessing the location can often be difficult for participants, therefore all options should be considered and supported. Discuss with participants whether there is a need to organise support workers to support participants or to bring a support person.
- Discuss what transport options are available and potentially research individual transport itineraries for each participant. Ensure that public transport is paid for or cab charges provided for participants.
- Sometimes participation in person is not an option and there may be a need to offer attendance via teleconference or webchat.

Benefits of co-design

Most importantly, there are many benefits of the consumer participation process. Some of these are listed below.

Consumer skill development

The consumer participation process is a paid position with an EOI process. That is, consumer participation is seen as a job where people are paid for their skills, experiences and knowledge. Where some people may gain knowledge from university or formalised training, consumer participation focuses on knowledge gained through lived experience and values the importance of this in improving mental health services. Engaging in consumer participation has improved capacity and skills for participants – these are transferrable to other roles they may take on.

Consumer validation

Consumer participation is a positive process, which results in participants often offering their expertise for further co-design projects and opportunities. There is an interest in using lived experience to help others and have an input into the services or resources that are targeted towards people living with a mental illness.

"Thank you for valuing my opinion and asking us here today. It shows you actually care about what I have to say."
- consumer

Relevant resources

Importantly, consumer participation is critical to producing relevant resources and services. The Pictorial Health Prompt is mental health relevant in its design and is seen through the lens of both people with lived experience and staff. For example, the original design included comprehensive instructions on skin checks, however, consumer participants reflected that this was inappropriate as that group did not want to look at their skin that closely.

Additionally, it ensures cultural relevance. For example, while appropriate in other versions of non-culturally specific Health Prompts, in the Aboriginal and Torres Strait Islander Pictorial Health Prompt, it was inappropriate to have a picture of a white lab coat to indicate a GP and participants reflected that this would act as a deterrent.

Ensuring relevance increases the useability and accessibility of the resource. The Pictorial Health Prompt included in its design some strategies that make it easier for users to complete the Health Prompt, in addition to keeping up with the six-monthly review.

Social benefits

A benefit that may not be so obvious when considering consumer participation, and though potentially not a direct objective, is the opportunity for socialisation. For many consumer participants, isolation is a key barrier to engagement. Consumer participation has often acted as a motivating factor to get out of the house, and usually is a positive experience where the participant is glad to have made the effort to leave their home.

Conclusion

Consumer participation needs to be embedded into core practice in mental health reform and resource development. Though there are barriers and challenges, these need to be viewed as learning opportunities and used as a strength towards developing meaningful mental health strategies. Consumer participation has extensive benefits that enrich not only mental health strategic directions, but also have many positive benefits for people with a lived experience of mental illness. Organisations need to develop a consumer participation framework and toolkit to support the consumer participation process in resource development, planning, delivering and evaluating the service. This needs to be overseen by consumers, with the potential of employing a specific lived experience role to develop and preside over consumer participation in the organisation.

Theme: Peer work and co-design

Active8 – a peer-led physical health and wellbeing project

Presentation Links

Slides

Whitney Lee and Vicki Langan
Neami National

Presenter:

WHITNEY LEE

Whitney completed a Bachelor of Psychology and began her career working at a non-government mental health organisation, Neami National. It was here, that as a support worker, she witnessed the gap in physical health for people living with a mental illness. As she has always taken an interest in physical health and is passionate about leading a healthy lifestyle, she undertook a Master of Public Health (Health Promotion), to be able to work in the space to prevent poor health and promote physically healthy lifestyles for people living with a mental illness. Her role as Health and Wellbeing Officer at Neami National allows her to tie in both her passions to promote physical health for people living with a mental illness. She works closely with mental health consumers to co-design strength-based initiatives to improve physical health opportunities, access and health literacy for people living with a mental illness

VICKI LANGAN

Vicki began her career working in Juvenile Justice and AOD services. With a background in Sports Science, she worked with the Irish Sports Council concentrating her efforts developing strategies in disadvantaged communities engaging young people in physical activity/sport. With a lived experience and qualifications in Addiction Studies, Vicki clearly saw the link between poor mental health and the impact on physical health. In 2012, Vicki began working as a frontline mental health outreach worker the Aboriginal homelessness service within Neami, moving into the NSW Health Promotion Officer position and then to her current position as the Health and Wellbeing Manager for NSW. Vicki has contributed to the development of several physical health programs/initiatives and research projects with UWO, Neami's Health Literacy Project and Oral Health E-Learning with University of Melbourne. Vicki is dedicated to improving the physical health of people living with mental illness through innovation and collaboration.

Abstract:

There is a growing body of evidence which suggests peer coaching in recovery-oriented practice is an effective approach to supporting consumers in mental health service settings. The value of peer support in mental health recovery lies in its ability to inspire hope, motivation and an increased ability to overcome challenges.

Neami National's Active8 program in NSW is an innovative alternative to traditional approaches. In keeping with Neami's recovery-oriented practice framework, the program is person-centered, collaborative and designed to maximise opportunities for participants to build skills in self-management.

The Active8 program offers a combination of an individual program of Coaching for Physical Health, delivered one-to-one by a peer support worker, and Eat, Plant, Learn a group program co-facilitated by the peer workers,

who promotes healthy and sustainable eating. The programs support consumers to identify and work on physical health-related goals; as well as improve their health literacy, engagement with health services, self-management and self-efficacy. Consumers participate in either Coaching for Physical Health (CPH) or Eat, Plant, Learn (EPL) or both programs according to their identified needs and goals. Everyone is offered six one-to-one coaching sessions with an introductory session and an exit support session and access to several tailored group EPL sessions, dependent on their individual needs. The CPH sessions are delivered face-to-face at the consumers home, preferred community location, or over the telephone. One-to-one sessions are scheduled at intervals of two and four weeks to allow them work on their identified goals between sessions.

Unlike a counsellor or mentor, the peer coach does not rely on offering advice but rather helps the individual brainstorm ideas and develop achievable goals, they selectively use self-disclosure to inspire hope, self-determination and reduce stigma. Neami Peer coaches understand the link between physical and mental health and are passionate about supporting people through the challenges of making behavioural changes. The Active8 peer support workers specialise in techniques to support and guide consumers to find sustainable and meaningful strategies to achieve their physical health goals. They are skilled at keeping sessions on the topic of physical health, whilst being creative and flexible to respond to individual needs.

Paper:

Active8, Neami National's Physical Health and Wellbeing project, targets people experiencing mental illness as well as physical health issues, particularly preventable illness. Funded by Coordinare, the South Eastern NSW PHN since February 2017, the Active8 project aims to address the poor physical health commonly experienced by people who have a mental illness. In keeping with Neami's recovery-oriented practice framework, the program is person-centred, collaborative and designed to maximise opportunities for participants to build self-management skills.

The project is currently delivered across the Illawarra-Shoalhaven region and offers a combination of one-to-one Coaching for Physical Health, delivered by a peer worker, and a group program (Eat Plant Learn) that promotes healthy and sustainable eating. The programs help participants to identify and work on physical-health-related goals; as well as to improve their health literacy, engagement with health services, self-management and self-efficacy. Participants can participate in either or both programs, Coaching for Physical Health and Eat Plant Learn, according to their identified needs and goals.

Coaching for Physical Health

Coaching for Physical Health is based on the Peer Health Coaching program which was first developed with Neami peer workers and the health promotion officer, in partnership with SANE Australia. Integral to the Coaching for Physical Health program is the delivery of support by peer support workers – people who have lived experience of recovery from mental illness and an understanding of the challenges of making physical health behaviour changes when living with a mental illness. They are trained in the delivery of health coaching, with ongoing coaching to support their practice.

Each participant is offered six one-to-one coaching sessions, including entry and exit meetings. These sessions are delivered face-to-face at the participant's home, preferred community location, or over the telephone. One-to-one sessions can be scheduled at intervals of between two and four days to allow participants to work on their identified goals between sessions.

Sessions focus on developing strategies to identify and work on health-related goals. They are based on a coaching relationship and focus on enhancing the capacity of the participant to self-direct their health-related goals.

Eat Plan Learn

Eat Plant Learn is a module selection program that can run from two to eight sessions and supports participants to learn about healthy eating and to gain skills in growing and cooking their own food. It covers the following topics:

- Introduction to healthy and sustainable food
- The benefits of healthy eating
- Growing your own food
- Seasonal cooking
- Sourcing healthy and sustainable food at affordable prices

The group sessions include practical activities such as growing vegetables, cooking and food-shopping. The sessions are held at different local venues, such as community gardens and community centres.

To allow for greater access across the region, Eat Plant Learn is delivered in the community, accessing community venues familiar to the consumers. Participants are also invited to co-facilitate subsequent programs delivered in their local area.

Outcomes

Active8 has proved to be effective at reaching people living with a mental illness in the Illawarra-Shoalhaven region, with 156 referrals into the program, all of whom asked to participate in Eat Plant Learn. One of the unique elements to this project that contributed to the high number of referrals was the acceptance of referrals from individuals with self-reported mental health issues, such as those without a formal diagnosis from a clinical health professional. Out of the 156 referrals, 106 individuals identified as having self-reported mental health issues or chose not to disclose their mental illness. Coaching for Physical Health received 123 referrals, with 81 engaging in two or more session, 35 not engaging for differing reasons and seven not eligible. Eat Plan Learn had 142 referrals participate in three or more group sessions.

Preliminary results indicate that there has been a positive change in knowledge of food options and confidence to source healthy food after participating in Active8. The changes were measured through focus groups and stories collected through interviews with participants, workers and stakeholders. Some key themes were knowledge attainment, impacts on mental health, motivation and challenges.

"The most significant thing for me has been to take a look at my life and my healthy eating—to see that there have been some gaps and then finding ideas to actually change it for the better—simple things about my eating and smoking." - consumer

"Now I don't run out of food. I was supported with connecting (with) the community service, the Food Pantry. It was good to go into the food co-op. I knew it was there but haven't felt comfortable to enter the shop." - consumer

"I learnt how to make date bliss balls and omelette. [Eat Plant Learn] inspired me to be more healthy, eat more fruit and vegetables, and to do more cooking at home." - consumer

Learnings

The evaluation process of the Active8 program is notably different to that of the first year of Active8. As Active8 moves into its third year, evaluation has been adapted to better capture the outcomes for individuals accessing this project. Below is the information that will be captured in future evaluations of the Active8 program.

Referrals to Active8 include:

- Key sociodemographic information for comparison with other initiatives.
- Health and mental health condition question using validated HLQ-4 domains.

Participation in programs:

- Number and percentage of total referrals who have completed CPH and EPL full program.

Progress towards improving physical health and wellbeing through both CPH and EPL:

- Percentage of participants completing Health Prompt (physical health screening tool).
- Percentage of participants in Health Coaching where SMART health goal is recorded.
- Self-reported food and cooking knowledge and measured individual cooking practice.
- Using relevant questions selected from validated CAFPAS Cooking and Food Provisioning Action Scale – measuring tool for individual cooking practice (1).

Customer satisfaction:

- Percentage of participants rating low and high (comparative) satisfaction on recognised measure, YES Survey.

Consumer engagement in community and health services:

- Number and type of referrals to community and health services.
- Percentage of consumers referred to GP services.

Reference List

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Theme: Focus on community care

The development of a side effect and preventive health screening tool in a community mental health setting

Presentation Links

Slides

Andy Simpson
Sydney Local Health District

Presenter:

ANDY SIMPSON
Andy Simpson completed psychology and then mental health nursing training in the UK where he worked for 12 years across various inpatient mental health settings. Since moving to Sydney 9 years ago he has worked as a care coordinator, clinical nurse educator, community mental health team leader, and is now the program manager for Living Well Living Longer, which aims to improve the physical health of mental health consumers across Sydney Local Health District. He is committed to improving the physical health and wellbeing of mental health consumers to address the 20-30 year life expectancy gap.

Abstract:

Mental health consumers typically experience a range of side-effects from anti-psychotic medication which are often under-reported. Many neglect their physical health, and life expectancy for people with severe & enduring mental illness is 20-30 years less than the population average. Currently, mental health services routinely check metabolic monitoring every 13 weeks and recommend annual physical health reviews with the GP, but there is no routine monitoring of side effects or preventive health screening status.

The M-SEPHS: Marrickville Side Effect & Preventive Health Screening Tool has been developed to quickly and concisely identify side-effects and preventive health screening status and is designed to be completed every 13 weeks alongside metabolic monitoring. A 12-month pilot of consumers who attend Marrickville Health Centre for their Long-Acting Injection has been completed. During this pilot, 100 individuals completed 149 screening tools, with a total of 235 side effects reported.

While 28% of individuals reported no side-effects, 31% experienced three or more. Adherence to best practice guidelines for preventive health screening was extremely low. For individuals who were screened twice or more (n=41) there was no significant change in number of side effects reported or preventive health screening status, but there was a significant improvement in engagement with GP and dentist and a reduction of smoking. Recommended interventions will be developed to assist clinicians to respond appropriately to the findings. In addition, a consumer feedback survey has been implemented.

From 23 surveys reviewed, 85% of respondents report that they think the tool is useful, with 50% reporting that new side effects were identified and 20% believing this led to a change of dose or treatment. 45% of respondents said that they followed up identified preventive health gaps with their GP. The tool is now being implemented further across Sydney Local Health District.

Paper:

Introduction: Background and context

Mental health consumers typically experience a range of side effects from anti-psychotic medication. These are often under-reported. The literature suggests that 77% of mental health consumers experience medication side effects, with 61% reporting impairment in their daily life as a result (Morgan et al., 2018). Side effects have been strongly linked with discontinuation of treatment (Haw et al., 2016). Assessment of side effects by mental health clinicians has historically been limited. A structured assessment tool has been shown to increase assessment rates (Haw et al., 2016).

People who live with a severe mental illness are six times more likely to die from cardiovascular disease, five times more likely to smoke, and four times more likely to die from respiratory disease compared to the general population. As a result of these and other factors, life expectancy for people with severe and enduring mental illness is 14-23 years less than the population average. Lower rates of physical health screening among consumers with mental illness leads to under-detection of comorbid physical illnesses (Cocoman & Casey, 2018).

Currently mental health services routinely check metabolic monitoring every 13 weeks and recommend annual physical health reviews with the GP, but there is no routine monitoring of side effects or preventive health screening status.

Method: Project description/actions

The *SEPHS: Side Effect & Preventive Health Screening Tool* has been developed by the community mental health team at Marrickville, Sydney Local Health District. The goal is to quickly and concisely identify side effects and preventive health screening status in mental health consumers. The SEPHS is designed to be completed every 13 weeks alongside routine metabolic monitoring, without being too onerous or time consuming for either consumer or clinician. A 12-month pilot of consumers who attend Marrickville Health Centre for their long acting injection has been completed. Following the pilot, a feedback survey was introduced to see how people feel about being asked the questions. As well as reviewing each individual question from the SEPHS there were some yes/no questions to evaluate whether consumers felt any new side effects or preventive health screening absences had been identified, whether anything had changed as a result, and overall whether they think it's a useful tool.

Results: Outcomes/key points

During the pilot, 100 individuals completed 149 screening tools, with a total of 235 side effects reported. While 29% of individuals reported no side effects, 31% experienced three or more. The most common was restlessness or stiffness (31%) followed by dizziness or drowsiness (26%) and sexual side effects (22%). All 15 side effects on the tool were identified in at least two individuals.

Adherence to best practice guidelines for preventive health screening was extremely low. For example, the rates of participation in national cancer screening programs across Australia are around 40% for bowel, 58% for cervical and 55% for breast cancer screening, but these dropped to 3%, 20% and 16% respectively in our cohort.

For individuals who were screened twice or more (n=41) there was no significant change in number of side effects reported or preventive health screening status during our pilot, but there was a significant improvement in engagement with GP and dentist and a reduction of smoking. This is attributed to the proactive response of the clinician implementing the tool, who would offer to book a dental or GP appointment for individuals who identified that they did not have a GP or dentist, and made a referral to a smoking cessation specialist for smokers who accepted this offer.

A review of the SEPHS feedback survey shows that on the whole, responses were overwhelmingly positive, with people reporting that they really appreciated being asked the questions. Clinicians report the SEPHS is a tool for improved engagement with consumers. The least popular questions were about sexual side effects and smoking status with a small minority stating that they resented being asked, but they were strongly outweighed by those who appreciated being asked these questions. Fifty-six per cent reported that they thought new side effects were identified using the tool, 36% said that it prompted them to follow up with their GP, and 80% said that overall, they thought it was a useful tool.

Discussion: Key implications, lessons, recommendations

Surveys have shown that only 42% of individuals report complete adherence to medication (DiBonaventura et al., 2012) and only 24% of people experiencing a side effect report it to their physician (Cascade et al., 2010). This would suggest that people are more likely to reduce or even cease taking their medication than they are to disclose side effects to their treating team. This potentially has a huge public health impact, with a systematic review of 65 RCTs suggesting that people are approximately two-and-a-half times more likely to experience a relapse and be admitted to hospital if randomised to placebo vs. treatment group (Leucht et al., 2012). The clear inference is that mental health services need to do better at monitoring for side effects and responding accordingly.

Early indications are that the SEPHS Tool may begin to bridge this gap, and not only lead to improved outcomes for consumers in terms of side effects and physical health, but also improved engagement with mental health clinicians. Further validation of the tool is required—it will need to be tested in a variety of clinical settings to ensure that it achieves these objectives.

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Theme: Focus on community care

Embedding a specialist preventive care clinician in a community mental health service

Caitlin Fehily, Kate Bartlem, John Wiggers, Paula Wye, Richard Clancy, David Castle, Sonia Wutzke, Chris Rissel, Andrew Wilson, Kim Colyvas, Rebecca Hodder and Jenny Bowman

Presentation Links

Slides

Presenter:

CAITLIN FEHILY

Caitlin Fehily is a PhD candidate at the University of Newcastle. Her research focuses on identifying effective and cost-effective strategies to address the poor physical health of people with a mental illness. Her PhD trials one model for enhancing the provision of preventive care (for smoking, nutrition, alcohol consumption and physical inactivity) in mental health services; whereby a specialist clinician is allocated to this specific role. Ms Fehily is passionate about enhancing positive health behaviours. She is particularly interested in researching service delivery methods to address the high prevalence of chronic disease risk factors among people with a mental illness.

Abstract:

Background: People with a mental illness are more likely to engage in modifiable risk behaviours: smoking, poor nutrition, harmful alcohol consumption and physical inactivity, compared to the general population. Guidelines recommend that mental health services routinely provide 'preventive care' to address risk behaviours, however, provision of this care is low. This study aimed to assess the effectiveness of providing preventive care via the offer of an additional consultation with a specialist preventive care clinician in a mental health service.

Methods: A randomised controlled trial was conducted within one community mental health service. Clients (n=811) were randomised to receive either usual care (preventive care directed by policy to be provided in routine consultations) or usual care plus the offer of an additional consultation with a specialist preventive care clinician (intervention group). Telephone interviews were undertaken at baseline and a one-month follow-up to assess participants' views towards this model and receipt of preventive care.

Results: 82% of the intervention group stated that this model of preventive care provision was acceptable, and 95% agreed that it was a good idea. One third of clients allocated to the intervention attended the preventive care consultation, and participants who attended reported high levels of satisfaction. Preliminary intention to treat analyses indicated that the intervention group were significantly more likely to have been asked about their risk behaviours (RR 4.00), advised to change at-risk behaviours (RR 2.40) and offered referral(s) to specialist behaviour change services (RR 20.13).

Conclusions: Clients of a community mental health service viewed the offer of an additional preventive care consultation to be acceptable and satisfactory. This model of service delivery resulted in significantly greater receipt of preventive care, as compared to usual care. This model may be a means of providing care to clients of community mental health services worthy of further testing.

Paper:

People with a mental illness experience poorer physical health than the general population, including a greater morbidity and mortality from chronic diseases.

This is contributed to by a higher prevalence of modifiable health and lifestyle behaviours: tobacco smoking, poor nutrition, harmful alcohol consumption, and physical inactivity.

Clinical practice guidelines recommend that mental health services systematically provide ‘preventive care’ (care to encourage positive changes in risk behaviours) to their clients, however, the routine provision of such care is low.

An alternative approach is to allocate a specialist clinician to the dedicated role of offering and providing clients of a community mental health service with an additional appointment, focused solely on preventive care.

We conducted a randomised controlled trial to examine the effectiveness of this model of care in increasing the number of clients who receive recommended preventive care; as well as determining clients’ perceived acceptability of and satisfaction with this approach.

The findings show that this may be an effective approach to providing preventive care to people with a mental illness, though further research is required to explore its feasibility to implement.

Theme: Equally Well New Zealand and Australia: collaboration and collective impact

What makes for successful collaboration?

Emma Wood
Te Pou o te Whakaaro Nui

Presentation Links

Slides Video

Presenter:

EMMA WOOD

Emma is the Manager – Practice at Te Pou o te Whakaaro Nui a national centre for evidence based workforce development for the mental health, addiction and disability sectors in New Zealand.

Emma's work oversees a portfolio of initiatives that aim to enhance the values, attitudes, knowledge and skills of the workforce working with people with mental health and addiction needs. Trained as a social worker and a partnership broker, one of her interests is how we make working in collaborations such as Equally Well successful in both how our organisations work as well as developing the right knowledge and skills of the workforce.

Abstract:

Working in a collaborative like Equally Well needs us to work in partnership, both with people with mental health, and addiction needs and with other organisations and roles that we may not have worked with before.

The workshop will focus on understanding the different types of collaborations, what makes these successful and how we go about ensuring we equip both ourselves and our organisations to do these well.

Paper:

Background

Equally Well Aotearoa New Zealand is a collaborative of people and organisations with the common goal of achieving physical health equity for people who experience mental health and addiction issues. This requires working in partnership with people with lived experience, a range of organisations, sectors and different roles.

To do this successfully we need to recognise the importance of building our knowledge and skills about how to work collaboratively through understanding the values and behaviours of collaborative workers and organisations.

Te Pou o te Whakaaro Nui (Te Pou) and Platform Trust have explored the meaning and application of collaborative capability in the mental health and addiction sector in New Zealand. This reflects a vision for:

- A local system of support based on meaningful partnerships between people accessing services and the networks around them;
- A whole of population health approach based on the notion of wellbeing;
- Engaged and healthy individuals, families/wh-nau and communities.

The report, Collaborative capability in the mental health and addiction sector (Te Pou o te Whakaaro Nui, 2018), provides useful information ensuring we are that assists to ensure that we are developing the values, knowledge and skills to work collaboratively in the initiatives that are part of Equally Well.

Developing the individual and organisational capability for collaboration

Collaborative capability is essential to be able to:

- Form mutual partnerships with people accessing services;
- Integrate across existing boundaries;
- Collaborate within communities.

Values of collaborative workers are:

- Humble, honest and kind;
- Committed to equity, openness, trust, respect and diversity;
- Committed to working with others for mutual benefit;
- Open to risk, innovation and change;
- Committed to enhancing people's rights.

Behaviours of collaborative workers are:

- Able to connect with and work in partnership with people;
- Flexible and adaptable in relation to:
  - » Making decisions;
  - » Giving up autonomy;
  - » Accommodating different points of view and ways of working;
  - » Working in diverse community settings.
- Able to network and connect with colleagues within and across organisations;
- Able to communicate well.

Collaborative organisations have:

- Mutual respect for and understanding among partner organisations;
- A commitment to innovation, divergent thinking, risk and change;
- A reputation for honesty, trust and respect;
- A culture of reflection and learning.

Collaboration and formal partnerships need to be supported through:

- Workforce development, such as the development of collaborative skills, having clear roles with responsibilities for collaboration, acknowledging the importance of networking between teams, organisations and sectors;
- Organisational behaviour – will include alignment with collaborative values, understanding collaborative best practice and valuing people through co-design processes;
- Clear systems and processes which support collaboration and partnerships through effective governance, shared decision-making and mutually agreed strategic goals.

One of the key principles of Equally Well Aotearoa New Zealand is working in partnership. Reflecting on how we are developing the values and behaviours of collaboration for both workers and organisations will enhance the success of Equally Well initiatives and the outcomes for people accessing services.

To access a copy of the full report, Collaborative capability in the mental health and addiction sector – literature review, visit: https://www.tepou.co.nz/resources/collaborative-capability-in-the-mental-health-and-addiction-sector---literature-review/862

To find out more about Equally Well Aotearoa, visit: https://www.tepou.co.nz/initiatives/equally-well-physical-health/37

Theme: Supporting healthy lifestyles – smoking

Existing interventions and future directions

Peer-reviewed paper

Presentation Links

Slides

Cathy Segan
Quit Victoria

Presenter:

CATHY SEGAN

Dr Cathy Segan is Innovation Fellow at Quit Victoria. She is interested in tailoring Quitline services to meet the needs of people living with mental illness, e.g. by introducing monitoring of nicotine withdrawal symptoms to help allay concerns that quitting might worsen mental health.

Cathy is CI on a NHMRC trial examining the effectiveness of peer worker brief intervention plus referral to an enhanced Quitline service for people with severe mental illness. Previously she led a beyondblue project demonstrating the value of Quitline-doctor co-management of smoking cessation and depression. Cathy also co-supervised a PhD on quitting success stories among people with severe mental illness.

Abstract:

Mental health practitioners are well placed to deliver brief advice for smoking cessation that can link consumers to effective smoking cessation treatments. The most effective treatments combine a multi-session behavioural intervention (eg groups courses, quitline) with pharmacotherapy (eg Nicotine Replacement Therapy (NRT), varenicline, bupropion). Routinely offering brief smoking cessation help to consumers, regardless of their level of interest in stopping smoking, empowers consumers by letting them know what works, and offering to link or enrol them into treatment increases uptake. Enabling factors that can improve the routine delivery of brief advice and ideas for improving the quality of current treatments are discussed.

Paper:

Background

In recent years there has been increasing momentum and acknowledgement of the need to address tobacco smoking in people living with mental illness. Factors that may explain this include: the expansion of smoke-free policies into mental health care settings, evidence that smoking cessation does not exacerbate mental ill-health[1] and is in fact, associated with improved mood for people living with and without mental illness,[2] the increasing financial impacts and continued negative health effects of smoking that impede mental health recovery, evidence that smoking cessation pharmacotherapies such as nicotine replacement therapy (NRT), varenicline (Champix) and bupropion (Zyban) are safe for people with mental illness to use[3] and recommendations that smoking be addressed concurrently with mental health and substance use treatment.[4,5]

Despite increasing acknowledgement that smoking should be treated as a clinical issue rather than viewed as an individual lifestyle choice, it is rare for smoking cessation help to be routinely offered to consumers. This is a major problem because most people who smoke are reluctant to seek out treatment themselves given the strong levels of ambivalence, common to any addictive behaviour e.g., “I really want to quit but I’m not sure how I’ll cope without cigarettes”, pervasive beliefs about how people quit, e.g., “All you need is willpower”, and lack of awareness of what treatments work. Thus, it is vital that we work together to bring smoking cessation treatments to consumers. Many consumers want to stop smoking6 and when proactively offered help, some consumers will accept it.

Best practice smoking cessation support

The most effective treatment model is for health professionals to provide brief advice on stopping smoking that offers to proactively link consumers to effective treatments. Effective treatments, both for people with and without a mental illness, combine a multi-session behavioural intervention (e.g., group courses, Quitline) and pharmacotherapy (e.g., a combination Nicotine Replacement Therapy (NRT), varenicline, bupropion)[1,7,8] (see Table 1). These treatments have an additive effect as pharmacotherapies ease withdrawal symptoms or help remove the desire to smoke, which enables people to better focus on dealing with triggers to smoke. We now consider each of the three components of best practice cessation support in turn, i.e. brief advice, multi-session behavioural interventions and pharmacotherapy.

Brief advice +	**Stop smoking + pharmacotherapy**	**Multi-session behavioural intervention**
Ask about smoking Advise benefits of quitting	Combination nicotine replacement therapy (NRT)	1:1 counselling by phone (e.g., Quitline) or face-to-face
Help – provide referrals for pharmacotherapy and a multi-session behavioural intervention	Varenicline (Champix) Bupropion (Zyban)	Group courses

Table 1 Three key elements of best practice smoking care

Brief advice

The aim of brief advice is to start the conversation about smoking, to provide information on the benefits of quitting and effective quitting methods and to link people to effective treatments. Brief advice reinforces to consumers the importance of stopping smoking and can act as a powerful trigger for quit attempts. Brief advice has been shown to increase 6-month continuous abstinence by up to 2% among smokers in the general population.[9] Its effectiveness (in and of itself) has not been adequately studied in people living with severe mental illness.[10] Regardless, the value of brief advice lies in its enormous potential to increase the uptake of treatments with demonstrated effectiveness for people living with mental illness, i.e. pharmacotherapy and multi-session behavioural interventions.

Ask

Do you smoke tobacco (or anything else)?

Advise

Seek permission to give advice about smoking, “Would you like to hear what help is available for your smoking?”and how it might be interacting with the presenting condition, “Stopping smoking can improve mental health and wellbeing.”

Help

Make an enthusiastic offer of help: provide self-help material, advice regarding pharmacotherapy and offer referral to Quitline or a stop smoking specialist.

Quit offers online training accessible nationally to support the delivery of brief advice: www.quit.org.au.

Table 2 Practice tips: 3 step brief advice

There are several factors to consider in improving the routine provision of brief advice. Supportive systems and policies (e.g., having a smoking care policy as well as a smoke-free policy) play a vital role in setting expectations regarding the provision of smoking care and in providing support for staff to do so. Quality improvement payments from government to hospital and health services even if intermittent can help services develop supportive systems and policies and can increase the delivery of quit support received by patients, including provision of NRT and referrals to Quitline.[11] Clinical pathways within services help clarify who, where and when smoking care is delivered, from initial assessment of smoking status, provision of brief advice, and specifying pathways for provision of pharmacotherapy and referrals for behavioural treatment.

Staff training that builds knowledge, confidence and enthusiasm about providing smoking care is also a critical component. Training needs to cover the multiple benefits of smoking cessation not only for physical health but for mental health recovery, address common barriers to raising the issue of smoking (see Table 3), build confidence in the effectiveness of behavioural interventions and safety of pharmacotherapy, provide clear guidance on how to link consumers to behavioural interventions and pharmacotherapies and ideally provide opportunities to practise brief advice provision. Some healthcare workers are uncomfortable with the notion of providing advice, seeing it as counter to client-led approaches. Training can help demonstrate how brief advice can be provided in a supportive and non-judgemental manner. Quit offers online training accessible nationally to support the delivery of brief advice: www.quit.org.au.

Table 3 Addressing common barriers to tackling smoking

Perceived barrier	Response
Consumer disinterest	Most consumers who smoke are interested in stopping smoking[6] Brief advice empowers consumers by letting them know what works and that help is there when they are ready
Not right time	Smoking can be addressed while treating mood, substance use and other conditions and may improve treatment outcomes
Will worsen mental health/affect psychotropic medications	Multi-session behavioural interventions monitor mood and medication side-effects
Smoking helps with stress	Much of the "stress relief" from smoking is relief of nicotine withdrawal symptoms (e.g., restlessness, difficulty concentrating, anxiety) arising between cigarettes. Stopping smoking provides an opportunity to learn other ways to deal with stress.

Recovery-oriented approaches also hold much promise. Peer workers are well placed to provide smoking cessation brief advice. Marginalisation and stigma can play a role in reinforcing smoking behaviours and in contrast peer workers offer hope and connection and can increase engagement with smoking cessation treatment.[12]

Multi-session behavioural interventions

Behavioural interventions delivered by quit specialists help guide people through the process of stopping smoking, including building motivation and confidence to reduce smoking and make a quit attempt, coping with cravings and nicotine withdrawal and adjusting to a smoke-free lifestyle. Behavioural interventions include an individualised assessment of smoking behaviour to help form a plan, tailored psychoeducation about (stopping) smoking, strategies to enhance motivation, and skills building to help people manage smoking triggers e.g., refusal skills, stress management, alternative rewards, and assistance with using pharmacotherapies. The setting of specific and realistic goal(s) within sessions with follow up at the subsequent session is a key component. Formats for multi-session behavioural interventions can include one-to-one delivery either by phone (e.g., Quitline) or face-to-face as well as group programs.

UK research examining the real-world effectiveness of smoking cessation interventions in the general population has demonstrated that adding a multi-session behavioural intervention to brief advice and NRT significantly improved the odds of quit success. Compared with people who received no help, people who received brief advice and NRT were 1.6 times more likely to quit, but those who also received a multi-session behavioural intervention were

2.6 times more likely to stop smoking.7 Evidence from UK stop smoking services also suggests that behavioural interventions run by quit specialists, i.e. people whose substantive role is providing smoking cessation behavioural interventions, tend to be more effective than behavioural interventions run by quit 'generalists' (e.g., pharmacists or general practitioners).13 In addition, tailoring of the UK's stop smoking service to help improve engagement and meet the needs of people with severe mental illness has significantly improved smoking cessation outcomes.[14] The bespoke service included treatment from a trained mental health smoking cessation practitioner who worked in conjunction with the client's general practitioner or mental health specialist (who determined appropriate pharmacotherapy and reviewed medications affected by smoking cessation), the offering of home treatment sessions, extra pre-quit sessions and additional support following unsuccessful quit attempts or smoking relapse.

Telephone smoking cessation interventions have been found to be just as effective as face-to-face interventions for people living with mental illness.[15] In Australia Quitline is the most readily available and cheapest (there is no charge) multi-session behavioural intervention. Quitlines are effective[16] and have been found to have positive impacts on smoking cessation among smokers with mental illness.[17],[18] Given the high numbers of smokers presenting with mental health issues, quitlines are increasingly tailoring their services to address barriers to cessation for people with mental illness.[19] Smokers with mental illness and their health care providers are often concerned that smoking cessation will worsen mental health. Smokers with mental illness tend to be more nicotine dependent and experience more severe symptoms of nicotine withdrawal, some of which are difficult to distinguish from psychiatric symptoms (e.g., depression, anxiety, and anger/irritability). Also, smoking cessation can increase the blood levels and hence side-effects of some psychotropic medications.[4]

The Victorian Quitline's service for people disclosing mental illness encourages use of mood management strategies that dually aid cessation, e.g., relaxation, exercise, scheduling pleasant activites18 and includes monitoring of nicotine withdrawal and medication side-effects to help distinguish temporary withdrawal symptoms from psychiatric symptoms and facilitate targeted treatment to help smokers with mental illness manage the acute phase of nicotine withdrawal.20 A trial with mental health service users is underway to examine the effectiveness of peer worker referral to the service together with combination NRT and coordinated care with the client's treating doctor compared to peer worker smoking cessation brief advice.[21] Other research from the US suggests that the addition of incentive payments for smoking abstinence may also improve treatment outcomes for quitline clients with mental illness.[22]

Currently Quitline services are underutilised. Referrals to Quitline need to be embedded within the health care system. This could be facilitated by using opt out (rather than opt in) referral to Quitline within brief advice interventions, auto-populating Quitline referral for practitioners' client management systems, ensuring that Quitline services routinely provide feedback on client outcomes to referrers and repositioning health professionals' perceptions of Quitline from a "telephone help line" to a quality "clinical service" that can meet the needs of smokers with mental illness.

Pharmacotherapy

Effective and safe pharmacotherapies for smoking cessation for people with and without mental illness include NRT (patch, gum, lozenge, inhalator and mouth spray), varenicline (Champix) and bupropion (Zyban).23 Improved access to pharmacotherapy for people with mental illness is needed. Cost is a commonly cited barrier to the use of NRT among people with mental illness. Currently only nicotine patch or nicotine gum or lozenge are available at significantly reduced cost as part of the Australian Government's Pharmaceutical Benefits Scheme (PBS) when best practice for nicotine dependent smokers is combination therapy (patch plus a short acting form). Higher doses of NRT may be appropriate for highly dependent smokers but there is currently inconsistency between product information and clinical best practice.24 Provision of NRT vouchers via quitlines may help improve uptake of both treatments but is currently only available for priority population smokers in Queensland. In addition, while smoke-free inpatient services routinely offer free combination NRT to manage nicotine withdrawal, it is rare for combination NRT to be provided on discharge to help maintain abstinence, despite evidence that this strategy combined with telephone counselling can increase cessation among people with mental illness.[25]

Conclusion "The Vision"

Together we need to work toward and advocate for health systems that integrate best practice smoking cessation treatment into usual care. In this way treatments would be automatically offered to people who smoke rather than expecting consumers to proactively seek out treatment for themselves. Ideally all consumers would be asked about smoking and those who smoke provided with brief advice that includes offering a multi-session behavioural intervention plus pharmacotherapy. All mental health staff would be trained to understand the devastating impact of tobacco on consumers' physical and mental health and would feel confident to deliver brief advice on smoking cessation and would work in services with systems that support access to multi-session behavioural interventions tailored to meet the needs of smokers with mental illness as well as free smoking cessation pharmacotherapies. Together such initiatives could significantly improve and extend the lives of people living with severe mental illness.

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Theme: Supporting healthy lifestyles - diet and exercise

Physical health is everyone's business: let's make it standard practice in mental health

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Rebecca Hallam and Liza Hopkins
headspace YEPP

Presentation Links

Slides

Presenter:

REBECCA HALLAM

Rebecca is the Senior Exercise Physiologist with the headspace Youth Early Psychosis Program (hYEPP) in Melbourne. She is an experienced Accredited Exercise Physiologist (AEP) who has worked across the healthcare spectrum with clients from all backgrounds with a variety of health conditions.

Rebecca is passionate about embedding the role of exercise into standard care in mental illness, and treating the whole person, rather than categorising people as physical or mental health conditions. Rebecca leads a team of four AEP's at hYEPP covering a large area of south-eastern Melbourne, servicing young people between the ages of 12 and 26.

Until 2019 Rebecca has served on the Victorian State Chapter for Exercise and Sports Science Australia (ESSA), chairing the chapter from 2016-2018.

Abstract:

Whilst at a societal level there have been challenges in bringing Mental Health to everyone's attention, from a traditional Mental Health Care perspective Physical Health has not been at the top of the agenda. With a groundswell of attention towards considering the physical health perspective, perhaps the time is right to flip the focus. This requires a multi-faceted approach to increase knowledge, awareness and confidence of Mental Health Clinicians in addressing physical health concerns, as well as empowering consumers to make choices that improve their physical health and overall wellbeing.

Exercise Physiology is a discipline that considers health from that holistic perspective. Whilst many people benefit from specific exercise prescription to treat their condition, it is also about addressing the underlying barriers to participation. Accredited Exercise Physiologists tackle the challenges from the physical, psychological, emotional and social perspectives to support people to maximise their opportunity to exercise for both enjoyment and optimal health.

There are a number of Mental Health Services across the country where Exercise Physiologists have been a vital part in 'flying the flag' for addressing physical health concerns and implementing clinical exercise interventions. This presentation will explore the challenges and triumphs of one service's experience in not only introducing Exercise Physiology into recovery, but also the multiple layers from which physical health must be approached in order to facilitate the changes in culture, practice and everyday interaction that are necessary for embedding physical health into standard care for those experiencing Severe Mental Illness.

Themes to be explored will include: Culture change – organisation wide, management, treatment teams and

individual clinicians; training – improving knowledge for both clients and staff; infrastructure – what is required to support this to happen: equipment, staffing, resources.

Paper:

Introduction

Mental health has traditionally lagged behind physical health both in public attention and care pathways. While this is changing, integrating physical health care into mental health services remains inconsistent. With evidence attesting to the importance of considering the interplay of physical and mental health factors building, the time is right to broaden the focus. This requires a multi-faceted approach toward increased knowledge, awareness and confidence of mental health clinicians in addressing physical health concerns, and in empowering consumers to make choices that improve their physical health and wellbeing.

Exercise physiology (EP) is a discipline that considers health from that holistic perspective. While many people benefit from a specific exercise prescription to treat their condition, EP is also about addressing the underlying barriers to participation. Accredited exercise physiologists (AEPs) tackle the challenges from the physical, psychological, emotional and social perspectives to support people to exercise for both enjoyment and optimal health.

Mental health services across the country are beginning to use EPs to address physical health concerns and implement clinical exercise interventions. This paper explores the experience of one specialist youth mental health service in including an EP in its recovery program.

It also examines the factors which facilitate the changes in culture, practice and daily interaction that are necessary for embedding physical health into standard care for those experiencing severe mental illness (SMI). We will also identify some of the barriers to change and make recommendations for future action in our own and other mental health services.

Context

The physical health consequences of living with SMI are becoming more widely known, with recent data suggesting a life expectancy gap of 10-15 years for people with SMI compared to the general population [1]. This gap is often misattributed to higher rates of suicide within this population, whereas the majority of the gap is due to the consequences of co-morbid physical health conditions [2, 3]. These co-morbidities can occur as a result of lifestyle factors associated with poor mental health, however, they can also occur as a direct, iatrogenic result of anti-psychotic medication and associated side effects.

Studies have shown that weight gain in first episode psychosis, and associated health consequences can be prevented or reduced with lifestyle interventions, including exercise [4]. For this reason, the headspace Youth Early Psychosis Program (hYEPP) in Bentleigh, Victoria, has included AEP services within the Recovery Program since 2015. The Recovery Program at hYEPP works with young people and their families to establish individual psycho-social support towards functional recovery, including vocational, educational and social support.

Although the AEP program has been established throughout the duration of clinical services within the hYEPP, integration of physical health care within the setting has continued to be challenging. Most mental health clinicians are not trained in physical health care, and may be unaware of, or lack confidence in, the provision of care for physical health conditions. The RANZCP cited an editorial in *The Lancet* concluding that patients with mental health problems were being denied care for their physical health in part due to a lack of confidence among physical health teams in helping people with SMI, and among mental health staff in providing physical health care [5].

The multifaceted nature of problems faced by people experiencing both physical and mental illness requires commitment from all levels of government, health care, various health professionals, and those with a lived experience of mental illness [5].

The role of exercise

In 2009, Professor Steven Blair published data indicating that the attributable fraction of all-cause mortality to low cardiorespiratory fitness (CRF) was approximately 16% for men, and 17% for women, across a 12-year longitudinal study. This was significantly higher than all other attributable fractions, other than hypertension for men (approx. 15%) [6]. Fig 1.

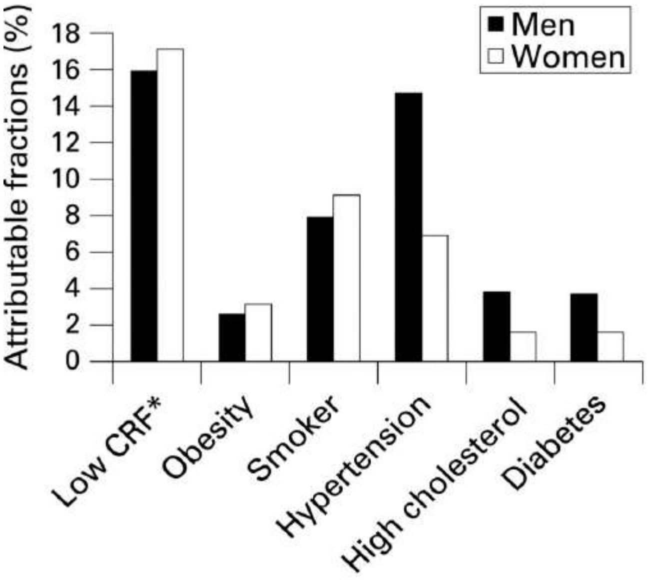

Fig. 1 (6).

A growing body of evidence recognises exercise as playing a significant role in the prevention, treatment and management of the risk factors noted in the study [6]. While there are medications that may be used to treat those risk factors, the only treatment for low CRF is regular physical activity and exercise.

Australian Physical Activity & Sedentary Behaviour Guidelines for adults recommend accumulating 150-300 minutes of moderate intensity physical activity per week, or 75-150 minutes of vigorous intensity physical activity each week; being active on most, preferably all days; and doing muscle strengthening activities on at least two days each week [7]. For those aged between five and 17 years, these recommendations are even higher—60 minutes most days of the week, and three days per week of strengthening activity [7]. Where there are no other significant risk factors for exercise, these guidelines may be recommended and encouraged across the whole population, with some exercise being better than none at all. Individuals who present with additional risk factors, or complex health conditions, including mental health conditions, may be recommended for referral to their GP, or health professionals such as AEPs.

Accredited exercise physiology

Accredited exercise physiologists (AEPs) are tertiary qualified allied health professionals, skilled in the delivery of exercise and physical activity interventions for the prevention, treatment and management of almost all non-communicable health conditions. The EP service at hYEPP has been operating since 2015 and currently stands at 1.4EFT. Services have been provided throughout the south-east region of Melbourne.

Service priorities for AEPs have included the implementation of physical activity interventions for young people between the ages of 12 and 26, as well as delivery of exercise based group sessions, and working with young people and learning consultants in the production and delivery of Discovery College courses related to physical activity and other lifestyle interventions. Move Your Body is the general exercise group that runs weekly, whereby different types of exercise are completed to a monthly theme determined by the group participants in consultation with the facilitator. Participants are primarily from within the hYEPP service.

Additionally, the AEP team has contributed towards physical health and metabolic monitoring working parties, to review and develop physical health and metabolic health screening procedures and guidelines. The team has contributed towards service wide physical health interventions, and planning for EP contributions to the Alfred Mental Health and Addiction Services, the lead agency overseeing the hYEPP program.

Metabolic monitoring

One of the key projects completed by the hYEPP physical health portfolio group was the development of a flowchart to assist hYEPP clinicians to conduct metabolic monitoring screens and identify appropriate pathways for referral to the EP team, or for further medical review where indicated (Fig 2.)

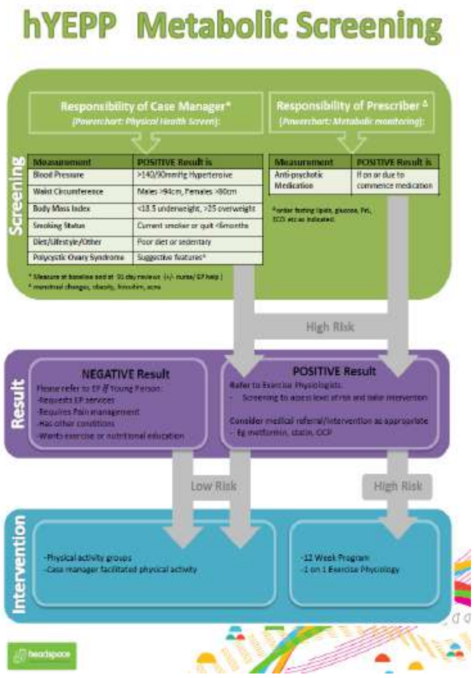

Fig 2.

The flowchart was presented by the group to a whole hYEPP service staff meeting, with practical activities to assist in training clinicians to undertake physical and metabolic health screens, with an associated presentation detailing the importance and rationale for addressing physical health for hYEPP clients. This session was followed up with team-based practical sessions to allow staff to further practice undertaking the screening process.

The response to these sessions was mixed, and potentially reflective of the low confidence of mental health clinicians in addressing physical health that has been noted elsewhere [5]. Some anecdotal concerns were that clinicians who have previously been hands off (such as social workers) were not skilled, nor working within their scope by conducting physical health screening that included waist circumference and blood pressure, and that non-nursing staff monitoring blood pressure may pose an increased risk to clients. Current policy within the health service is for nurses to conduct blood pressure measurements. This is consistent with the literature reporting a mix of poor knowledge and skill among mental health practitioners in the context of addressing physical health [2], and a reluctance to take on functions that may be seen as additional to the primary role of the practitioner [6, 5]. Even among psychiatrists, there has been suggestions that there is uncertainty as to the appropriateness of widening the scope of clinical practice to include physical health assessments [8]. Within the hYEPP service there has been a drive from the psychiatrists involved to implement physical health screening for all young people in the service.

While staff at the time were provided with laminated copies of the flowchart to keep at their desks, there remains a gap between process and implementation. Regarding physical health as a whole, it has been postulated that "the greatest current barrier to increasing the life expectancy of persons with serious mental illness is no longer a knowledge gap, it is an implementation gap" [9].

Embedding physical health into standard care in mental health

In addition to mitigating physical health risks for young people with SMI, physical health interventions are increasingly seen to improve mental health outcomes. A meta-analysis of physical activity interventions concluded that symptoms of depression may be reduced via physical activity interventions, regardless of psychiatric diagnoses, and also that positive and negative symptoms of schizophrenia may be reduced with physical activity [10]. This suggests that clinicians should refer patients to physical activity interventions for the improvement of both mental and physical health outcomes. Likewise, it has been recommended that exercise and dietary intervention are likely to have important short-term benefits for mental and physical health, while also preventing the development of chronic lifestyle-related diseases, and therefore should be universally included in treatment and recovery from SMI [11].

In addressing the implementation gap, key themes that have been explored within the literature discuss the impact of diagnostic overshadowing, infrequent physical examination, physical health complaints being regarded as psychosomatic symptoms, and beliefs that people with SMI are not able to adopt healthy lifestyles [5]. For clinicians who are less familiar and/or less confident with physical health and metabolic screening procedures, these actions may be considered an extra thing to fit into an already busy schedule and may not be weighted with the same level of importance as other aspects of clinical care. Until these skills become a routine part of daily practice, they may require more time and be less streamlined as a part of the process.

Low confidence of mental health clinicians in the conduct of physical health screens may lead to decreased confidence and skill in communicating the reasons for the screening and subsequent intervention. It may also lead to young people accessing the service being more wary or afraid of such intervention, and therefore declining services. This may be incorrectly seen as a lack of readiness for the young person to be referred for further consultation with an AEP. Likewise, stigmatisation of weight gain and other lifestyle factors that may be present, such as a sub-optimal diet, smoking and use of alcohol and other drugs, may contribute towards a young person's reluctance to access physical health interventions.

In the context of consent, it may seem that to offer a service such as exercise physiology to a young person as a question and answer, accept or decline is sufficient to determine whether that young person will engage in an EP program, or even in a physical health or physical activity program that is less clinically focused. However, if sufficient information is not provided regarding the potential or even likely effects of the medications that are being prescribed, or education about the known bidirectional relationship between mental disorders and other non-communicable diseases [12], are we really allowing the individual to be empowered to make an informed choice?

Embedding physical health into standard care for mental health care requires a commitment to change from multiple levels. Offering specialist services such as exercise physiology is one level, but it has to come from more than just one voice. It is incumbent upon those providing care to ensure that it does not cause harm to the clients that we engage with. The HeAL declaration includes the goal of ensuring that positive physical health outcomes are valued equally with mental health outcomes in recovery [14].

Another consensus statement from multiple international accrediting bodies for exercise and sports science professionals identified key areas for change when working to reduce the life expectancy gap for people with mental illness [15], each of which are important considerations in embedding physical health within mental health services. These areas are discussed as follows:

Infrastructure

The key place to begin within the context of the hYEPP services was to develop the infrastructure to support an EP service, in terms of EFT, dedicated space, and exercise equipment that could meet the needs across a variety of sites. In terms of embedding physical health screening and monitoring throughout the clinical teams, each team and site required the provision of metabolic monitoring kits to support outcome measurements such as blood pressure and waist circumference. Likewise, physical health and metabolic screening tools need to be readily available for all clinicians involved in client contact pertaining to physical health, with appropriate implementation guidelines to support.

Training

As was noted above, it would appear common for clinicians who have worked primarily within a mental health setting to be unfamiliar with and lacking confidence in undertaking and talking about physical health, and its importance in long-term wellness and health care [5]. Within the hYEPP service, education for staff was considered in a variety of ways including team-based presentations outlining the EP role, referral pathways, procedures and practical sessions to train staff in the conduct of physical health screening and monitoring. Future plans include consideration of ways to provide learning and support in developing the language to confidently address physical health with young people. Appropriate use of language is critical in empowering young people to make informed choices about their physical health, and how it may be measured and recorded, without fear or stigma. Arguably most important is to be able to identify and implement effective strategies in engaging young people to learn about and feel empowered to choose to improve their physical health. This can be developed through educational opportunities for staff, clinician discussion and self-directed learning.

The EP team contributed towards co-produced discovery college courses about nutrition and exercise, using both expertise by profession and expertise by lived experience. This created learning opportunities for all in the space to better work together in exploring and understanding health as a whole, and the importance of both nutrition and exercise in maintaining health. There remains further opportunity to continue to refine service wide co-design, production and facilitation in embedding lived experience within physical health interventions, education and recovery.

While training, education and learning are important for clinicians and consumers to develop further knowledge regarding physical health, there has also been learning for AEPs who may not have previously experienced working in mental health care settings, and who may have limited knowledge of SMI from either the lived experience or professional perspectives. Acquiring skills and knowledge of mental health is crucial in developing their roles within the service.

Currently, work is focused on considering what is required to support whole service transition from knowledge to implementation, through a range of strategies. These include peer-based learning and support for clinicians on a daily basis, further staff-based education sessions, and participating in co-produced seminars where young people, their support (family or otherwise) and staff participate to build collective knowledge about physical health.

Culture

The final main consideration from the consensus statement was culture. To enable change to occur in facilitating improved physical health requires a supportive individual, team and organisational culture. This is fundamental at every level – from management supporting change through developing infrastructure and education, to peer and family peer work to engage young people and their families in positive behaviour change. A team-based culture of accountability in ensuring that physical health factors are routinely assessed may be supported by an understanding that anyone can ask for assistance or offer support to observe and assist in ensuring that the physical needs of the client are met.

Additionally, culture must support the identification and addressing of the educational needs of those who may lack the confidence or competence to address physical health concerns. The HeAL declaration [13] describes a duty of care for psychiatric services to do no harm to the persons coming under their care. When we know that these members of our community are far more likely to be disadvantaged on multiple levels when it comes to their health, it is incumbent upon us to provide holistic care where body and mind are treated simultaneously [z14], and that medication does not treat mental health at the expense of physical health.

Another key driver to culture change is to encourage and support staff wellness programs, to facilitate role-modelling behaviour, and to consider programs and opportunities that are inclusive of staff, clients and their support networks to learn and participate together in striving towards physical and holistic health goals.

Conclusion and action recommendations

When undertaking the integration of physical and mental health care as standard practice within health services, multiple factors need to be considered to bridge gaps in knowledge, skills and implementation. Change requires a commitment from all levels of an organisation to build skills, capacity and accountability for integrated care, whether addressing mental health in a ‘physical health’ setting, or physical health in a ‘mental health setting’. Consumers’ voice is critical in the development of appropriate and acceptable educational material and service development, and a broadening of knowledge may be required across the board to empower all staff to feel confident in their skills and knowledge when considering physical health. Also, all service users and their families must be empowered to make informed choices about their holistic health needs. Improving physical health outcomes for people living with SMI requires a coordinated approach to ensure that adequate support is provided. Service users should not have their physical health needs impacted by the diagnostic overshadowing of SMI, nor should those needs be missed due to clinical staff expecting someone else to do something. Consistency of messaging both within and beyond the service is key in helping to empower individuals to prioritise whole of health needs including physical health.

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Theme: Ensuring the right to health is maintained in mental health services

People's right to have to their medical and other health and disability needs recognised and responded to by mental health services – data and insights from complaints to the Victorian Mental Health Complaints Commissioner (MHCC)[1]

Lynne Coulson Barr
Mental Health Complaints Commission

Presentation Links

Slides

Presenter:

DR LYNNE COULSON BARR

The principles of Victoria's Mental Health Act 2014 require mental health services to recognise and to respond to people's medical and other health needs, as well as other individual needs including disability supports and alcohol and other drug issues. Complaints to the Mental Health Complaints Commissioner over its first four years of operation have identified concerning examples of people's physical and disability needs not being met by mental health services. This presentation will discuss the ways in which complaints can identify key areas for attention and service improvement and highlight service's obligations under the Act and the Victorian Charter for Human Rights and Responsibilities 2006.

Abstract:

The principles of Victoria's Mental Health Act 2014 require mental health services to recognise and to respond to people's medical and other health needs, as well as other individual needs including disability supports and alcohol and other drug issues. Complaints to the Mental Health Complaints Commissioner over its first four years of operation have identified concerning examples of people's physical and disability needs not being met by mental health services. This presentation will discuss the ways in which complaints can identify key areas for attention and service improvement and highlight service's obligations under the Act and the Victorian Charter for Human Rights and Responsibilities 2006.

Paper:

Introduction

This paper describes the background, purpose and legislative context for the MHCC and provides examples of specific issues that have arisen in complaints relating to health and disability needs not being recognised and responded to by mental health services, as well as recommendations for improvement that the MHCC have made to services following these complaints. It will identify shortcomings in the collection of data relating to

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[1] This paper is based on a presentation by Commissioner Lynne Coulson Barr at the National Equally Well Symposium March 2019.

these issues, and opportunities for improvement.

The MHCC was established under the Mental Health Act 2014 as an independent specialist statutory complaints body to safeguard people's rights, resolve complaints about Victorian public mental health services and use information from complaints to recommend service and system improvements. Complaints are a vital window into people's experiences and the culture of services. The MHCC receives about 2,000 complaints and almost 7,000 calls each year, and also receives data on complaints made directly to services. Over four years of operation, the MHCC has accumulated data on more than 12,000 complaints made to the MHCC or reported by services and provided feedback to services through more than 800 education and engagement activities.

The MHCC assesses complaints through the 'lens' of the Act, which refers to the rights of people to have their medical and other health and disability needs recognised and responded to by mental health services. In particular, the Act outlines several mental health principles, which include that:

People receiving mental health services should have their:

- Rights, dignity and autonomy respected and promoted – s11(1)(e);
- Medical and other health needs, including alcohol and other drug problems, recognised and responded to – s11(1)(f);
- Individual needs (whether as to disability or other matters) recognised and responded to – s11(1)(g).

Complaints relating to medical and other health and disability needs not being recognised and responded to by mental health services

The total numbers of enquiries[1] and complaints received in each year of operation of the MHCC up to 2017-18 are shown in **Figure 1**. The MHCC classifies complaints according to a three-level taxonomy of issues, and the most frequent high-level issues raised in in-scope complaints in 2017-18 to the MHCC are shown in **Figure 2**.

Figure 1: Enquiries and complaints received by the MHCC

As can be seen in Figure 2, the most frequently raised issue in complaints was treatment. This treatment category includes a subcategory of suboptimal treatment, which in turn includes a subcategory of needs not met in relation to physical health.

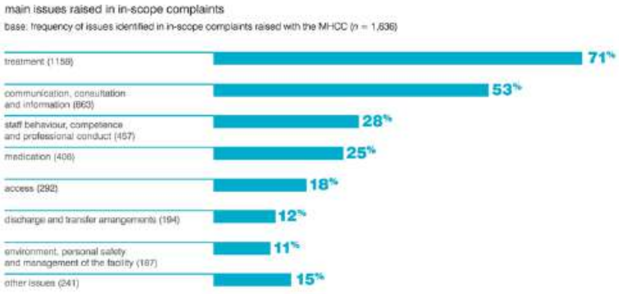

Figure 2: High-level issues raised in complaints to the MHCC

The MHCC undertook a thematic review of complaints classified to the physical health needs not met subcategory that were received from 2014-15 to 2017-18. About 170 issues were identified, primarily relating to inpatient admissions.

A key theme in these complaints was that treatment or medications for physical conditions were not provided. This included treatment or medication for spinal or musculoskeletal conditions, bladder/ bowel infections, heart conditions, asthma and respiratory issues, and sleep disorders. Another key theme was delayed or inadequate treatment

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[1] An enquiry is a request for information, advice or assistance, while a complaint is an expression of dissatisfaction about a service for which a response or resolution is explicitly or implicitly expected from the MHCC or legally required (based on Australian Standard AS/ NZS 10002:2014).

for injuries sustained during admission to or while on inpatient units. This included injuries sustained through the use of mechanical and physical restraint and by assaults by other patients. A final key theme related to women's health needs not being met. This included a lack of pregnancy and STI testing, lack of consideration of side effects of medication for pregnancy and lack of access to lactation support.

The MHCC has made specific recommendations to services in relation to these complaints, including addressing issues associated with:

- The use of bariatric equipment;
- Webster packs in residential services;
- Assessment and referrals to allied health and access to special order medications;
- Access to breast pumps;
- Consequences of the use of restraint for people with pre-existing medical conditions
- Information provided on electronic cigarettes and quit smoking aides;
- Medication errors and required systems/ responses;
- Management of naso-gastric tube pumps;
- Access to disability assessments, aides and accessibility requirements;
- Access to appropriate pain management for injuries;
- Arrangements for medical, allied health and appropriate tests/investigations during inpatient admissions;
- Decision-making on access to medical devices, including CPAP machines, during inpatient admissions;
- Service responses to alleged assaults and injuries.

Issues, opportunities and questions

The issue of physical health needs not being met is commonly identified through the MHCC's assessment of complaints, rather than as a primary issue that people making complaints may raise. The number of complaints recorded about these issues is therefore not likely to be representative of the level of issues experienced by consumers. In addition, local complaint reporting data provided by services does not readily identify this issue, as health complaints data systems such as the Victorian Health Incident Management System (VHIMS) do not recognise physical health needs as a separate issue category. The standard questions in the Your Experience of Service or 'YES' survey likewise has not included questions that explore consumers' experiences with this issue. There are, however, plans in Victoria for a question about physical health needs to be added to the next 'YES' survey, which will help provide a better picture of people's experiences.

The MHCC will consider how can it ensure that it hears the complaints and concerns about people's physical health and disability needs in services, how these issues can be elevated in data categories and survey questions, how the MHCC can better use the data we have to drive positive action and service improvements, and what is needed to ensure that the right to health is embedded in mental health services.

Theme: Prevention and early intervention across life’s stages

How does promotion, prevention and early intervention apply to people living with enduring mental illness?

Peer-reviewed paper

Russell Roberts
Charles Sturt University

Presentation Links

Slides Video

Presenter:

DR RUSSELL ROBERTS

Dr Russell Roberts is a Professor at Charles Sturt University and Adjunct Clinical Associate Professor at the University of Sydney.

Living in Orange, NSW he is a board member of the ANZ Mental Health Association, Chair of the Australian Rural and Remote Mental Health Symposium and Editor in Chief of the Australian Journal of Rural Health. He has also been on the NSW Mental Health Commission Advisory Council and Director of Clinical Training at Griffith University, Queensland. He has previously served as director of a large regional mental health service of over 1,000 staff, delivering comprehensive services across the spectrum of mental health care.

Abstract:

Previous models of mental health promotion and prevention1 did not guide and inform actions addressing promotion and prevention, across the spectrum of health and illness and have overlooked the social determinants and other domains of health and wellbeing. This presentation presents a contemporary model of promotion, prevention and early intervention that seeks to overcome these limitations. This model2 was developed while the author presided as Chair of the NSW Promotion, Prevention and Early Intervention Committee. This contemporary model converts definitional terms such as primary, secondary and tertiary prevention to action-oriented, descriptive language. Using the framework of the new model, the presentation provides examples of actions across the spectrum of health and illness, across the various domains of physical health, and across the domains the social health of people living with mental illness.

1 – Haggerty, R. J., & Mrazek, P. J. (1994). Reducing risks for mental disorders: Frontiers for preventive intervention research: National Academies Press.

2 – Roberts, R. Building Better Mental Health: A New Model of Promotion, Prevention and Early Intervention. The 21st Annual TheMHS Conference, Adelaide, Sept. 2011.

Paper:

Background

The main causes of early death of people living with mental illness are preventable.

Taking a health promotion and illness prevention approach

Focussing on the physical health of people living with mental illness, this paper presents a promotion, prevention and early intervention (PPEI) framework to help inform and direct the actions outlined in Element 2 of the Equally Well National Consensus Statement.[1] Element Two: Effective Promotion, Prevention and Early Intervention notes that:

Much of the premature death and physical illness associated with mental illness is preventable. Promotion, prevention and early intervention can help prevent the onset or development of an illness, lower its severity and duration, and reduce its impact (p. 16).

The PPEI framework presented in this paper helps guide and inform actions to prevent the poor health and early death of people living with mental illness. The paper will briefly outline the Building Better Mental Health PPEI framework.[2] It will then describe how the framework can be applied to the physical health of people living with mental illness.

Much of the poor physical health of people living with mental illness is entirely preventable

The Australian Institute of Health and Welfare states that "38 per cent of the total burden of disease (Disability Adjusted Life Years) experienced by Australians in 2015 could have been prevented by reducing exposure to the risk factors included in this study"[3] (p. 9). For cardiovascular disease in people living with mental illness this figure is almost 70%.[4] These data highlight the importance of taking a health promotion and illness prevention approach to the physical health of people living with mental illness.

The physical health of people living with a mental illness is a priority of the Fifth National Mental Health and Suicide Prevention Plan[5] which states:

> *…ensuring that people living with mental illness receive better screening for physical illness, and that interventions are provided early as part of a person-centred treatment and care plan, will be critical to improving the long-term physical and mental health outcomes for people living with mental illness and people with a chronic or debilitating illness who may be at a higher risk of a mental illness (p. 37).*

In addition to committing to the Equally Well National Consensus Statement, The Fifth National Mental Health and Suicide Prevention Plan outlines four key actions to address the poor physical health of people living with mental illness. These include: providing advice on screening, detection, treatment and early medical intervention for people known to be at high risk of physical ill health; and supporting and integrated physical and mental health care.

Traditional approaches to promotion, prevention and early intervention

Traditional approaches to PPEI in mental health have focussed only on mental illness. The commonly cited models of PPEI place mental health interventions across a spectrum, ranging from health promotion, to early intervention, to acute care, through to long-term care.[6] The Mrazek and Haggerty model[7] was adapted by the Mental Health Promotion and Prevention Working Party and presented in its Action Plan8 (Figure 1). Both models were developed a long time ago, and 20 to 25 years later some limitations have become apparent – the old models appear to:

- Overlook the social determinants of mental health and physical health[3]
- Neglect other domains important to mental health and wellbeing (Fig 3)
- Not address stigma and discrimination
- Not inform PPEI actions across the spectrum of mental illness, but rather, divide promotion and prevention across the spectrum
- Fail to facilitate a comprehensive and holistic approach to recovery.

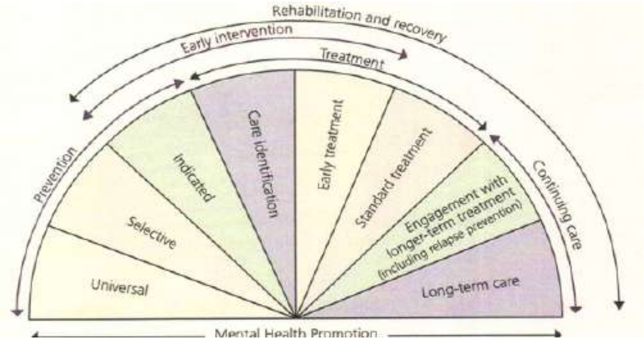

Figure 1. The spectrum of interventions for mental health problems and mental disorders[8]

The fundamental flaw in these models is that prevention and early intervention ceases when people begin 'standard treatment' and beyond. This paper presents a framework which assists clinicians to adopt a promotion and prevention approach across both the spectrum and domains of wellness and illness.

A new model of mental health promotion, prevention and early intervention

A new model of PPEI, Building Better Mental Health[2] (see Figure 2) was developed by the NSW Mental Health Promotion, Prevention and Early Intervention Standing Committee. This committee comprised members from health services, consumers, carers, academics, non-government organisations, CALD, Aboriginal community controlled health organisations, government policy analysts and the Hunter Institute of Mental Health. The model seeks to address the limitations of the Mrazek and Haggerty model and includes the following features:

- It indicates the PPEI can and should occur across the spectrum of mental health and illness. Health promotion is the foundation of this framework and underpins all interventions across the spectrum of care
- It considers mental health as just one component of social and emotional wellbeing, in which illness, community connection and wellness interact
- It invites health interventions at different levels, and across the various domains of wellness (see Figure 3)
- It directs and structures PPEI actions across the spectrum of wellness and illness
- It supports a specific focus on the physical health of someone experiencing mental illness
- The framework directly links its definitions to actions (see Table 1)
- It suggests PPEI actions for each of the seven identified population groups.

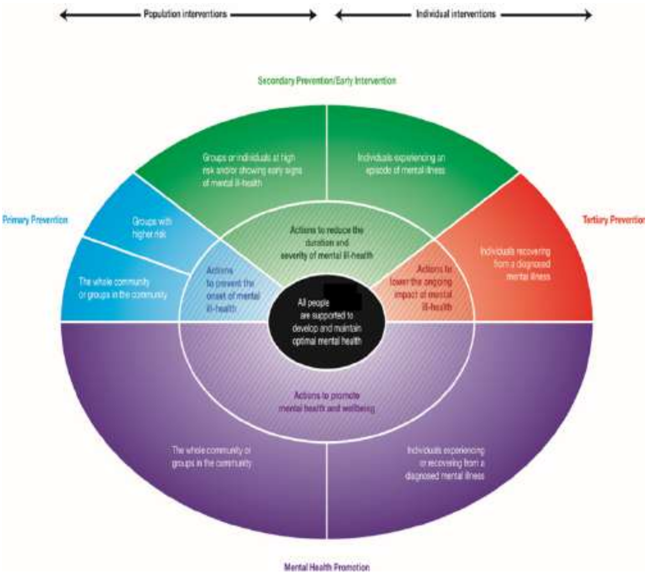

Figure 2. Mental health promotion, prevention and early intervention across the spectrum of mental health care[2]

Target groups and settings

Prevention for people of all ages: Not just the young

While PPEI is often viewed within the context of the early years of life (newborn, children, adolescents and young adults), the Building Better Mental Health PPEI framework applies equally across the lifespan, and includes adults and older people with mental illness or at risk of mental illness. In fact, a dramatic increase in comorbid physical illnesses occurs between 40 and 65 years of age.[9] This suggests that middle age and older people should be a priority group for the PPEI initiatives to improve physical health.[10, 11]

All domains of wellbeing: Not just mental health

While traditional approaches have focussed on PPEI only within the domain of mental health, more recent conceptualisations highlight the complex and dynamic relationship between mental health and other domains of wellbeing (see Figure 3).[12] As such, a holistic approach to PPEI for people living with mental illness should consider all the wellbeing domains within a person-centred, recovery-oriented approach to care (see Figure 3).

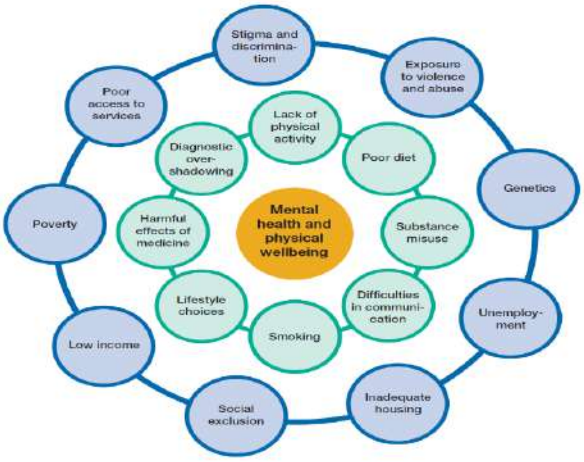

Figure 3. Integrated dynamic elements affecting mental health and physical wellbeing[12]

Focussing PPEI on the physical health of people living with mental illness

While the framework invites the consideration of PPEI actions within each domain of wellness, the remainder of this paper will focus on a PPEI approach to improving the physical health of people living with mental illness.

Improving physical health enhances mental health

Poor physical health is a major contributor to poor mental health[13, 14] and suicide.[15] Australian research with Aboriginal and non-Aboriginal populations indicated that 42% and 21% of the variance in mental health was accounted for by chronic physical health conditions, respectively.[14] Similarly, Lorem et al. in their large cohort study found that physical health accounted for 42% of the total effect on self-reported mental health.[13] Almost 80% of people living with mental illness suffer a mortality related physical health condition,[16] and 55% suffer two or more physical health conditions.[9] Physical illness impacts adversely on mental health. Thus, improving the physical health of people living with mental illness should be considered an effective approach to improving mental health.

A promotion, prevention and early intervention approach to improving the physical health of people living with mental illness

By focussing on the physical health of people living

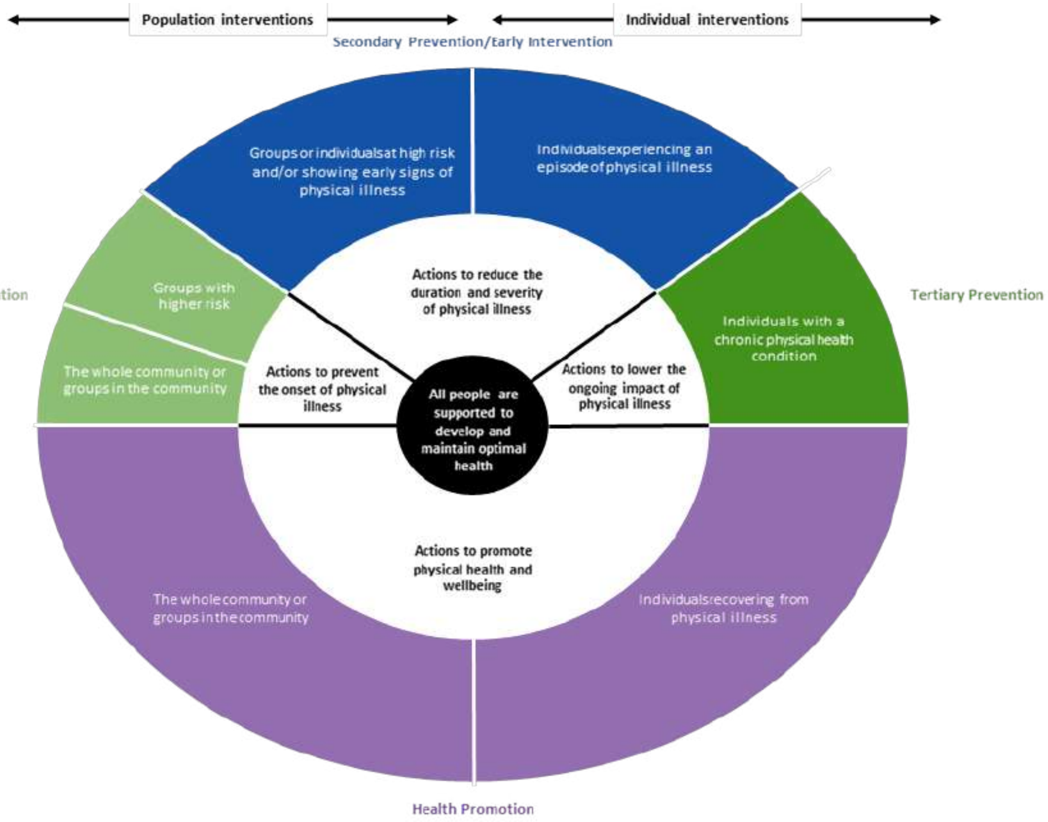

Figure 4. Building better physical health for people living with mental illness: a PPEI approach

Actions to promote physical health and wellbeing in the whole community of people living with mental illness or groups in the community	▪▪▪▶	Action Area 1
Actions to prevent the onset of physical ill-health in the whole community of people living with mental illness or groups in the community	▪▪▪▶	Action Area 2
Actions to prevent the onset of physical ill-health in groups of people at higher risk of developing mental illness	▪▪▪▶	Action Area 3
Actions to intervene early and reduce the duration and severity of physical ill-health for groups or individuals at high risk and/or showing early signs of mental ill-health	▪▪▪▶	Action Area 4
Actions to reduce the duration and severity of physical ill-health for people experiencing an episode of mental illness	▪▪▪▶	Action Area 5
Actions to reduce the ongoing impact of physical ill-health on individuals experiencing or recovering from a diagnosed mental illness	▪▪▪▶	Action Area 6
Actions to promote physical health and wellbeing in individuals experiencing or recovering from a diagnosed mental illness	▪▪▪▶	Action Area 7

Table 1. Actions to improve the physical health of people living with mental illness

with mental illness, the Building Better Mental Health PPEI framework can guide and direct actions specifically addressing the priorities in Chapter 5 of The Fifth National Mental Health and Suicide Prevention Plan: Improving the physical health of people living with mental illness and reducing early mortality.[5] Likewise, it can also direct and guide actions against Element Two (Effective PPEI) of the Equally Well National Consensus Statement.[1] Figure 3 shows how the Building Better Mental Health framework can be applied to the physical health of people living with mental illness.

Table 1. shows how the seven actions of the Building Better Mental Health PPEI framework can be refocussed on the physical health of people living with mental illness. Each of the seven actions related to the Building Better Mental Health PPEI framework invite and inform actions to promote, protect and enhance the physical health of people living with mental illness. The following section outlines specific actions within each of the seven action areas.

Action Area 1: Health Promotion

The AIHW burden of disease study[17] and the ABS premature mortality data[18] both point to the increased risk of cancer, cardiovascular disease, respiratory disease and diabetes (see Figure 5) for people living with mental illness. Comprising 12.9 % of the population, people living with mental illness represent over 50% of all premature deaths. In addition, people living with mental illness are over-represented for related risk factors (smoking, obesity and diet). These data show the potential benefit of a health promotion approach to smoking, diet, alcohol and physical activity as specific areas of focus for health promotion interventions.

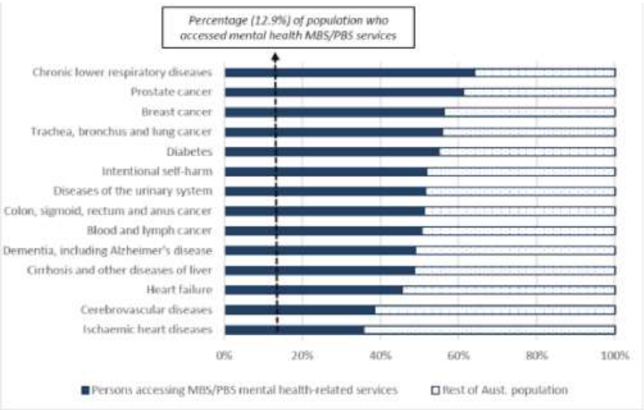

Figure 5. The relative risk of early death for people accessing mental-health related care, by cause of death[19].

There is an imperative to act to promote good physical health and prevent the development of chronic physical illness. Chronic physical health conditions become more prevalent as we age, but can largely be prevented by promoting physical exercise, community engagement and good nutrition. Many frameworks exist for comprehensive health promotion and public health programs in the community. For example, the Smoking, Nutrition, Alcohol, Physical activity (SNAP) framework structures and guides health promotion interventions for people living with mental illness.20

S Creating a smoke-free environment and encouraging smoking cessation has positive benefits at all ages, including for older people

N Dieticians can provide valuable advice on the provision of nutritious healthy food

A Screening alcohol and substance use with tools such as the AUDIT (Alcohol Use Disorders Identification Test) can provide a foundation to encourage and promote the responsible use of alcohol

P Consideration of ways to increase physical activity and exercise for people throughout their lifespan should be a key aspect of any health promotion program or mental health intervention.

The research evidence on the importance of community engagement and physical activity on both mental health and physical health is strong and rapidly accumulating. Recent meta-analyses have indicated that exercise has a strong positive effect on mental health and should now be considered a routine therapeutic intervention for depression.[21] As such, increasing levels of physical activity to improve both physical health and mental health is becoming increasingly recognised as a necessary first-line intervention in mental health care.

Action Areas 2 & 3: Primary Prevention. Actions to prevent the onset of physical illness

Primary prevention incorporates actions directed at specific groups in the community. Comprehensive physical health screening followed by prevention focussed actions are two ways to dramatically improve health outcomes for people living with mental illness.

Screening

Four in five people seen by mental health workers will also have a physical illness. For many, their coexisting physical health conditions are undiagnosed. Thus, the odds are that anyone seeing a mental health professional will have one or more co-existing physical health conditions. This underscores the need to ensure periodic, comprehensive physical health assessments.

Suicide risk assessment is a routine and required component of mental health intake and assessment processes, and rightly so. However, for every person with mental illness who dies due to suicide, 10 die early due to physical health conditions.[19] While predicting and preventing suicide can be complex, the interventions for preventing chronic physical health conditions are well known, simple and achievable. As such, physical health screening should always be a routine and essential part of safe and quality mental health care.

Prevention

Another major physical health risk for people living with mental illness occurs when starting antipsychotic medications. The serious side-effects of antipsychotic medications are well known, so steps must be taken to minimise, reduce and eliminate these adverse side-effects. Antipsychotic medications are associated with cardiovascular disease, diabetes, poor oral health,[22] and a fourfold increase in obesity.[23] There is also evidence of rapid and dramatic weight gain associated with initiating some antipsychotics. Critically, once this weight gain has occurred, it is extremely difficult to reverse.[24] This weight gain (up to 40 kg) can lead to decades of physical and psychological distress and severe restriction to daily activities.[25] The weight gain and metabolic syndrome associated with the use of these drugs may account for much of the early death due to other physical causes. Thus, prevention and early intervention to prevent weight gain is vital.

Most states and territories in Australian have existing screening, algorithms and guidelines relating to the physical health of people living with mental illness. If not, there are guidelines and resources developed by the International Physical Health in Youth Working Group[26] and others[27, 28] that can be easily adapted and applied to all people starting antipsychotics. These evidence-based programs and resources are useful for designing and implementing prevention and early intervention actions.[29, 30] Early intervention to lessen or prevent the negative side-effects of antipsychotics is vital and will dramatically improve longevity, quality of life and self-esteem.

Action Areas 4 & 5: Secondary Prevention/ Early Intervention: Actions to intervene early to reduce the severity and duration of physical ill health

Early intervention

As the major causes of early death are well established, comprehensive physical health check-ups that specifically screen for these risks (see Figure 5) should be routinely conducted. Algorithms are available to determine level of risk[27, 28] and it is recommended that clinicians should first consult the clinical guidelines of their particular organisation when planning early intervention actions.

“Don’t just screen: intervene”

Routine and regular screening and appropriate treatment are essential for effective secondary

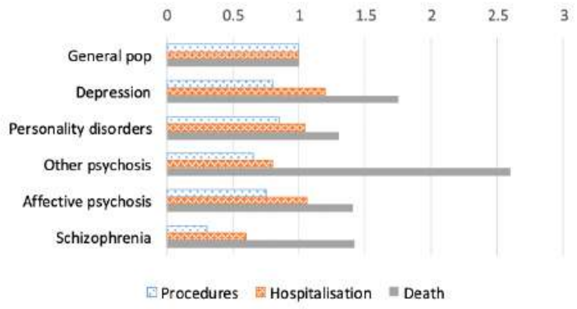

Figure 6. Procedures, hospitalisations and death rates for cardiovascular disease by diagnosis

prevention and intervention. More than 50% of all premature deaths in Australia are of people living with mental illness. Based on the risk profile from the ABS review of early mortality of people accessing mental health-related treatments, the major increased risks are chronic lower respiratory disease, prostate cancer, breast cancer, lung cancer, and diabetes (see Figure 5). Physical health assessment and screening should cover all the 14 major causes of early death for people living with mental illness (see Figure 5).

The most important step in good physical health care is to ensure access to effective care and treatment. Screening alone is not sufficient. Lawrence and Coghlan's research[17] shows that even when people living with mental illness are diagnosed with a chronic physical health condition, the rate of treatment, intervention and hospitalisation is lower than that for the general population (see Figure 6). Thus the advocacy of mental health professionals at every point of contact with physical health services is important to help to avoid this discrimination and differential treatment.

Smoking Cessation

Smoking is a significant contributor to the risk of heart disease, respiratory disease, cancer and many other physical illnesses. Relating certain behaviours to specific diseases in the general population, the AIHW reported: "Tobacco use contributed to 41% of all respiratory burden and 22% of all cancer burden"3 (p. 10). People living with mental illness have a much higher prevalence of smoking than the overall population. This is probably reflected in greater smoking-related harm and the very high rates of premature deaths due to trachea, bronchus and lung cancer and lower respiratory disease (see Fig 5).[18]

A recent study found that only 80% of mental health care professionals even asked about smoking, while just 45% advised clients to quit and only one-third referred to Quitline or offered cessation assistance.[31] Mental health workers are uniquely placed to advise, refer and implement smoking cessation programs. Smoking kills one in two users.[32] So, for every two people a mental health worker helps quit smoking, they will add 20 to 30 years of healthy life to one.

Despite the fact that many clinicians believe people living with mental illness are not interested in quitting,[33] motivation to quit is about the same as the general population[34] and quit attempts are common[35, 36] and if properly designed, smoking cessation interventions are effective.[36] Mental health workers are well placed to deliver evidence-based smoking cessation interventions within the context of usual treatment. Even a brief intervention may trigger a quit attempt and result in cessation, especially if it includes referral to evidence-based help.

Action Area 6: Tertiary Prevention: Actions to reduce the ongoing impact of poor physical health

The high incidence of co-existing physical health conditions in people living with mental illness means it is the responsibility of mental health workers to ensure effective physical health treatment or remediation regimes are in place. Unfortunately, it is far too common for people living with mental illness to suffer for years with the symptoms of untreated chronic health conditions.

Not effectively managing chronic physical health conditions, pain and disability has a significant impact on an individual's mental health and wellbeing. Fässberg et al.[15, 37] noted that poor physical health accounted for 42% of suicidality. Likewise, McNamara et al.[14] found that 42% of self-reported psychological distress in people of Aboriginal and Torres Strait Islander descent was accounted for by physical health status.

Implications: Don't blame the victim

Many of the causes of poor physical health are socially determined. The person-centred, therapist-client partnership approach to recovery and wellness planning requires a fine balance between supporting personal agency while not, at the same time, implicitly blaming people for their physical health condition. Understanding and acknowledging the stigma and discrimination that people living with mental illness experience when in contact with the health system helps in this respect. It also underscores the need for someone within the system to advocate to ensure their client receives high quality care.

The prevailing power dynamics in health systems tend to be hierarchical, with most of the power residing with doctors and clinicians and the least with patients, and the very least with mental health patients. Adopting a respectful partnership approach to assessment and care planning can help redress the detrimental health effects of the power inequities in health systems.

Some of the causes of poor physical health of people living with mental illness can be attributed to stigma and discrimination. When people living with mental illness do access care they often experience diagnostic overshadowing and discrimination. Past experiences of poor interpersonal treatment and discrimination, mean many people living with mental illness find arranging and attending medical appointments intimidating. The Building Better Mental Health PPEI framework tries to address and lessen this difference by providing a framework for improving physical health across the spectrum and domains of wellness for everyone.

Conclusion

A PPEI approach to mental health is a well-established framework in mental health policy, planning and service delivery.[8] This paper has presented the Building Better Mental Health PPEI framework[2] and focussed it on the physical health of people living with mental illness.

The PPEI framework should be applied across all domains of mental health and wellbeing. The term mental ill health could almost be replaced by homelessness, trauma, unemployment or community disengagement.[19, 38] A comprehensive and holistic approach to wellness and recovery planning should not only incorporate the dynamic elements of physical health (Figure 2), it should also include consideration of how a PPEI approach can be applied to each of the dynamic elements of mental health and wellbeing.

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Appendix. Building Better Physical Health: Target groups, definitions and equivalent terms

Focus	Domain	Target groups	Definition	Terms from the literature
Actions to promote physical health	Physical health promotion	All people living with mental illness or groups in the community	Interventions to enhance the physical health and quality of life for people living with mental illness. The initiatives can occur within mental health services from community to inpatient care.	Health promotion
		Individuals experiencing or recovering from a diagnosed mental illness	Interventions to enhance the physical health and quality of life of the whole population or selected groups. These initiatives can occur in any setting (including schools, workplaces, the home)	Health promotion, recovery
Actions to prevent the onset of physical illness	Primary Prevention	All people living with mental illness	Interventions that work by focussing on reducing physical health risk factors and enhancing protective factors in the whole community, regardless of risk.	Universal prevention Primary prevention
		Groups at higher risk of physical illness	Interventions that work by focussing on reducing physical health risk factors and enhancing protective factors to prevent the onset of a physical health problem or illness in groups known to be a higher risk.	Targeted prevention Primary Prevention
Actions to intervene early to reduce the severity and duration of physical ill health	Secondary Prevention	Groups or individuals at high risk and/or showing early signs of physical illness	Early identification of individuals showing signs of poor physical health and ensuring access to appropriate treatment.	Early intervention (prevention focussed) Secondary prevention Early identification
		Individuals experiencing an episode of physical illness	Interventions that focus on reducing risk factors and promoting protective factors to lessen the severity and impact of the physical illness by providing evidence-based treatment.	Early intervention (treatment focussed) Secondary prevention Early treatment
Actions to reduce the ongoing impact of poor physical health	Tertiary Prevention	Individuals recovering from an episode of physical illness	Interventions that work by focussing on reducing risk factors and enhancing protective factors to reduce the impact of the physical illness through rehabilitation or relapse preventions.	Tertiary Prevention Relapse prevention Rehabilitation Ongoing care

Theme: Prevention and early intervention across life's stages

What do we know about the physical health of older people with mental illness, and what does this mean for improving care?

Kate Jackson
Mental Health Branch, NSW Ministry of Health

Presentation Links

Slides Video

Presenter:

KATE JACKSON
Kate Jackson is the Director, Older People's Mental Health Policy, Mental Health Branch, NSW Ministry of Health. Kate has been in this role since 2004 and has overseen the development and implementation of one 10-year statewide service plan for older people's mental health services, and now the development and early implementation of a second 10-year statewide older people's mental health service plan. She has led a range of policy and program developments in older people's mental health over this time, including the development of new models of care for community, inpatient and mental health-residential aged care partnership services. Kate's previous roles have covered dementia, carer support and disability, aged care and mental health.

Kate's formal qualifications include a Bachelor of Arts – History, PhD – History, and Executive Masters of Public Administration (Australia New Zealand School of Government) – all through Sydney University.

Abstract:

The Australian population is ageing, and the number of older people with mental illness is projected to increase significantly. Some people develop a mental illness as they age, while others grow older with a continuing experience of mental illness that developed earlier in their lives. For older people, mental illness often co-occurs with other physical health conditions. There is significant evidence that older people with mental illness experience disadvantage in accessing appropriate physical health assessment and care, and poorer physical health and earlier mortality than the general population. This is particularly so for people who grow older with a continuing experience of severe and persistent mental illness, compared with older people who have developed mental illness in later life and generally have a history of better health care management. In general, the Australian population is 'ageing well' and the 'younger old' (65-75 years) experience better physical health. However, the growing 'older old' population are likely to present with more complex co-existing conditions.

This paper will explore mental health and physical health in the context of an ageing population. It will examine what we know about the physical health needs of older people with mental illness (including different sub-groups of older people) and how we are going in meeting those needs, particularly in mental health services and mental health service partnerships. It will highlight some of the challenges and lessons for improving care, drawing on the NSW experience in older people's mental health (OPMH) services. It will provide the context for Rod McKay's paper reflecting on the journey in NSW in this area, and our current

work to improve physical health assessment and care for older people with mental illness, focussing on consumers of NSW OPMH services.

Paper:

Introduction

The Australian population is ageing, and the number of older people with mental illness is projected to increase significantly. Some people develop a mental illness as they age, while others grow older with a continuing experience of mental illness that developed earlier in their lives. For older people, mental illness often co-occurs with physical health conditions. Physical and mental health co-morbidity rises dramatically from 10% in people under 45 years to 60% in people over 65 years. Therefore integrating physical health care and mental health care is particularly important.

In general, the Australian population is 'ageing well' and the 'younger old' experience better physical health. However, those in the growing 'older old' population are likely to present with more complex co-existing conditions. The ageing population and demographic drive to the 'older old' means that Australia needs to be geared up to address the needs of a much larger and increasing group of older people, and significant numbers of people with complex co-existing mental and physical health care needs.

There is evidence that older people with mental illness experience disadvantage in accessing appropriate physical health assessments and care, and poorer physical health and earlier mortality than the general population. This is particularly so for people who grow older with a continuing experience of severe and persistent mental illness, compared with older people who have developed mental illness in later life and generally have a history of better health care management.

Correll *et al*. have highlighted the impacts of various psychiatric medications on people with mental illness, including older people [1]. Their study found that antipsychotics, and to a lesser degree antidepressants and mood stabilisers, are associated with an increased risk for several physical diseases, including obesity, dyslipidemia, diabetes mellitus, thyroid disorders, hyponatremia; cardiovascular, respiratory tract, gastrointestinal, haematological, musculoskeletal and renal diseases, as well as movement and seizure disorders. Higher dosages, polypharmacy (common in older people) and treatment in older people are associated with greater absolute risk for most of these physical diseases.

NSW Health policy guidance highlights a number of risks associated with physical health assessment and care for older people with mental illness [2, 3]. Older people are particularly at risk of problems related to falls, multiple medication use, malnutrition, pressure areas (if they have reduced mobility), musculo-skeletal limitations and pain, and constipation. Delirium is a key risk, particularly in new presentations and in relapse of established illness in older people. Potential challenges to obtaining an accurate and complete physical health history may include hearing or visual impairment, memory impairment and minimisation of symptoms or conditions. Moreover, consent to examination and treatment may be complex (e.g., where there is lack of capacity).

Each year, more people aged 65-85 years living with mental illness die than the entire rest of the population in that age range, so early death is a significant risk for older people with mental illness.

Method

This paper explores a number of sources to provide insights into how mental health and other key services are currently responding to the physical health needs of older people with mental illness, and the implications for action. It includes findings from some relevant international literature, insights from statewide benchmarking data and consumer experience of service survey data for older people's mental health (OPMH) services in NSW, and relevant key findings from evaluation of early implementation of the good practice NSW OPMH Community Services Model of Care. It highlights some areas for further action to address the physical health needs of older people with mental illness.

Results/analysis

A number of studies provide insights into how health services are responding to the physical health needs of older people with mental illness. A Danish study of older people with schizophrenia found that this group was similar to controls in terms of registered chronic medical illnesses, but significantly less likely to receive medication for cardiovascular diseases and more likely to be treated with analgesics [4]. While hospitalisation patterns were similar in the two groups, older people with schizophrenia had significantly fewer general medical outpatient contacts.

A Dutch prospective study of mortality and its determinants in late-life schizophrenia found that the excess mortality in schizophrenia continues into late life, affecting men more often than women [5]. It highlights the need to identify modifiable clinical and social risk factors. A US study by Konz ***et al.*** found a higher frequency of metabolic syndrome in elderly patients with severe mental illness than comparison subjects [6], suggesting that this is an area for targeted intervention.

A study by Crawford ***et al.*** highlights problems with under-assessment and under-treatment of physical health problems such as obesity, diabetes and hypertension in older people with schizophrenia, despite known risk factors [7]. This suggests further areas for targeted intervention.

Looking more specifically at mental health service responses, Clifton ***et al.'s*** exploration of clinicians' attitudes towards older people with severe mental illness and physical illness highlights the challenges clinicians experience in managing physical healthcare needs in addition to mental health issues, a lack of clarity about responsibilities, and the need for more collaboration between services, as well as ongoing clinician education [8].

NSW OPMH annual benchmarking self-audit results against a range of good practice standards indicate that OPMH services are challenged by a number of standards relating to physical health care. These include:

- Involvement of GPs (in pre-admission processes, initial assessment and care, care coordination)
- Access to nursing staff trained in intravenous medication and fluids, sub-cutaneous fluids in inpatient settings
- Physical examination of older consumers (in community OPMH services)
- Action about falls prevention (especially in community OPMH services)

An evaluation of initial implementation of the NSW OPMH Community Services Model of Care confirms the challenges experienced by OPMH community services in physical health assessment, accessing skilled staff for assessment and management (physiotherapists, dietitians, GPs), and falls prevention in particular.

Results of consumer experience of OPMH services surveys indicate that, while services provide a high level of information/advice about healthy eating and diet, exercise and physical activity, they provide less information/advice about possible side effects of medications (slightly better in community services), alcohol and drug use (better in community services), smoking (where relevant) and sexual health.

Discussion

So what does this mean for care? An ageing population means we need to be geared up for addressing the needs of a much larger and increasing group of older people. In considering the physical health care needs of older people with mental illness, we need to consider the needs of different sub-groups – younger old and older old; people with earlier onset and/or severe and persistent mental illness and people with later onset mental illness – and we need to tailor our approaches to improving physical health care accordingly. Given the levels of co-morbid physical and mental health issues, we can't afford to ignore the need for good physical health assessment and care for older people with mental illness (and appropriate mental health assessment and care for older people). Integrated physical and mental health care is imperative.

The international literature suggests that we need to improve assessment and treatment of known physical health risks in older people with mental illness, particularly those with schizophrenia and other severe mental illnesses (e.g., cardiovascular conditions, metabolic syndrome, obesity, diabetes, and hypertension). And we need to identify modifiable clinical and social risk factors for early mortality (particularly in older men with schizophrenia). We also need to provide guidance for health and mental health professionals about the particular physical health risks for older people with mental illness (e.g., risks related to falls and multiple medication use).

The perspectives of OPMH service clinicians in the UK and NSW give some further insights. We need to look at clarifying roles across the service system and promoting more collaboration between key services (e.g., OPMH services, aged health services, GPs). We should consider ongoing education of healthcare staff to improve physical health care of older people with mental illness. We may want to focus on involvement of GPs in physical health assessment and care of OPMH service consumers, physical examination more generally, action relating to falls prevention, and access to skilled staff for specific areas of physical health assessment and management (e.g., physiotherapists, dieticians).

Importantly, looking at the feedback we are receiving from consumers of OPMH services, we need to consider the information and advice that OPMH services and other key services provide to consumers about areas such as possible side effects of medications, alcohol and drug use, smoking and sexual health. By equipping consumers with relevant information about physical health risks and management, we may assist them in maximising their own physical health.

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Theme: Consumer perspectives and rights

Healing – I couldn't do it without you – a modern day posse

Maggie Toko
Victorian Mental Illness Awareness Council

Presenter:

MAGGIE TOKO
Maggie Toko is from Aotearoa and is of Maori descent. Maggie is from the Ngati Whatua and Ngapuhi people and identifies as GLBTIQ and someone who lives with schizophrenia.

Maggie is also the CEO of the Victorian Mental Illness Awareness Council which is the PEAK Mental Health Consumer Body in Victoria. She has worked in youth, homelessness and family violence services for the past 25 years and is passionate about Human Rights in and outside of work. Maggie can be seen utilising her talents as a stand-up comedian to get her message across.

Abstract:

This paper takes the audience on a journey of the last 2 year period in my life where I was lucky enough to gather a team of friends and professionals to assist me with the biggest fight of my life – being diagnosed with Cancer not once but twice. I talk about what it is like having a diagnosis of schizophrenia and how that impacts on my physical and mental health. I talk about human survival when you feel like nothing is going to pick you up – when paranoia and pain collide. The challenge isn't about surviving'- it's about making it through the day.

Paper:

I have type 2 diabetes and a diagnosis of paranoid schizophrenia. I am CEO of the Victorian Mental Illness Awareness Council. I am someone's partner, our son's confidant and a good friend who takes relationships seriously. My two-year journey with cancer would see me suffer with severe pain and periods of paranoia. It would see me dig deep to find ounces of positivity when things seemed dark; it saw me make a 29-minute film and preview it at the Sun Theatre Yarraville to an audience of 50 people. I sought solace from my partner, my friends, my therapist and my medical team.

I was diagnosed with uterine cancer on 9 January 2017 via a phone call on my way to work. In the 10 minutes that the doctor told me my diagnosis I had organised in my mind how this situation would play out for me. It was 6.30 a.m. and I rang some friends and asked them to go to my house to support my partner as I was about to ring them and tell them the news. This single phone call set the ball rolling for the next two years of my life. I asked my gynaecologist if he would ring my GP (yes), would I need a hysterectomy (yes), would I need radiation or chemotherapy (not sure), was there a surgeon (yes), had an appointment been planned (yes), was I likely to die from this cancer (silence), and was there a good success rate (yes). So, the treadmill started at the same time that I was moving house; in fact on the same day. I saw the surgeon, she assured me that she would keep my GP (a person whom I trust and who had been responsible for overseeing my mental health for the past 10 years) in the loop – she kept this promise. So, my medical team ended up consisting of gynaecologist oncologist, GP, radiation oncologist, chemotherapy oncologist, nurse coordinator and radiologists. I spent six weeks having radiation following two months recovery from the operation. I was told I was in remission after six months of treatment. The side effects were bearable and consisted of being incredibly tired. I became sick two months later.

On 9 January 2018, a year to the day, I was diagnosed with para aorta cancer. My warm collection of friends gathered together to talk about what they could do – form a posse. I was told I would need to go through eight weeks of radiation and chemotherapy. I would take 16 tablets a day. My posse formed a roster of support which would see someone come and collect me every day and take me to the Peter MacCallum Cancer Centre in Melbourne, wait while I had treatment, speak to the specialist, ask questions on behalf of my partner, write down answers and relay them back to Cris my partner. This time I took five months off work – I thought I was going to die.

My medical team was and still remain excellent. They welcomed my posse and never wavered in supporting them as well. My trust in all of the medical team made life that much more bearable in times of pain. My GP remains a solid support for me as he liaises regularly with everyone else on the medical team. My experience would see me question life itself – the value of it, I came away believing in humanity, believing in the human spirit which transcends all of us – I came away a survivor.

Theme: Supporting healthy lifestyles – diet and exercise

Exercise medicine: Improving the physical health of people living with mental illness

Katie Stewart, Courtnee Dewhurst and Michael Phillips

Harry Perkins Institute for Medical Research, Perth; Centre for Medical Research, University of Western Australia, Perth; Royal Perth Hospital, Perth, Western Australia.

Presentation Links

Slides

Presenter:

KATIE STEWART

After graduating from Southern Cross University in 1996 Katie worked for high performance triathlon coach Kieran Barry in Sydney, before moving to Perth in 2001. In 2002 she opened The Beach Lifestyle Club, one of Perth's first health studios offering exercise physiology and sports science services. Katie started The Exercise Therapist at The Thrive Clinic in 2015. Here she designed, implemented and evaluated a unique exercise medicine protocol that removes psychological objections to exercise. This protocol has been clinically proven to significantly reduce symptoms in patients with mental and physical co and multi-morbidity chronic conditions. Her research findings will be published in a paper under the guidance of Chief Scientist of WA Peter Klinken AC.

Abstract:

Of the four million people in Australia currently living with a diagnosed mental illness 59.8% have a chronic physical health condition including, but not limited to, coronary heart disease, chronic obstructive pulmonary disorder, back pain, cancer & type 2 diabetes. They can also expect to live ten years less than the national average (14 years less if they live in Western Australia). One of the most telling statistics is the reality that 54% don't seek treatment.

By using a clinically proven, evidence-based exercise medicine intervention to treat, manage and prevent mental illness at a primary care level, along-side chronic conditions. We offer the patient, medical system and government health funding agencies a fiscally viable & clinically effective primary health care solution to the current combined mental health and chronic disease crisis.

The efficiencies of combining health promotion, prevention and treatment of mental and physical chronic illness in combination at a primary care level supported by GP and specialist referral offers a natural extension to the already approved government health care homes project.

A repeatable clinically based exercise medicine intervention has just been validated in a three year efficacy and compliance study with the guidance and support of the Chief Scientist of Western Australia in Perth, WA. We hope to present this research paper for the first time at the Equally well National Symposium.

A secondary impact study is in planning with private and public health stakeholders to develop the concept into a model able to be rolled out nationally.

The opportunity to present and share this research at the Equally Well Symposium will assist in this process and enable us to translate this simple research into practice all Australians with mental illness can benefit from.

Paper:

The effectiveness of a specific mental and physical (MAP) exercise medicine (EM) intervention in a real-world setting treating patients at a primary care level with varied mental and physical chronic conditions

Background and context

The issue addressed

Of the 4 million Australians with a diagnosed mental health condition [1], 59.8% have one or more chronic conditions [2] and they can expect to live ten years less than other Australians [1, 3-4]. In Western Australia the rate is even more profound, with life expectancy 14 years less than other Australians [5]. The rise in these combined cases of mental and physical multi and co-morbidities and how they will be treated and managed in the future is an important consideration for policy makers influencing primary care and allied health referral and rebate strategies over the next decade [1, 4, 6-7].

This reality drove our investigations into effective complementary treatment options at a primary care level that offered high health care value outside of pharmaceutical prescriptions. Current non-prescriptive GP treatment options for chronic mental and physical conditions are often fractured and segregated into mental and physical silos.

One viable and potentially effective treatment option that has been heavily researched and clinically proven for various specific chronic mental and physical conditions is physical activity. When referring to specific populations with chronic conditions this area is often referred to as exercise medicine.

Despite the examples of successful clinical translation, exercise as a clinically proven, cost effective intervention remains under-used in the successful prevention, treatment and management of mental and physical chronic conditions in Australia [9].

Research for example, has proven exercise to be clinically effective in the treatment of depression and cancer independently, but there is little collective evidence or real-world research to validate its effectiveness in treating both mental and physical conditions simultaneously with a repeatable intervention and protocol.

Physical inactivity is one of the two leading modifiable risk factors for chronic disease. The other being diet. Fifty-six per cent of Australians fail to do enough activity [8,12]. **Poor adherence and motivation are attributable** [8, 13-18].

This presents an enormous opportunity to tap into and treat the currently inactive half of Australians with one or more mental and physical chronic conditions. If we can identify and use a clinical exercise medicine intervention that can improve adherence and increase motivation to exercise, we can effectively treat, manage and prevent chronic disease in the half of the population that needs it the most. We can then develop, improve and refine the prescriptive specialisation of exercise medicine for the currently active population.

Investigations into EM and its potential impact and effectiveness in treating, managing and preventing chronic mental and physical conditions at the primary care level have been the discussion point of many key papers and government health documents in recent years. These papers and recommendations were considerations in this research. [1, 10, 19-21].

Target group and setting

One-hundred-and-ninety-eight participants who presented to a community based chronic disease treatment clinic in Mosman Park, Perth between January 2016 and December 2017 were observed. Of the 198 participants, 28.8% were referred by their GP on a Chronic Disease Management (CDM) plan or GP Management Plan (GPMP); 64.7% were referred by a friend, family member or by word of mouth; and 6.6% were referred by specialists (psychiatrists). The average age of participants was 51.2 years.

Participants only completed questionnaires relevant to their presenting chronic condition. Therefore, not all participants completed all aspects of data. Reviews were completed every four weeks.

The exercise medicine intervention was prescribed and administered in small group sessions that were supervised by an AEP. The clinic had capacity to see up to six patients per hour. The patient's sessions were performed in a relaxed community GP-style setting that did not resemble traditional exercise venues or gyms.

Goal and objectives

The study looked to investigate ***the effectiveness of a specific EM intervention*** in a real-world setting as ***defined by*** the ***participants' compliance to the intervention,*** their ***resulting motivation to exercise*** and their ***perceived rate of exertion and cardiovascular fitness*** measured by pre and post rate of perceived exertion (RPE) and heart rate response during effort and rest.

Participants

The one hundred and ninety eight participants who had varied professions lived predominantly in Perth's western and southern suburbs. The population pool comprised the following presentations: 17.7% age-related biomechanical and postural decline (including osteoarthritis); 1.5% osteopenia; 14.7% mental health; 1% respiratory related; 7.6% musculoskeletal injury and chronic pain; 23.7% lower body musculoskeletal chronic injury and pain; 6.1% endocrine, menopause and metabolic/overweight related; 0.5% diabetes; 3.5% cardiovascular disease; 2.5% varied chronic pain; 1% chronic fatigue; 7.6% cancer; 11.6% lower back pain; 1% rheumatoid arthritis.

Actions and project

Approach

The EM intervention was designed to develop a treatment protocol that was simple, repeatable and effective for individuals with one or more chronic mental or physical conditions. Consideration was given to the associated psychological barriers to exercise [22-24]. The intervention incorporates the heavily researched modalities of EM and the psychological treatment modality of mindfulness and Cognitive Behavioural Therapy (CBT) [10, 22, 25]. The intervention was made up of four training pillars, a combination of a 15-minute mindfulness practice, self-administered soft tissue management (foam rolling/stretching and range of motion activities), functional strength exercise, and high intensity interval training [10, 26]. The specific elements of each of the four training pillars was related to the findings of the initial screening of the participant.

Method

Following an initial consultation, where patients underwent musculoskeletal screening and completed questionnaires which related to their symptoms and medical history, accredited exercise physiologists (AEP) developed and prescribed a personal exercise program. Depending on their symptom severity, financial status, and time commitments, patients decided on an eight or 12-week program attending an AEP supervised exercise clinic two to three sessions per week. A review assessment was completed every four weeks throughout this time. Reviews involved reassessment and comparison of the initial screening and questionnaires. Questionnaires considered in this study were the Perceived Personal Health Assessment (PPHA) [27], DASS21 [28], and Menopause Specific Quality of Life Questionnaire (MenQoL) [29]. Note, the Perceived Personal Health Assessment is a short nine-question assessment which was developed in-clinic with guidance from the short form-36 (SF-36); a quality of life and multipurpose

Table 1 Participant description and involvement including testing and questionnaire responses

	Heart Rate	Blood Pressure	Perceived Personal Health Assessment (PPHA)	DASS21	Menopause Quality of Life Questionnaire (MenQoL)
Total participants	109	13	128	41	72
Male (%)	20.2%	53.8%	20.3%	19.5%	0%
Female (%)	79.8%	46.2%	79.7%	80.5%	100%
Mean age (years)	49.7	57.5	50.7	48.5	49.6

health survey [27]. These programs were self-funded by patients with varied combinations of both private health and Medicare rebates.

Primary measurements

1. ***Adherence to exercise*** was analysed by visit frequency, completion, and repeated program.
2. ***Motivation to exercise*** was assessed using the Perceived Personal Health Assessment (PPHA). This questionnaire assessed the patient's self-perception of aspects of their health including overall health and wellbeing, weight, motivation to exercise, daily stress, ability to cope with daily stress, daily fatigue, current fitness, happiness and sleep quality.
3. ***Perceived rate of exertion and cardiovascular fitness*** was measured during the cardiovascular phase of the session, specifically analysing the relationship between pre and post-exercise rating of perceived exertion (RPE) [30]. The participant indicated their perceived capacity of exertion prior to the start of the HIIT session. They were asked again at the conclusion of their prescribed maximal 30 second efforts with recovery ranging from 30 seconds to one minute, to indicate how hard they thought they worked using the RPE scale.

Self-perception, quality of life, and endocrine symptom impact were secondary measurements to questionnaires given to patients to monitor their progress during their program. Questionnaires used to provide secondary measurements were DASS21 and the Menopause Specific Quality of Life Questionnaire (MenQoL).

Effort and rest/recovery heart rates were collected for all cardiovascular HIIT sessions. Daily fatigue was assessed using a 1-10 Likert scale. Depending on patient presentation, pre and post-session RPE, blood pressure, pain level and anxiety level were also recorded.

Descriptive statistics used means and medians as appropriate for continuous variables and percentages were used for categorical variables. Inferential longitudinal analysis used mixed-effects regression models with maximum likelihood estimation for the nested data with multiple observations for each subject. A statistically significant probability was pre-defined as less than 0.05. All analysis was conducted using the Stata package (StataCorp. 2015. Stata Statistical Software: Release 14. College Station, TX: StataCorp LP.).

Results, outcomes and key points

1. ***Level of engagement/participation***

   The results showed a very high, statistically significant adherence rate of 85.4%. Over the 24-month period that data was collected, 85.4% of participants completed their eight or twelve-week program consisting of two to three contact sessions a week. Two visits a week for eight weeks and three visits a week for twelve weeks proved to be the most frequent intervention options. These program options were also the most successful with regards to completion rates. Sixty per cent of participants chose to repeat the intervention. The remaining forty percent returned to independent exercise and physical activities. However, dropout rates of gym memberships can be as high as forty four percent and low usage rates are about twenty seven percent, leaving only twenty nine percent effectively active [2]. In a clinical setting non-adherence to prevention or treatment can be as high as seventy percent if regimens are complex and/or require lifestyle changes and modification of existing habits [31-32]. Instructions from clinicians may not be followed through by the patient due to: patients not understanding, patients being unwilling to engage, or the presence of physical, emotional, or cognitive barriers [13-14, 21, 24, 33-35]. Greater amounts of physical activity are achieved in supervised training compared to unsupervised training. In addition, supervised participants showed greater adherence and consistency compared to unsupervised participants [25, 31-32, 36-38].

   The adherence findings show that the varied chronic illness presentation of the participants had no significant impact on the interventions ability to produce high levels of adherence and repetition of the program and intervention. A total of 60.4% of patients elected to repeat the intervention program while 39.6% returned to independent physical activity with significantly increased motivation to engage in ongoing physical activity and exercise. Given the effectiveness of the intervention these findings warrant discussion and action into government funded education and GP awareness campaigns to increase the rate of GP referrals for patients with chronic conditions and injury.

2. *Outcome, impact and results*

The primary results support the objectives of this study with statistical significance. The tested EM intervention resulted in strong and frequent adherence to exercise of 85.3%. It not only reduced blood pressure over time, but improved motivation, self-perceptions and chronic mental and physical health condition indicators. All aspects of which are supported by previous research [6]. In addition, the intervention increased the patient's capacity to work during exercise.

a. *Mental health indicators*

The findings show ***a statistically significant reduction in both stress and anxiety*** in the assessed participants who had not been diagnosed with a mental health condition. As both stress and anxiety are indicators of future risk of clinical mental health conditions these findings support the use of the intervention in the monitoring and prevention of the onset development of mental health rates in chronic illness patients. The patients who presented with a primary mental health diagnosis experienced a significant reduction in all three symptom scores for depression, anxiety and stress. (Refer to mental health data).

The intervention also treated the associated secondary side effects that often come with chronic mental health conditions as discussed and explored at length in "Australia's mental and physical health tracker" [39].

b. *Motivation to exercise*

The results showed the EM intervention was successful in i***mproving participants' motivation to exercise with statistical significance*** during and up to 300 days post-program completion. Motivation to exercise was increased with statistical significance within the first four weeks, which was maintained for up to 300 days. There was a plateauing at the eight-week mark. Motivation then continued to increase peaking at the 12-week mark with a mean response of 6.5/10. The average motivation of participants being sustained above 6/10 for up to 300 days.

These findings are interesting when considering the design and execution of any effective government or private health insurance funded inactivity, obesity and/or chronic disease programs or funding. Additional study and observation of longer periods of adherence to investigate if motivation continues to increase proportionally to duration is needed. If so, does it then have an elongated benefit past 300 days?

c. *Perceived capacity and tolerance for high intensity interval training EM*

There was a significant improvement in capacity for work once engaged in the EM intervention as defined by heart rate response during effort and rest. The self-efficacy of all participants' health perceptions significantly improved along with physical fitness and cardiovascular capacity.

The EM interventions ability to increase motivation to exercise alongside compliance and capacity for work are indicators of the interventions effectiveness in the role of treating combined mental and physical chronic conditions in our communities at a primary care level.

The results indicate self-directed intensity and capacity for work resulted in a statistically significant and consistent improvement in the participants' cardiovascular condition over the duration. Most significantly these findings support the idea that self-directed workloads are successful in improving the cardiovascular health of patients with chronic disease [40]. These findings also support the idea that self-efficacy and capacity for work improve innately over time in line with cardiovascular adaptations. Self-perception of capacity and physical capacity align [41-44].

3. Strengths and limitations of this study

This effectiveness (pragmatic) study was carried out in a clinical real-world setting, rather than laboratory, so observations and outcomes are authentic to community application. The presenting chronic illness cases are indicative of the socio-economic status and referral base of the cohort observed. One of the major weaknesses of this study was the absence of a comparison group or control group. Due to the real-world setting of this study it has been challenging to find relevant comparative adherence to exercise intervention papers and figures. A weakness in this study is the lack of control of presenting pathologies and chronic conditions, and participant numbers with each condition. It would be ideal to evaluate the effectiveness of the intervention with a larger cohort particularly on participants with type 2 diabetes, cardiovascular disease, osteoporosis and respiratory conditions.

Lessons for the future

This MAP EM intervention and protocol generates statistically significant levels of adherence, motivation and capacity for exercise. If we are to be successful in using and applying exercise in the fight against chronic disease, we need to focus our approach and conversation on engaging the currently inactive half of the population. We can reduce inactivity rates by introducing exercise medicine at the primary health care level.

Secondly, using the same EM intervention and protocol, patients referred with a primary mental condition who were taking prescription medication and seeing their psychologist and psychiatrist regularly reduced symptomology with statistical significance. Chronic mental and physical health conditions can be effectively treated with the same, simple, repeatable EM intervention.

Thirdly, EM programs at a primary care level can be used not only to treat but to prevent, educate and collect data on patients with co and multi morbidities to help reduce hospital presentations, support community focused primary care and reduce the burden of chronic disease on participants quality of life.

Recommendations for future actions in this area?

1. Repeating this real-world study with the EM intervention being available within a GP clinic at three additional different geographic locations in Perth to capture more data on the other key chronic conditions being diabetes, heart disease, COPD and asthma. The purpose of this study would be to evaluate the impact of the ***intervention on the participants' health determining its health care value.***
2. To work with private health insurers and the health department to get this and other proven effective EM interventions and programs approved for rebates.
3. Partner with operational GP clinics such as St John's Urgent Care to trial a chronic care arm to services that offers exercise medicine and allied health service provision and programs.

Other Information:

Funding statement

This work was supported by the Medical Research Foundation, Royal Perth Hospital.

Data sharing statement

Secure data register through University of Western Australia. University of Western Australia require authorisation of corresponding author in order to gain access to data.

Patient and public involvement statement

As the research was carried out in a real-world setting, patients were aware of the ongoing research process, and that their deidentified data would be collected. A small group of patients was initially involved when developing the intervention, more so in relation to the mindfulness aspect of the intervention. Patients were not limited to a time within the intervention participation, and although provided with advice, it was their choice for what timeframe and frequency they did attend.

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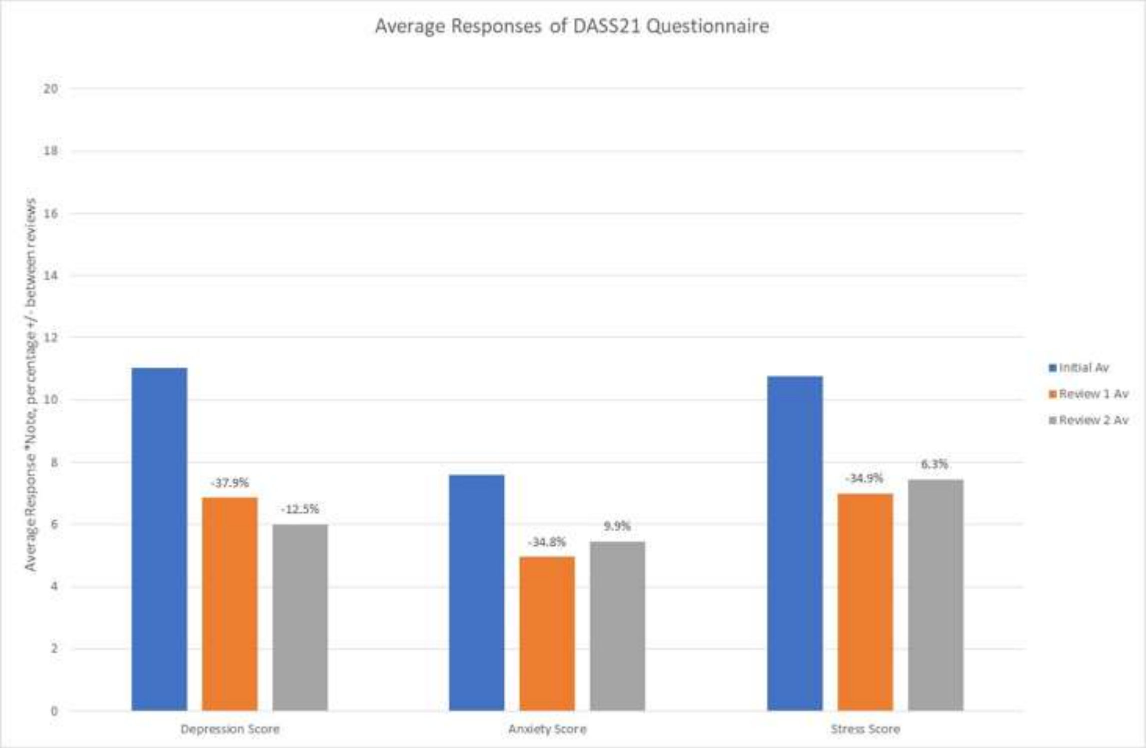
Average Responses of DASS21 Questionnaire
Average Response *Note, percentage +/- between reviews
20
18
16
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10
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4
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Depression Score
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■ Review 1 Av
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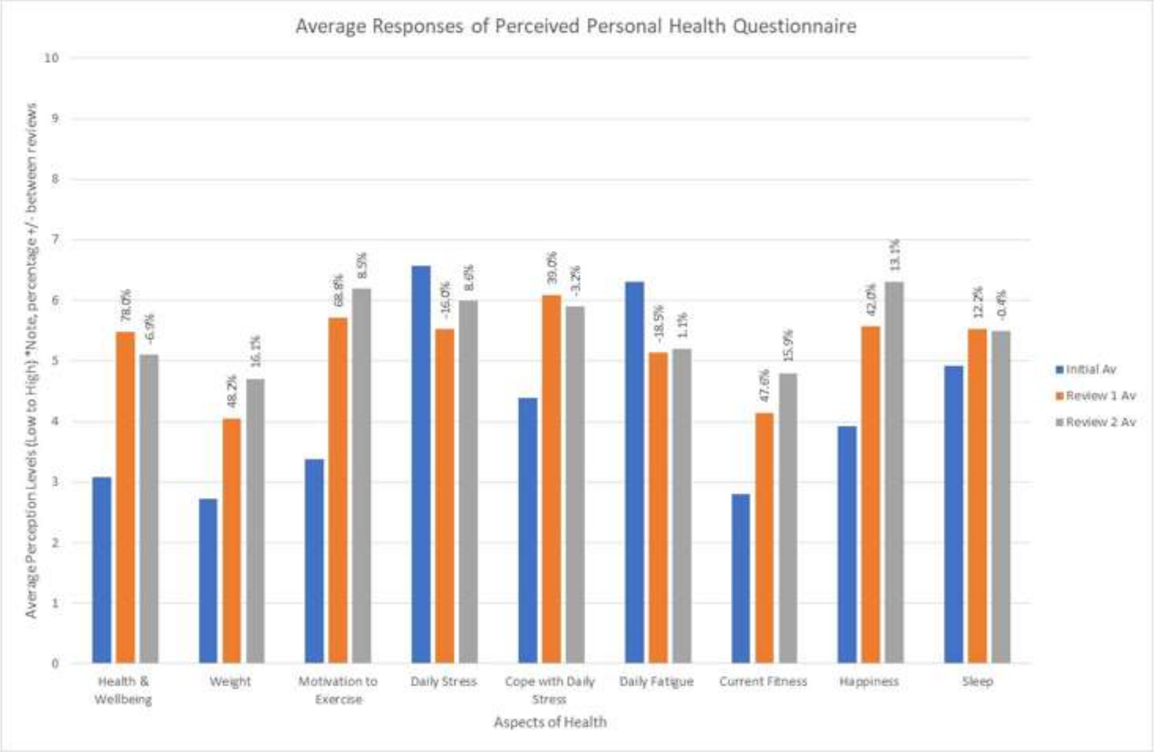
Average Responses of Perceived Personal Health Questionnaire
Average Perception Levels (Low to High) *Note, percentage +/- between reviews
10
9
8
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5
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78.0%
-6.9%
48.2%
16.1%
68.8%
8.5%
-16.0%
8.6%
39.0%
-3.2%
-18.5%
1.1%
47.6%
15.9%
42.0%
13.1%
12.2%
-0.4%
Health & Wellbeing
Weight
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Cope with Daily Stress
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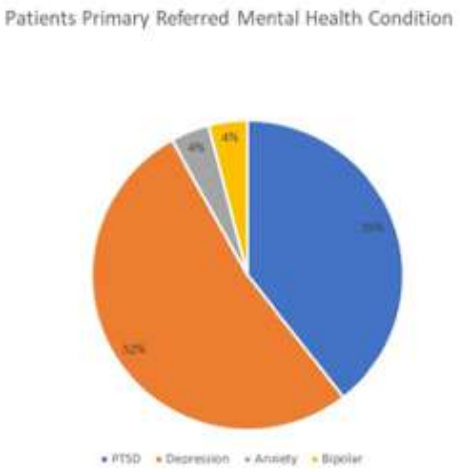

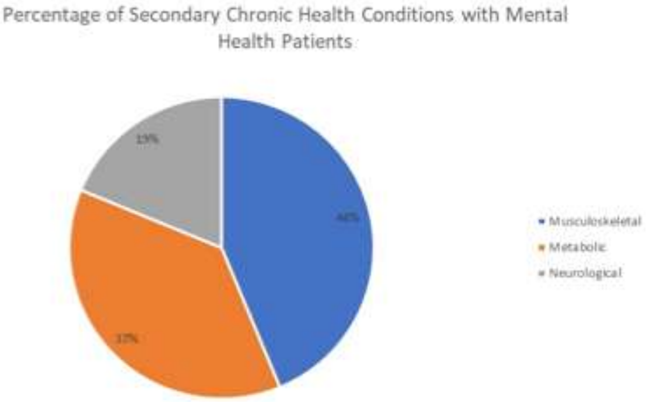

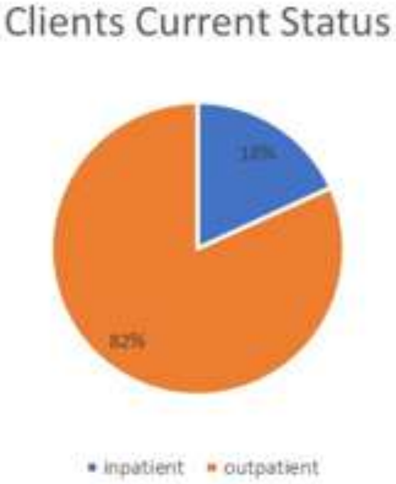

Of the 73.9% of referred mental health clients, a secondary chronic health condition is present.

This data is based on 21 clients who have been referred for mental health. The presented statistics are slightly greater than the 59.8% reported in the Australian Mental and Physical Health Tracker.

Theme: The national perspective

Australia's Mental and Physical Health Tracker – targeting action and accountability

Presentation Links

Slides

Harris, B, Duggan, M, Batterham, P, Bartlem, K, Clinton-McHarg, T, Dunbar, J, Fehily, C, Lawrence, D, Morgan, M & Rosenbaum, S

Presenter:

BEN HARRIS

Ben Harris is Health Policy Lead at the Mitchell Institute, Victoria University, which manages the Australian Health Policy Collaboration. Ben has worked in health and social policy roles for state and federal governments, for professional associations and for a consumer organisation. He has worked as an adviser to a Commonwealth Health Minister, and has also served as Chief of Staff to the Victorian Minister for Community Services, Mental Health and Disability Reform.

Ben has extensive policy experience in workforce, health financing, population health, community services and disability reform. He is a strong strategic thinker and has a sound understanding of government processes.

Ben is an economist and holds degrees from the Australian National University and Monash University. He has a range of publications, including opinion pieces and research work. Recent publications include Australia's Mental and Physical Health Tracker, and Australia's Health Tracker by Socioeconomic Status.

Abstract:

The relationship between mental health and physical health is well known yet there is a persistent gap in morbidity and mortality.

Australia's Mental and Physical Health Tracker is a national report card on chronic disease and their risk factors for people with mental and behavioural issues compared to the Australian population as a whole, and differentiated by gender. It examines issues such as smoking, risking drinking, obesity and overweight, physical activity, blood pressure and cholesterol levels which are the major risk factors for chronic conditions such as cardiovascular diseases, diabetes and cancer.

For the first time, data from the National Health Survey are used to quantify the differences in chronic disease risk factors for people with mental and behavioural issues, and to highlight the gender differences.

Australia's Mental and Physical Health Tracker also quantifies, for the first time in Australia, the comorbidities associated with mental health conditions. Living with a mental health condition – including common conditions anxiety and depression – dramatically increases the chances of living with another chronic disease. Approximately 2.5 million Australians have both a mental and physical health condition.

We have known for a long time that people with mental health conditions are more likely to have physical health issues, and less likely to have those issues addressed. The Tracker demonstrates that this holds true for all mental health conditions, including those affecting millions of Australians.

Poor physical health experienced by people with mental health issues will continue to affect welfare and education, health systems and costs, productivity and employment, and social participation.

Improving the physical health of people living with mental health conditions must become a priority to improve the health of all Australians. Australia's Mental and Physical Health Tracker provides data to help focus our efforts, and a tool to track our progress.

Paper:

Introduction

Australia's Mental and Physical Health Tracker (2018) demonstrates that living with a mental health condition dramatically increases the risk of having another physical chronic health condition [1]. For the first time in Australia, we can quantify the added risk of comorbidity for people living with a mental health condition.

People living with mental health conditions die earlier than the average Australian, and those with severe mental illness die 10–15 years earlier. More than three-quarters of the excess mortality is a consequence of chronic physical health conditions [2]. Many of these early deaths are preventable.

Multimorbidity is increasing in the general population, particularly among older people, women and those from disadvantaged backgrounds [3]. Multimorbidity is associated with decreased quality of life, functional decline, and increased healthcare utilisation, including emergency admissions, particularly with higher numbers of coexisting conditions [4-6].

The costs of healthcare for people with multimorbidities are generally higher [5, 7]. The costs of treating co-existing mental and physical conditions are significantly greater than the costs of treating the physical conditions alone [8]. There are, in addition, wider negative impacts of multimorbidity on family functioning, standard of living, child development and educational attainment [9].

People with both mental and physical morbidities have a worse quality of life than people with two or more physical health problems [10]. Mental and physical health problems together can have a greater effect on functional status and quality of life than physical illness alone [10]. A significant part of the reason for these poorer outcomes is that a co-existing mental health problem may reduce a person's ability to actively manage their other health conditions [11].

Patients with multimorbidity have a high treatment burden in terms of understanding and self-managing the conditions, attending multiple appointments, and managing complex drug regimens [12]. Qualitative research highlights the "endless struggle" patients experience in trying to manage their conditions [13].

Method

Data in this report were collected by the Australian Bureau of Statistics as part of the National Health Survey 2014–15, a stratified multistage area sample which included around 19,000 people in nearly 15,000 private dwellings. To determine the association between mental and physical health conditions, we examined the prevalences of physical health conditions among people reporting mental health conditions and compared those data to the population as a whole. More details on methodology for this study are available elsewhere [1].

Results

People reporting mental health conditions in the National Health Survey are much more likely to have physical chronic diseases than the general population.

Men with mental health conditions are 52% more likely to report having a circulatory system disease, while women with mental health conditions are 41% more likely to report having a circulatory system disease.

Circulatory system diseases are more common in

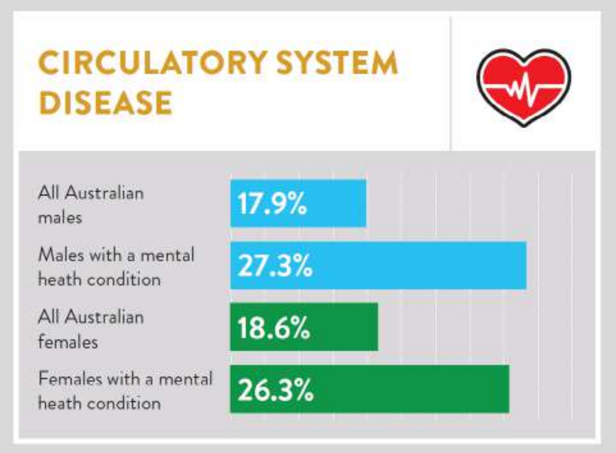

Fig 1.

rural and remote areas [14], and people living in the lowest socioeconomic areas in Australia are more than twice as likely to have coronary heart disease as adults living in the highest socioeconomic areas [15]. Aboriginal and Torres Strait Islanders have significantly increased risk of both cardiovascular disease and dementia [16].

Men with mental health conditions are 74% more likely to report having diabetes than the population as a whole, while women with mental health conditions are 46% more likely to report having diabetes.

Diabetes is more than two-and-a-half times as prevalent in the lowest socioeconomic quintile than the top quintile, and more common in rural and regional areas than in major cities [14]. Analysis of data from the Australian Aboriginal and Torres Strait Islander Health Survey 2012–13, adjusting for differences in age structure, found that Aboriginal and Torres Strait Islander people were more than three times as likely as non-Indigenous people to have diabetes or pre-diabetes [16]. Diabetes was the second leading cause of death for Aboriginal and Torres Strait Islander Australians in 2016, with the standardised death rate five times that of non-Indigenous Australians [17].

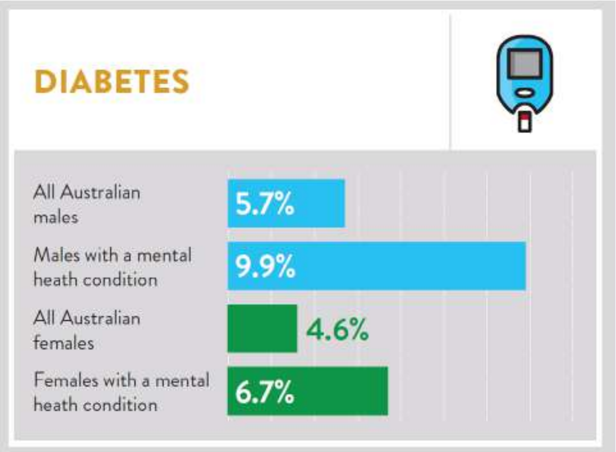

Fig 2.

Men with mental health conditions are 74% more likely to report having back pain and women with mental health conditions are 68% more likely to report having back pain than the general population.

Men in inner regional and rural and remote Australia are more likely to report back problems than men in major cities, but this pattern is not evident for women [18]. Australians in the two lowest socioeconomic status quintiles are more likely to have back problems than adults living in the highest two socioeconomic quintiles [18]. Aboriginal and Torres Strait Islander peoples are significantly more likely to report back problems, particularly females [18].

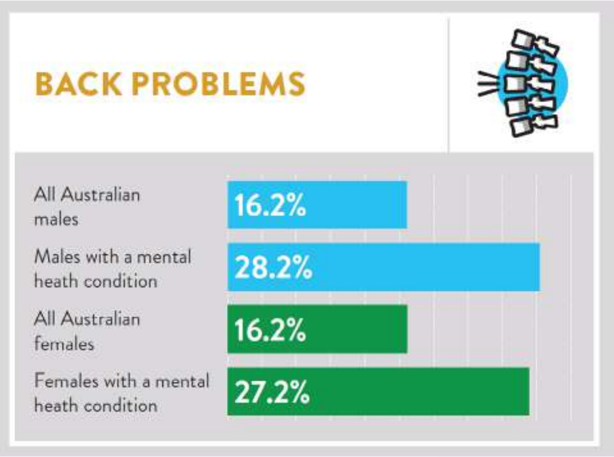

Fig 3.

Men with mental health conditions are 66% more likely to report having arthritis, while women with mental health conditions are 46% more likely to report having arthritis than the general population.

Arthritis is more common in rural and regional areas than in major cities, and more common among the lower quintiles of socioeconomic status [14].

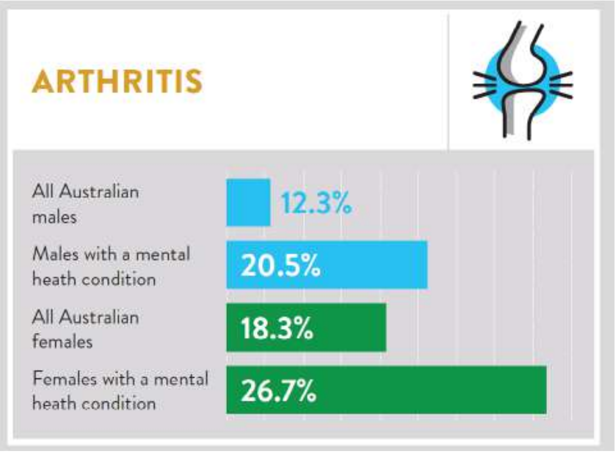

Fig 4.

Men with mental health conditions are 49% more likely to report having asthma, while women with mental health conditions are 70% more likely to report having asthma.

Asthma is more prevalent in rural areas than in major cities, and more prevalent in lower socioeconomic groups [19]. After adjusting for differences in age structure between the two populations, Aboriginal and Torres Strait Islander people were almost twice as likely as non-Indigenous people to have asthma [16].

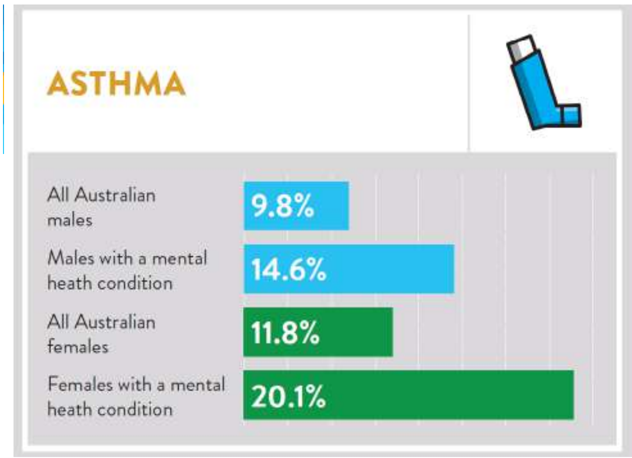

Fig 5.

Men with mental health conditions are 82% more likely to report having cancer, while women with mental health conditions are 20% more likely to report having cancer. [1]

Discussion

The common risk factors for chronic disease, including raised cholesterol and blood pressure, smoking, obesity, excessive alcohol intake, and physical inactivity are all more common among people with mental health conditions [14], explained in part by socioeconomic circumstances [1].

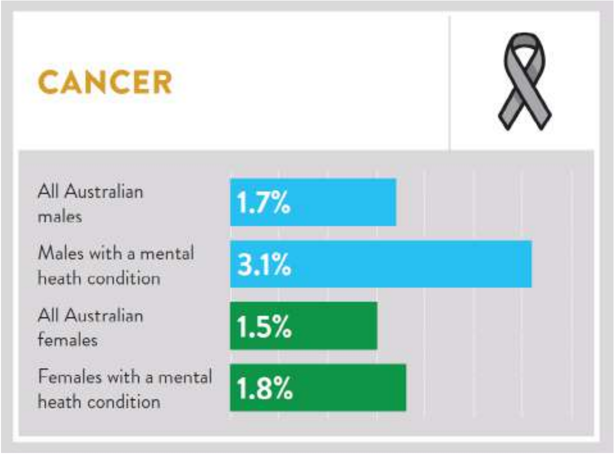

Fig 6.

The economic conditions of where you live matters, as socioeconomic status is intrinsically linked to health [20]. Jobs and employment, community participation and educational opportunities affect health status [15]. Rural people are generally older, poorer and less educated than metropolitan populations [15]. Aboriginal and Torres Strait Islander Australians generally have poorer health outcomes, with distance and socioeconomic status being contributory but not wholly explanatory factors.

People living with mental health conditions have worse physical health and a higher prevalence of chronic disease, and a significant proportion die earlier than the rest of the population. National and international evidence suggests that meeting the psychological and mental health needs of people with concurrent physical health conditions improves both physical and mental health [21].

Implementing Absolute Cardiovascular Risk Assessment for all Australians over 45 years (over 35 for Aboriginal and Torres Strait Islander people) is a key step in addressing preventable chronic disease and early death [22]. The data demonstrate that people living with mental health conditions would disproportionately benefit from implementing Absolute Cardiovascular Risk Assessment.

The scale of physical and mental health multimorbidity suggests that regular mental health assessments in primary care for people with chronic physical conditions, as currently recommended by the Royal Australian College of General Practitioners [23], should be promoted and supported.

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Theme: Focus on quality care

From understanding the problem to developing a solution: the introduction of a specialist physical health nurse consultant role

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Brenda Happell
University of Newcastle

Presentation Links

Slides

Presenter:

BRENDA HAPPELL

Professor Brenda Happell, University of Newcastle, is a registered nurse with specialist qualifications in mental health nursing. She has 29 years' experience in academia in Victoria, Queensland, New South Wales and the ACT.

Throughout her career she has been a passionate and unrelenting advocate for Mental Health Nursing. Brenda was the inaugural Director of the Centre for Psychiatric Nursing at the University of Melbourne, former Director of the Institute for Health and Social Science Research at Central Queensland University and Professor of Nursing and Executive Director of Synergy, Nursing and Midwifery Research Centre at University of Canberra and ACT Health.

Brenda is a Fellow and Board Director of the Australian College of Mental Health Nurses, and former Editor of the International Journal of Mental Health Nursing. Her research interests include: consumer participation in mental health services, physical health of people experiencing mental illness, and mental health nursing education.

Brenda is the lead investigator of a NHMRC grant: Improving the cardiometabolic health of people with psychosis: The Physical Health Nurse Consultant service, a nurse-led initiative. She was the proud recipient of the inaugural VMIAC lifetime ally award in 2018.

Abstract:

The physical health challenges and reduced life expectancy experienced by people accessing mental health services are clearly documented. Unfortunately, this knowledge has not translated into significant and widespread practice change. The Physical Health Nurse Consultant position was developed by a multidisciplinary research team and is directly informed by research undertaken with consumers, carers and nurses in mental health. With National Health and Medical Research Council funding, this position is being trialled in the ACT. A Randomised Controlled Trial is comparing the Physical Health Nurse Consultant to treatment as usual. A comprehensive evaluation will compare the two groups using clinical outcomes, access to and acceptability of treatment, quality of life, burden of disease and cost-effectiveness. This presentation will provide a brief overview of the development and implementation of this nurse-led position, reflecting the perspectives of consumers, carers and nurses. It will include a warts and all overview of the barriers encountered through the implementation process and the team is learning about major barriers to providing quality physical health care within mental health services. If evaluation is positive, this strategy could provide a model for the improvement of physical health care within mental health services and address a major health inequity.

Paper:

Introduction

The increased attention to physical health challenges facing people diagnosed with mental illness is encouraging and highlights a significant health inequity. When it comes to responses to the identified problems, there is less cause for celebration. Solutions are needed as a matter of priority. Furthermore, solutions must be demonstrably effective. Evidence to date suggests that interventions based on monitoring and assessing physical health issues do not lead to a significant change in practice (Benson, Kisely, Korman, & Moss, 2018).

The physical health nurse consultant role

The physical health nurse consultant role was developed and introduced by a multidisciplinary research team in direct response to the identified barriers to quality and effective physical health care (Happell et al., 2018). This innovative role was developed with the input of key stakeholders including consumers, carers and nurses working in mental health settings (Happell et al., in press). Focus groups conducted separately with these three participant groups, demonstrated the inadequate attention to physical health issues within mental health services.

Consumer and carer participants describe their difficulties accessing physical health care, with physical health concerns often dismissed as symptoms of mental illness. Consumers also described their concerns being ignored or belittled, and access to services further impeded by financial limitations and the stigma they experienced in healthcare settings (Happell, Ewart, Bocking, Platania-Phung, & Stanton, 2016). Carers portrayed the complete lack of coordination and integration between mental health and other health services. These circumstances pressured them to assume the role of care coordinator, a role for which they found themselves lacking the skills, knowledge and expertise to execute effectively (Happell, Wilson, Platania-Phung, & Stanton, 2017).

Consumers, carers and nurses were supportive, in principle, of the proposed physical health nurse consultant role, provided it was responsive to individual consumer needs and not too closely aligned with the medical model. A pilot study of the physical health nurse consultant role was conducted in central Queensland and while numbers were not sufficient to determine statistical significance, they did suggest some improvements in health behaviours and healthy outcomes in the intervention group (Happell, Stanton, Platania-Phung, McKenna, & Scott, 2014).

The findings from these studies contributed substantially to the development of the physical health nurse consultant role and the funding application to the National Health and Medical Research Council. Due to the compelling evidence presented and clear rationale for the role and its capacity to address major barriers in physical health care, the project was funded. For more detail see our published protocol paper (Happell et al., 2018).

Implementation and its challenges

Implementation of the physical health nurse consultant role began in November 2018 at Canberra Hospital and Health Services, Australian Capital Territory. We have encountered many barriers that are part and parcel of clinical research. Recruitment has proven very challenging due to factors including lack of enthusiastic engagement from managers; lack of integration of health services (for example, blood collection requires a separate visit to an external organisation); and difficulties with transport to and from the community mental health centre.

While this is very frustrating in the quest for a robust sample size, the team has learnt from this endeavour – the trials and tribulations will be used to develop a stronger model for the specialist role, and ideally will identify strategies to address the barriers we have encountered. Our journey to date has reinforced the difficulties confronted in attempting to integrate physical and mental health care within mental health services. We continually bear in mind that however much this is a problem for the research and clinical teams, it is a far greater problem for consumers and carers. The health system as currently structured is not designed to be responsive to the diversity and complexity of needs unique to each individual consumer. Our efforts to improve physical health care will continue to be impeded until broader systemic issues are addressed.

To strengthen the quantitative data collected, we will conduct in-depth interviews and focus groups with consumers carers and staff to provide a deeper understanding of how the model for this role has been received, areas for potential improvement, and any other thoughts and observations those who have been closely connected to it bring to this experience. While the challenges are considerable, the potential outcomes are well worth the effort.

Conclusions

Physical health challenges experienced by people diagnosed with mental illness represent an unacceptable health inequity that must be addressed as a matter of priority. The physical health nurse consultant role was developed and implemented as a strategy to improve physical health within mental health services. The current research project provides the opportunity to further understand and evaluate its potential.

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Theme: Focus on quality care

Let's talk: Conversations for better health and wellbeing

Jade Ryall
Flourish Australia

Presentation Links

Slides

Presenter:

JADE RYALL
Jade Ryall is the Manager of Flourish Australia's Back On Track Health Program. Jade has a professional background in Occupational Therapy and has worked in community mental health for over 12 years. Jade has held a number of roles with-in Flourish Australia including delivering direct supports to people accessing the service, facilitating group activity programs and Chairing a number of Communities of Practice. Jade is a proud Wiradjuri woman dedicated to supporting people and communities to build their capacity to recognise and respond to gaps in service delivery and outcomes for people from vulnerable or marginalised communities.

Abstract:

Flourish Australia's Back On Track Health (BOTH) Program focuses on health promotion and prevention embedding physical health and wellbeing conversations in everything we do.

The BOTH program supports people to learn skills to self-manage their own physical health and wellbeing; to regularly review their physical health and wellbeing; and to take action by regularly accessing primary health care services, particularly GPs, to address their health concerns. To support conversations and self-management activities, Physical Health Cards, a Physical Health Microsite and information sheets, have been co-designed with people accessing services and staff. An evaluation of the resources has shown promising results in supporting people to review their physical health and connect with a GP to address their needs.

A new recordkeeping process, focussed on physical health and wellbeing, has been developed to support people to record key activities that promote physical health, and to assist the organisation to evaluate the effectiveness of the resources and supports offered. Early data is showing promising results.

This paper will outline the resources and procedures that have been developed, including the processes used in co-design, piloting, and evaluating the new resources. It will detail the resource evaluation outcomes, including perspectives from people accessing the service and staff; and provide preliminary data about the effectiveness of the BOTH program in connecting people with primary health care services.

Paper:

Background and context

Flourish Australia is a community based, not-for-profit mental health service working with people who have a lived experience of a mental health issue to help them live and thrive within their chosen communities.

1. The issue addressed

Flourish Australia's Back On Track Health (BOTH) program was established in 2010 in response to the decreased life expectancy, reduced access to general and specialist health care services and increased rates of chronic disease experienced by people living with a mental health issue when compared to the general population.

2. Target group and setting

The program targets people with a lived experience of a mental health issue, their families and carers – particularly those who may not have a regular GP or annual health checks.

It is also designed for people:

- With literacy needs – reading and writing difficulties;
- From culturally and linguistically diverse backgrounds;
- Who prefer a more visual way of learning about and exploring health needs;
- Who are less familiar with health/medical terminology.

3. Goal/objective

People with a lived experience of a mental health issue:

- Maintain a reflective and responsive approach towards their physical health and wellbeing;
- Learn new skills to review, identify and self-manage their own physical health and wellbeing; and
- Take action by regularly accessing primary health care services, particularly GPs, to address their health concerns and undertake key preventative health screens.

4. Participants

- The BOTH tools and resources were co-designed with people with a lived experience of a mental health issue, to be used by and/or with people with a lived experience of a mental health issue, peer workers, support workers, families and carers.

Actions/project

1. Approach

- Development of interactive person-led tools designed to review and identify health concerns or risks and support a person to plan and prepare for an appointment with the doctor to have the concerns discussed/addressed.

2. Method – what we did

- Co-designed a suite of tools resources, including:
    - Physical health cards
    - Physical health microsite
    - My health needs to-do list
    - My health check-in
    - Health information sheets

3. Method – how we went about it

- We engaged a physician to help us identify aspects of health that may indicate a risk or concern that would be important to talk about with a doctor.
- Using the risks factors we worked with people accessing the service to co-develop reflective prompt questions, in simple, easy to understand language, that would help a person review, identify and decide if there was a risk or concern that they would like to talk to the doctor about.
- The physical health cards or 'the cards' and the physical health microsite feature the prompt questions, which are paired with a visual image to represent the health topic area. The microsite features a list of reliable organisations and support resources related to each health topic area along with contact details and what they offer.
- An activity to accompany the cards and a my health needs to-do list was also developed. The activity is designed to support the person to prioritise the health areas that they would like to talk to someone about, as well as setting the agenda for their doctor's appointment. The to-do list is a reminder/prompt for the person to use during the appointment.

- The health check-in explores key preventative health activities and screens that people can use to keep their health on track.

4. Attributes of the physical health resources and tools

- Each resource is routinely offered to every person who accesses Flourish Australia's services.
- Support is available to people to use the resources and connect with any relevant health providers, services or information that the person would like so that they are able to address their concerns and make informed decisions.

Results/outcomes key points

- The resources were piloted to test the user friendliness of the tools and were evaluated to measure the impact on health behaviours.
- Early data has demonstrated promising results. They show people are identifying their own health needs and risks and making an appointment with a doctor or other relevant health provider to address their needs.
- Almost all participants in the evaluation indicated that the resources helped them identify a physical health risk or concern and almost all participants who indicated that they wanted to see a doctor to discuss their concerns went on to do so.
- About 80% of people who indicated that they see a doctor regularly reported that after using the cards they identified a new health concern they wanted to discuss with their doctor.

Lessons for the future

- People with a lived experience of a mental health issue value their physical health as much as their mental health.
- Despite regular attendance at the GP, not all health concerns are being identified and raised between the person and their doctor during appointments.

Recommendations for future actions

- Access to tools to help a person take control of their physical health is a step towards closing the gap in life expectancy and improved quality of life for people living with a mental health issue, their families and carers.
- We are confident that the resources will be welcomed by doctors and other health providers who are working with people with a lived experience of a mental health issue who are seeking to be involved in managing and maintaining their health needs and improving their health outcomes and quality of life.

For more information, contact Flourish Australia's BOTH program on (02) 9393 9000.

Equally Well
2019 Abstracts

Oral presentations not submitted as papers.

Key note presentations

Presentation Links

Symposium welcome and opening address
Lucy Brogden

Video

Presentation Links

Symposium opening address (day 2) from Equally Well UK
Andy Bell

Video

Presentation Links

Physical health as a human rights issue
Indigo Daya and Chris Maylea

Slides Video

Abstract:

For over a decade, international human rights law has demanded the right to health for mental health consumers. Physical health services and mental health services are bound 'to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs' of consumers'. Both anecdotal experience and empirical data show that this has not occurred. In this presentation, we interrogate the right to health and frame a human rights-based response, focusing on practical approaches to embed human rights in health service provision. We consider supported decision-making and consumer-led responses as best practice in rights-based treatment, care and support.

Presentation Links

Supporting healthy decision making
Dave Peters and Kate Johnston-Ataata

Slides Video

Authors:

Kate Johnston-Ataata, Dave Peters, Nicholas Hill, Jacinthe Flore and Renata Kokanovi.

Abstract:

People's stories or personal accounts of health and illness experiences online are becoming increasingly important in relation to how we think about, make use of, and design health care services. For other people experiencing similar conditions who may be trying to make sense of a new diagnosis, seek information about symptoms, or make decisions about treatment and care, accessing other people's lived experiences online can be helpful as a complement to clinical health information. Health service providers and policymakers also value people's health and illness experiences online as a source of evidence about what is and isn't working in healthcare systems. One noteworthy aspect of personal accounts of health conditions online is that they reveal the 'messiness' of lived experiences of health and illness vis à vis neat clinical diagnostic criteria or treatment guidelines. Stories highlight the prevalence of experiencing one or more health conditions at the same time, and in particular the inseparability of experiences of mental and physical health, a critical issue for people with a diagnosis of mental illness whose physical health experiences and needs are often overlooked.

In this talk, Kate Johnston-Ataata will introduce Healthtalk Australia (HTA), the leading research-based online repository of personal accounts of health and illness experiences in Australia and briefly outline its objectives and approach to collecting and disseminating personal stories online. Next, Dave Peters, a participant in the 'Mental Health and Supported Decision Making' HTA project, will reflect on sharing his lived experiences online and the interconnections between physical and mental health in his own story. The presenters will then discuss key findings from the 'Mental Health and Supported Decision Making' project relating to the intersection of mental and physical health, and offer suggestions for future research and online resource development on this important but neglected topic.

Presentation Links

Slides Video

Nurses: Part of the solution

Kim Ryan

Abstract:

There are over 400,000 Nurses and Midwives in Australia, working across all health care settings and more geographically dispersed than any other health care professional. Building awareness, and increasing assessment and monitoring of people's physical health, across this extensive workforce, will no doubt result in improvement of the physical health of people with mental illness. This presentation will discuss the work of the ACMHN to build knowledge and capacity across these workforces.

Presentation Links

Slides Video

Process and progress: The physical health of those with a serious mental illness -an advocacy priority

Kym Jenkins

Abstract:

People with serious mental illness typically live between 10 and 32 years less than the general population. Around 80% of this higher mortality rate can be attributed to the much higher rates of physical illnesses experienced by this population, such as cardiovascular and respiratory diseases and cancer.

Recognising the devastating human cost, as well as the cost of serious mental illness to the Australian economy in terms of health care, welfare, and lost productivity, this presentation will outline the Royal Australian and New Zealand College of Psychiatrists (RANZCP) role in advocating for best practice health care for people with mental illness.

All of us in the health sector, including psychiatrists; allied health and other medical professionals; community, mental health and health organisations; can and should advocate for policy and clinical changes to improve the life expectancy of people with serious mental illness.

The RANZCP produced a series of reports examining barriers to health care and the economic costs associated with serious mental illness. Developments since the production of these reports will be highlighted during this presentation, as well as other endeavours where the RANZCP has tried to affect changes in this important area.

Concurrent presentations

Theme: System level reform / Coordinated care

Addressing the physical health of people with mental health conditions – the Brisbane North PHN experience

Libby Dunstan

Presentation Links

Slides Video

Abstract:

Brisbane North PHN is one of 31 Primary Health Networks across Australia. We work with local communities, consumers, carers, health professionals, hospitals and community providers to understand our community and their needs. We then engage with stakeholders to design and commission programs and services to meet those needs. One of the Brisbane North PHN's priorities is improving the quality, coordination and integration of mental health, suicide prevention and alcohol and other drug services.

A key area of focus has been the development of a Regional Plan for North Brisbane and Moreton Bay focusing on mental health, suicide prevention and alcohol and other drug services 2018-2023. The regional plan sets out the challenges facing us and what we can all do over the next few years to improve the quality, coordination and integration of services. This presentation will cover some of the experiences of the Brisbane North PHN, the opportunities and challenges as a PHN in addressing the physical health needs of those living with mental illness, delivering on the intent of the Equally Well Consensus Statement.

Integrative multidisciplinary services — key to improvement in mental health care delivery

Steven David

Presentation Links

Slides Video

Abstract:

Background: Patients with psychiatric disorders have shorter life spans compared to the general population. Metabolic diseases, cardiovascular disorders and other adverse health conditions are common among patients with psychiatric disorders. In addition, Australian studies undertaken in the community health sector have shown that individuals with mental illnesses who receive a collaborative medicines review have between four and seven medication-related problems per person, including problems with adverse drug reactions and interactions.

Method: A community mental health team (CMHT) in rural New South Wales was introduced to a multidisciplinary approach of integrating the roles of nurses, Psychiatrists and mental health pharmacists in order to improve the quality of mental health service delivery. A steering committee was formed to recognise priority change ideas. The study focussed on: a) recognising high risk patients that would benefit from a comprehensive medication review b) developing strategies to regularly monitor and review cardio metabolic parameters in mental health care clients c) training CMHT staff to obtain a best possible medication history (BPMH) d) effectively engage GPs in the care of mental health care clients.

Results: Baseline data (February-April): less than 8% of CMHT clients had an accurate medication history and less than 5% of CMHT clients had a documented cardio metabolic screen in the previous 3 months. Post intervention data (October-November): 67% of CMHT clients had a documented cardio metabolic screen and an accurate medication history, 13 medication related errors and 6 events of adverse drug reactions were identified and prevented and 8 clients were commenced/had their therapy modified for a diagnosed cardio metabolic disease.

Conclusion: The need for multidisciplinary integration is essential in improving mental health care service delivery. This study highlights an approach all CMHTs can adopt to improve the care provided to their mental health clients.

Keeping the Body in Mind: A lifestyle intervention program for people with severe mental illness

Andrew Watkins

Presentation Links

Slides Video

Abstract:
Research literature consistently points towards the benefits of integrating lifestyle interventions into mental health services to address cardiometabolic disease in people that experience Severe Mental Illness. Despite this weight of evidence mental health services have largely struggled to find ways to implement lifestyle interventions into their activities.

Keeping the Body in Mind (KBIM) is a lifestyle intervention program that commenced in 2013 and has been successfully implemented in South East Sydney Local Health District. KBIM has been implemented in a staggered manner commencing with youth with psychosis, followed by consumers taking clozapine and then those on Long-Acting Injectable medications. This method has been followed to allow for culture change amongst service users and to ensure that lifestyle interventions can be assertively offered to all mental health service participants.

Another area of focus for KBIM has been culture change for management and clinicians within the mental health service, this has been achieved through extensive education and a lifestyle intervention program for staff. This program called Keeping our Staff in Mind has demonstrated improvements in attitudes, confidence and knowledge around metabolic health screening and interventions.

This presentation will describe the evolution of KBIM and discuss the progression of each stage of the rollout of the service along with evaluated outcomes of its implementation.

Theme: Supporting healthy lifestyles – Smoking

Presentation Links

Slides

Mental health and smoking cessation

John Allan

Abstract:

Restrictions on the sale, advertising and public use of tobacco products, public health messaging and widespread availability of effective treatments have all contributed to the lowest population smoking rate ever (11.1% smokers and 28.4% ex-smokers 55.9% never smoked, CHO Qld 2018). The significant disparity in smoking prevalence between the general population and people experiencing mental illness in Australia has been known for some time and despite our current efforts, that gap may be widening (56% smokers in mental health inpatient units, Qld 2017).

Considering the changes over the last 30 years it appears that public policy, pricing restrictions and messaging have had the biggest effect. Why hasn't this effect been achieved for people living with a mental illness?

This paper will explore the history of the relationship between the mental health system and tobacco and asks what further changes we need to make in public policy to achieve parity: setting targets, priorities for services, different messaging, outright bans, legislative change including new technologies. Should we modify our clinical approach to include harm minimisation for more people and do new technologies such as vaping offer a panacea or are they a dangerous flirtation?

Presentation Links

Slides

Quitlink: A peer supported smoking cessation research project

Nadine Cocks and Lisa Brophy

Abstract:

People with severe mental illness (SMI) typically die 20 years earlier than the general population, largely due to smoking related diseases. Their smoking rate is alarmingly high and persistent, which contrasts sharply with the steady decline in the general population's smoking rate. Smokers with SMI are equally motivated to quit smoking, but report less encouragement to quit by health professionals and are less able to succeed. When engaged in a program, some can quit successfully, but at lower rates than for the general population. Evidence-based smoking cessation interventions, such as quit lines, are underutilised by smokers with SMI. There is an urgent need to develop highly accessible, appropriately tailored cessation services for smokers with SMI to which mental health services can routinely refer smokers, and to explore why low smoking cessation rates persist among people with SMI receiving cessation treatment.

Quitlink, a research project led by the University of Newcastle will utilise peer workers to identify, support, and refer smokers with SMI in mental health services to Quitline, who will deliver a tailored, proactive and accessible smoking cessation intervention. We believe that the involvement of a peer researcher with lived experience of service usage, smoking and recovery, will enhance people's interest in the study and their willingness to participate. We are already seeing this evidenced in the work to date. Additionally, we wish to investigate participant and health worker perceptions of the support provided by Quitlink, the nature of barriers encountered and their impact on initiating and succeeding with cessation.

Theme: Carers and supporters

Catch 22: Taking a holistic approach to health - the mental health family and friends experience in Victoria

Marie Piu

Presentation Links

Slides

Abstract:

Tandem is proud to be the trusted voice of family and friends in mental health in Victoria. In February 2018 Tandem was one of the organisations and individuals gathered together by the Office of the Chief Psychiatrist to advise on the Victorian response to Equally Well; quality of life – equality of life. As part of our contribution, a focus group and follow up interviews were held with Tandem members, particularly those family and friends with in depth knowledge in this area. The topic was explored through a series of questions to provide insight into physical activity and wellbeing for those living with mental health issues, through the lens of family and friends (mental health carers).

Theme: Peer work and co-design

Physical health and mental illness: Giving a voice to consumers

Katherine Moss

Presentation Links

Slides

Abstract:

Authors: K Moss[1,2] E Heffernan[2,3] C Meurk[2,3] M Steele[2,3]

[1] West Moreton Hospital and Health Service, Brisbane, Australia

[2] Faculty of Medicine, University of Queensland, Brisbane, Australia

[3] Queensland Centre for Mental Health Research, Brisbane, Australia

Background: Implementation science developed out of the finding that evidence-based practices take, on average, seventeen years to be incorporated into routine practice in health. There is now widespread evidence documenting the benefits of physical activity for patients with severe mental illness. A forensic setting poses unique challenges with regards to implementing physical activity interventions for patients. Despite this, incorporating physical activity into treatment programs for patients who reside in government run secure settings can be regarded as an important component of recovery and care.

Objectives: This presentation will report the preliminary findings of a questionnaire informed by implementation science (theoretical domains framework) and semi-structured interviews with patients exploring barriers and facilitators to physical activity for patients with severe mental illness residing in a secure facility.

Methods: This study will gather qualitative data using a questionnaire and semi-structured interviews.

Findings: The following data regarding physical activity in a high secure setting will be reported on: (i) patient knowledge, (ii) environmental context and resources, (iii) motivations and goals, (iv) beliefs about capabilities, (v) skills, (vi) emotions, (vii) social influences, (viii) beliefs about consequences, (ix) action planning, (x) coping planning and (xi) goal conflict.

Conclusions: This study highlights the barriers and facilitators to physical activity as reported and experienced by forensic patients with severe mental illnesses residing in a secure facility. Implementation science can assist in identifying these factors.

Theme: Focus on community care

Chronic disease preventive care provision in one mental health community-managed organisation

Lauren Gibson

Presentation Links

Slides

Abstract:

Authors: Lauren Gibson, Kate Bartlem, Alison Rasmussen, Jade Ryall, Jenny Bowman

Background: Community Managed Organisations (CMOs) are a promising setting to deliver preventive care for chronic disease risk behaviours to people with a mental health issue. Previous research suggests that some CMOs are providing programs to support the physical health needs of consumers, but these do not seem to be systematically or routinely provided. This study aimed to explore the extent to which staff members of CMOs are currently providing preventive care for chronic disease risk behaviours to people with a mental health issue.

Method: A self-administered cross-sectional online survey was conducted with staff of one CMO from August to November 2017. A total of 268 current staff members completed the survey, with 232 providing information on current levels of preventive care delivery.

Results: Levels of preventive care provided differed depending on the type of risk behaviour; with the highest average proportion of consumers provided care for physical inactivity (44% to 68%) and the lowest average proportion of consumer provided care for harmful alcohol consumption (30% to 55%).The level of care provided also differed by preventive care element; ranging from 68% of consumers provided with an assessment of risk status (for physical activity), to 30% of consumers provided with a referral to a behavior change service (for those identified as 'at risk' for harmful alcohol consumption).

Conclusion: These results suggest that some chronic disease risk behaviours are being addressed more consistently than others, and more intensive preventive care elements, such as providing referrals to behavior change services, are provided less frequently. CMO staff members may require more training around how to provide preventive care and/or how to do this for particular risk behaviours that staff may not be comfortable or confident talking about. Further exploration of the barriers and facilitators to providing chronic disease preventive care in this setting is required.

CMO connect: a role for CMOs in connecting physical and mental health

Tara Clinton McHarg

Presentation Links

Slides

Abstract:

Authors: Tara Clinton McHarg, John Wiggers, Luke Wolfenden, Kate Bartlem, Andrew Searles, Andrew Wilson, Magdalena Wilczynska, Joanna Latter, Lauren Gibson, Jenny Bowman.

Background: The 'CMO Connect' project will explore the potential role that mental health community managed organisations (CMOs) might play in providing chronic disease preventive care to people with a mental health issue. The project aims to identify: 1) current CMO preventive care practices; 2) barriers and facilitators to CMO staff providing preventive care; 3) consumer preferences for receiving preventive care; and 4) the organisational mechanisms that may support CMOs to provide preventive care systematically.

Method: This collaborative project (utilising quantitative and qualitative methods) will be undertaken over 2.5 years with mental health CMOs in NSW. The methods of each of the project's sub-studies will be described including: an online survey of CMO leaders to identify the chronic disease-focused programs and support they offer consumers; an online survey to explore CMO staff member roles in the provision of preventive care; telephone interviews with consumers to learn about their preferences for support; and in-depth focus groups with consumers, staff and managers to gain insight into what models of preventive care might work in the CMO setting.

Results: The study will provide a comprehensive picture of the preventive care that is currently being provided by CMOs, the potential barriers and facilitators to its provision, and mechanisms that could enhance the systematic provision of such care. Based on the findings from the four sub-studies, one or more models of preventive care provision in CMOs will be developed and pilot tested in one CMO.

Conclusion: Learnings from this study will assist other CMOs, and those who work with them, to understand how preventive care might be able to be integrated into practice in their organisation. The project also hopes to deliver one or more feasible, cost-effective models for the provision of preventive care that could be adopted and implemented by CMOs across Australia.

Theme: GP care and PHN, NGO, LHN coordination

Presentation Links

Slides

Ways in which GPs can manage physical illness alongside mental illness and suggestions to support team-based collaborative care

Mark Morgan

Abstract:

The presentation will describe the rationale, development and outcomes of a series of projects in general practice that managed mental illness alongside diabetes and heart disease in the TrueBlue trial. Dr Morgan will describe some of the recent policy recommendations that have come from the Medical Benefits Schedule Review and the government's Health Care Home trial to support this work. The presentation will conclude with some thought-provoking suggestions for future policy directions.

Some lessons have been that whilst local ownership is important for 'on the ground change', this is difficult without connection to policy and broader networks supporting change. Another has been that partnerships enhance options for improving physical health: but the depth and orientation of local partnerships will, and probably should, determine local application.

NSW is currently applying these lessons in commencing a statewide project to improve physical healthcare of consumers of older persons mental health services. The presentation will conclude with a description of the methodology, partners and progress to date.

Theme: Prevention and early intervention across life's stages

Presentation Links

Slides Video

Improving physical health care in mental health services for older people: Reflections on a decade of local and statewide initiatives.

Rod McKay

Abstract:

2019 marks a decade since NSW released its first policy and guidelines regarding the physical health care of mental health consumers. As chair of the Expert Working Group that guided their development it also marks a decade of local and statewide activities by the author to improve such care: and other activities that promote good physical health care.

The breadth and nature of these activities reflects the broader approach to improving mental health services for older people in NSW, with state direction and facilitation encouraging local action. They also reflect the evolving recovery orientation of services, and increasing number of partners that entails. The presentation will provide reflections on lessons from activities over this time including development of guidelines, self audit tools, benchmarking and models of care.

Some lessons have been that whilst local ownership is important for 'on the ground change', this is difficult without connection to policy and broader networks supporting change. Another has been that partnerships enhance options for improving physical health: but the depth and orientation of local partnerships will, and probably should, determine local application.

NSW is currently applying these lessons in commencing a statewide project to improve physical healthcare of consumers of older persons mental health services. The presentation will conclude with a description of the methodology, partners and progress to date.

Presentation Links

Slides Video

Improving the health of LGBT+ people: what does "early intervention" mean in a landscape of social inequality?

Katherine Johnson

Abstract:

The health of LGBT+ people is widely recognised as carrying numerous consequences across the lifespan, including but not limited to, elevated rates of psychological distress and life-time risk for suicide, weight-related health concerns (too fat, too thin) and diseases associated with increased rates of smoking, alcohol and recreational drug use. Despite the individualising tone of much health prevention literature, within the field of LGBT health the impact of social discrimination is offered as a key explanatory factor where health outcomes are related to ability to access appropriate and acceptable health services, and health-related behaviours can be seen as coping strategies for stigma, rejection, and safety. Drawing on examples* from community-based research with LGBT people in the UK this paper examines the entwined relationship between physical and mental health for LGBT people and asks what might an early intervention to improve the health and wellbeing of LGBT people look like in a landscape of social inequality?

*** Content warning:** the material presented contains some accounts of psychological distress including suicidal thoughts and experiences.

Theme: Consumer perspectives and rights

Presentation Links

Slides

The role of advocacy in maintaining the right to health

Wanda Bennetts

Abstract:

IMHA is the first Independent Mental Health Advocacy service in Australia. It is a statewide non-legal advocacy service that provides advocacy to people who are at risk of or are subject to compulsory treatment under Victoria's Mental Health Act 2014. IMHA advocates work with people using a representational model of advocacy that is based on taking instructions from the person. Advocates work from a Supported Decision Making framework that allows a person to make their own decisions and express these to people in their lives.

Physical health and the response to these needs is a concern for many of the people that advocates work with, being an issue identified across the state over the past three years. This presentation will give you an overview of IMHA and some examples of how its advocacy model works in practice.

Presentation Links

Slides

Consumer/carer experiences of FND: The abyss between brain, mind and body

Katherine Gill

Abstract:

Functional Neurological Disorder (FND) is classified as a Mental Illness in the DSM-V, but involves a variety of disabling, distressing and debilitating neurological symptoms, including paralysis, gait disorder, tremors, fatigue, chronic pain, seizures and blindness. Historically FND was thought to be associated with trauma. Recent fMRI studies have identified abnormalities in the functioning of the brain(1). Functional disorders are one of the most common diagnoses in neurologic practice(2), but this is not reflected within mental health services, or the level of public awareness, funding and services available to people with FND.

A recent study funded by the National Mental Health Commission, surveyed 179 consumer and carers about their experiences of FND in Australia. The outcomes highlighted significant gaps in regards to knowledge, attitudes and services for FND. Many people (79%) reported distressing experiences when seeking care. Many struggled to obtain a diagnosis of FND. Failure to diagnose early, after onset of symptoms, can lead to iatrogenic harm, repeated testing and significantly worse outcomes. After diagnosis, treatment was difficult to access; only 36% of consumers accessed any form of treatment in the six months post-diagnosis, significantly increasing the risk for permanent disability.

FND crosses the divide between physical and mental health(3). It lacks a medical home, with neither neurology nor psychiatry taking ownership for the care of people with FND. This is reflected in the lack of services, and poor awareness and knowledge of FND across health services and the community. The system gaps are having devastating consequences on the mental and physical wellbeing of consumers. Their quality of life is greatly affected; people are unable to participate in valued daily activities, including employment, leading to dire financial impacts for many families. The outcomes of the study will be presented at the symposium with recommendations to address the serious system gaps.

References:

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2. Stone, J., et al., Functional disorders in the Neurology section of ICD-11: A landmark opportunity. Neurology, 2014. 83(24): p. 2299-2301.
3. Perez, D.L., et al., Bridging the Great Divide: What Can Neurology Learn From Psychiatry? The Journal of Neuropsychiatry and Clinical Neurosciences, 2018. online ahead of print: p. appi.neuropsych.17100200.

Theme: Supporting healthy lifestyles - diet and exercise

Presentation Links

Slides

The physical health and activity of forensic mental health patients

Katherine Moss

Abstract:

Authors: K Moss[1,2] E Heffernan[2,3] C Meurk[2,3] M Steele[2,3]

[1] West Moreton Hospital and Health Service, Brisbane, Australia

[2] Faculty of Medicine, University of Queensland, Brisbane, Australia

[3] Queensland Centre for Mental Health Research, Brisbane, Australia

Background: Addressing the physical health needs of forensic patients in high-security settings is complex. The physical health of patients is often compromised by the requirement of long term inpatient stays, limited access to physical activity and a high prevalence of psychotic illness and anti-psychotic treatment. It is important to consider diverse treatments, learn from previous research findings and address whether specific treatments will fit within the culture of an organisation.

Objectives: This presentation will explore: (1) the current physical health status and health risk factors (2) current physical activity and (3) patient activation measures of patients at the High Secure Unit of The Park, Centre for Mental Health.

Methods: This study is a descriptive study using a mixed methods approach. Both quantitative and qualitative date will be reported on.

Findings:

The following data will be reported on:

- Metabolic factors (height, weight, waist circumference, blood pressure, fasting glucose, triglycerides/cholesterol, HDL/LDL), weight change since admission, rates of metabolic syndrome/type 2 diabetes
- Medical history, family history of cardiovascular risk factors
- IPAQ – SF (International Physical Activity Questionnaires Short Form)
- PAM (Patient Activation Measure)

Conclusions: This study will demonstrate the ongoing poor physical health status of long-stay psychiatric patients. By considering diverse treatments and taking into consideration the culture of an organization, it is anticipated that improved treatment options can be devised.

Low intensity CBT for clients with chronic disease identified by allied health professionals

Nicci Tepper and Fiona Glover

Presentation Links

Slides

Abstract:

Supporting people with long term-conditions is a major challenge of health services globally (UN Secretary General, 2011). An increasing prevalence of long-term conditions and soaring costs create an urgent need to redesign health services (Tinetti, Fried, & Boyd, 20132). The case for integrating physical and mental health care is compelling. However, its translation into practice, both locally and internationally, is beset by health system siloes, service gaps, care coordination governance, agreement on what constitutes 'value' and cultural difference between professional groups (Naylor et al, 2016).

Individuals with a mental health diagnosis often experience many barriers to engaging in physical activity such as lack of motivation, increased physical comorbidities, pain and the side effects of medication (Firth et al, 2016a, 2016c). Evidence suggests that people who are "activated:, that is, have the knowledge, skills and confidence to manage their health effectively, are more likely to make healthy lifestyle choices and have better health outcomes and care experiences (Hibbard & Greende, 2013). Time spent with collaborating with health care providers is therefore key to providing resources and coaching that encourage self-management.

Remedy Healthcare delivers a broad range of health services across Australia, our multidisciplinary team, with expertise across both physical and mental health, provide us a unique opportunity to implement strategies to improve the overall health of clients. Recently, we have implemented an innovative model of care that leverages existing chronic disease management and care coordination programs with MindStep; a co-located Low intensity cognitive behavioural therapy (LiCBT) program to successfully integrate physical and mental health care in the private sector. This service now has the capacity to provide "dose-specific" levels of coaching required by the person to "activate" clients to engage in healthy lifestyle interventions such as physical activity, diet, sleep, and social engagement and address co-morbid mental health concerns, such as anxiety and depression.

During this presentation we will share outcomes of both the health coaching programs and MindStep Low-intensity cognitive behavioural therapy program and preliminary results for people when both programs are used in concert. We will also share our exciting plans for future service directions.

Referemces:

Hibbard, J.H., & Greene, J. (2013). Supporting people to manage their health – An Introduction to patient activation. London: The King's Fund

Naylor C, et al. 'Bringing together physical and mental health: A new frontier for integrated care' Journal of the Royal Society of Medicine, Oct 2016 [online] Available: https://journals.sagepub.com/doi/full/10.1177/0141076816665270 (Accessed Jan 2019)

Tinetti, M.E., Fried, T.R., & Boyd, C.M. (2012) Designing health are for the most common chronic condition – Multimorbitity. Journal of the American Medical Association, 307, 2493-2494

Promoting health without stigma: Delivering a weight-neutral behaviour change program

Mandy Lee-Noble

Presentation Links

Slides

Abstract:

Severe mental illness is characterised by a 20-year mortality gap due to cardiometabolic disease (Teasdale et al., 2016). Research dietitian Scott Teasdale from the University of New South Wales demonstrated a lifestyle program could improve dietary quality and physical activity in a group of people who had recently commenced antipsychotic medication. Healthy Bodies, Healthy Minds (HBHM) is designed to address this identified need. HBHM is an exercise and nutrition program for people with mental illness, delivered by exercise physiologists and dietitians. The program is held at gym facilities of PCYC Queensland and collaboratively delivered with a partnering mental health organisation. Since beginning in 2015, over 35 programs at 13 PCYC sites across Queensland. Richmond Fellowship Queensland (RFQ) have been the strongest partner in these initiatives, co-delivering half of these programs. Delivery of the programs by RFQ dietitians lies within the HAES® paradigm promoting all of the five HAES® principles: Weight Inclusivity, Health Enhancement, Respectful Care, Eating for Well-being and Life-enhancing Movement. The program involves a weekly two-hour group session. In the first hour participants eat together with a dietitian and discuss nutrition-related goals such as: realistic goal setting for health, accessing nourishing foods within a budget, enjoyment of eating. In the second hour the participants work with an exercise physiologist to build an enjoyable exercise program within their individual physical abilities. This program is currently being evaluated in a randomised controlled trial with QIMR Berghofer Medical Research Institute, Metro North Mental Health and Metro South Addictions and Mental Health Service. PCYC Queensland received the 2018 Open Minds Not-for-profit Large Mental Health Week Achievement Award, and Program Manager Dr Justin Chapman received the 2018 Open Minds Individual Achievement award for work associated with this program. An overview of the program and future directions will be provided in this presentation.

Teasdale, S. B., Ward, P. B., Rosenbaum, S., Watkins, A., Curtis, J., Kalucy, M., & Samaras, K. (2016). A nutrition intervention is effective in improving dietary components linked to cardiometabolic risk in youth with first-episode psychosis. British Journal of Nutrition, 115(11), 1987–1993. https://doi.org/10.1017/S0007114516001033

Theme: The National Perspective

The national perspective

Murray Wright

Presentation Links

Slides

Abstract:

The Fifth National Mental Health and Suicide Prevention Plan states that 'All Governments and mental health commissions will embed the elements of Equally Well and take action in their areas of influence to make changes towards improving the physical health of people with mental illness.'

In this presentation, Murray Wright will describe from the perspective of a national governance committee how this will be monitored, and ways in which this monitoring role can actually influence and accelerate change.

Presentation Links

Slides

Fifth Plan's priority 5 – Improving physical health: Progress and update

Marcus Nicol

Abstract:

Presented by Catherine Brown, National Mental Health Commission.

The presentation will cover the National Mental Health Commission's (NMHC) role in reporting progress on the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan), with a particular focus on Priority Area 5: "Improving the physical health of people living with mental illness and reducing early mortality relevant to physical health".

High-level results from the NMHC survey of Fifth Plan stakeholders will be presented, providing insight into feedback from key stakeholders (Primary Health Networks, state, territory and Commonwealth governments) with regards to achieving progress in Priority Area 5 of the Fifth Plan.

Presentation Links

Slides

What works in system reform

Jenny Bowman

Abstract:

'Improving the physical health of people with a mental health condition' is a complex, wicked problem. The myriad of interdependent factors at play – across levels that include individuals, organisations, communities and public policy – represent a system. Theory and research have helped identify strategies for achieving systems change… that can be helpful in whatever our own sphere of influence might be. Research with mental health services to increase the provision of preventive care for modifiable chronic disease risk behaviours is presented as an example of systems change strategies in action. Equally Well, and this symposium, can be seen as another.

Theme: Focus on quality care

Talking to people with serious mental illness about bowel cancer

Lisa Brophy

Presentation Links

Slides

Abstract:

Life expectancy in people with severe mental illness (SMI) is between 15 to 20 years less than that of the general population, a gap that is similar to that experienced by Indigenous Australians. The vast majority of excess deaths are due to chronic physical disease, including cancer. The team undertaking this study, led by Prof Steve Kisely at the University of Queensland, has undertaken previous research that has shown that cancer incidence rates in people with SMI are similar to those in the general population, but that cancer mortality is higher. Possible explanations include: 1) Poor cancer screening participation rates in those with SMI; 2) delays in diagnosis leading to more advanced disease at diagnosis; & 3) sub-optimal post-diagnosis management.

I will be leading the qualitative component of this large study that will further investigate these issues using a range of mixed data collection methods. In focus groups, we will investigate the experience of people with SMI and colorectal cancer (and their carers) in relation to the barriers and enablers to screening, diagnosis and optimal care. The focus groups will ensure that the voices of people with lived experience of SMI and bowel cancer are heard and contribute to helping to understand what is happening when people are diagnosed and access care. The overall results of the study may indicate the actions required to decrease inequity and enhance this marginalised group's access to optimal care, thereby improving their health outcomes. Findings may also have implications for other disadvantaged groups and other health problems.

Heartscapes: A new narrative for understanding the complexities that underpin cardiovascular vulnerability

Teresa Kelly

Presentation Links

Slides

Abstract:

Authors: Ms Teresa Kelly[1], Associate Professor Bridget Hamilton[1], Professor Sharon Lawn[2], Professor Suresh Sundram[3]

[1] School of Health Sciences, The University of Melbourne

[2] Department of Psychiatry, Flinders University

[3] School of Clinical Sciences, Monash University; Monash Health.

People who live with mental illness such as schizophrenia and bipolar disorder are vulnerable to premature mortality. The leading cause of death is cardiovascular disease. Extensive research has produced important biomedical knowledge of this complex health problem. However, this knowledge has not translated into improvements in the cardiovascular health of people who live with mental illness. This PhD research project explored this real-world problem through the stories of ten people who live with mental illness.

Using an interdisciplinary and multi-perspective approach generated a new narrative for understanding the cardiovascular risks associated with living with mental illness; one that views the person and their cardiovascular

vulnerabilities in the context of a much broader narrative.

This new narrative extends beyond the parameters of biomedical and biopsychosocial frames. It affirms mental illness to be a powerful generator of a complex array of interconnected cardiovascular risks. By shifting the lens from stories of illness to stories of transformation, this new narrative points to connection as a fundamental precursor to holistic heart health. From this perspective, heart health is not separate from recovery-oriented care; rather it depends on it.

The translation of the findings of this narrative research into policy in Victoria is already underway.

In this paper, we will showcase the Heartscapes. We will share the key discoveries and outline implications for policy, research, and practice. We will conclude with a call for a radical, relational and transformational approach to holistic heart health.

Theme: Lessons of implementation

Presentation Links

Slides Video

Rod McKay and Kate Jackson

Abstract:

Based on a combined 30 years of experience converting national and state policy into local action and service development, this workshop will briefly overview some of the essential enablers and difficult obstacles to effective implementation. The workshop participants will then consider ways of considering the populations that actions may target (eg different ages, settings, risk profile). Based on the principles of successful implementation, participants will be guided to draft specific actions they could apply to their particular context. Groups will then consider a set of recommendations for action for each population group. Finally the workshop will bring together and summarise recurrent themes from each of the workshop groups.

Theme: Navigating mental health in a digital world: How safe is it?

Presentation Links

Slides

Peggy Brown

Abstract:

As digital technology extends its reach into mental health and physical health care through a range of e-health options, how well are consumers, carers and clinicians equipped to assess the safety and effectiveness of a digital service? This workshop will outline a project that is looking to develop a quality assurance framework for digital mental health services and will explore some of the key issues under consideration.

Theme: Where best to invest enable meaningful reform

Presentation Links

Slides

John Allan

Abstract:
This interactive workshop will invite participants to consider the focus and modes of actions that might result in optimal physical health outcomes for people living with mental illness. Based on his experiences and leadership of local, state and national reform initiatives, John will reflect on mental health reforms in the past that have shown the "best return on investment" and skills or success factors required. This workshop will then develop focus areas for reform such as education, consumer empowerment, health service standards, and service development. The groups will then workshop action areas most likely represent best value for money for improving the physical health of people living with mental illness, both in the short-term and long-term. The participants will also consider how these action insights might be applied to their current role and context.

'A Spoonful of Sugar' - Medications and Side Effects

Presentation Links

Slides

Wanda Bennetts

Abstract:
Medication is a very controversial topic and one that can create a lot of challenges for those taking medications. There are many issues and these can vary for each person. The topic is even more critical in light of the impacts that medications have on a person's physical health particularly when they have no choice or legally compelled to take them.

This workshop is consumer led and asks participants to put themselves in the shoes of the person taking medication for a brief while. It invites the participants to reflect on their personal attitudes towards medications and how these attitudes impact upon practice. It also creates time and space for discussions to unpack the issues and consider how personal practice may change as a result of this reflection.

Panel and summary session

Presentation Links

Video

Mark Morgan, Indigo Daya and John Allan

Launch of the “Equally Well in Victoria” – Physical Health Framework for Specialist Mental Health Services

Anna Love

Presentation Links

Video

Action summary

Dave Peter, Russell Roberts, Kim Ryan and Chris Maylea

Presentation Links

Video

Call to action

“Do you plan on being old? I don’t!”

“Every man is guilty of all the good he did not do.”
Martin Luther King

“It is not sufficient to see and to know the beauty of a work. We must feel and be affected by it.”
Martin Luther King

Dear Reader,

This letter is not an academic paper, just as my presentation at the Equally Well Symposium in Melbourne in 2019 was not an academic presentation. It was not meant to be. I was invited to deliver the closing keynote address; to speak from my personal experience of having mental health issues and chronic physical health issues. I was also asked to speak from my long-term advocacy experience about the desperate need to close the gap between the health outcomes and premature deaths of people with mental health issues compared to people without mental health issues. I am capable of writing and delivering academic papers. I am a published academic writer. However, I have chosen to write a letter rather than a paper, because it is a mode of communication that is more in keeping with human to human communication and connection; peer connection.

As Martin Luther King so eloquently noted, “To know the beauty of a work we must feel and be affected by it”. I am writing to you to implore you to be affected by the plight of people who experience mental health issues and trauma, and to act accordingly in a powerful and positive way.

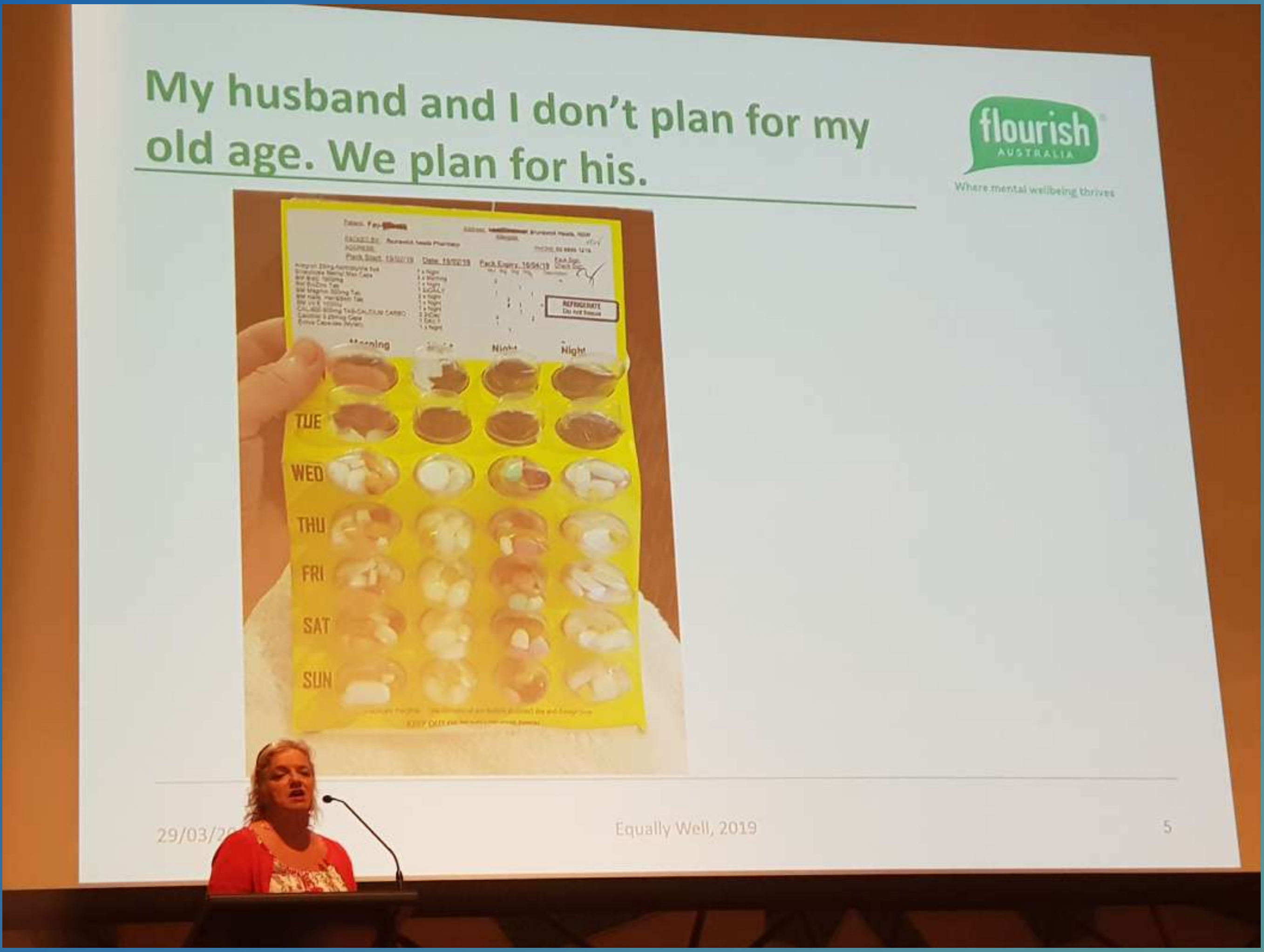
I am also writing a letter to you, rather than an academic paper including multiple references because I trust that my colleagues who presented at the symposium have written about the research and academic literature relating to the poor physical health of people with mental health issues. Please read their work.

Generally I do not use clinical language because this is the language of clinicians rather than the language of people with lived experience and peer workers. However, I have referred to mental illness a couple of times in this letter because if someone is doing an internet search about the physical health of people with mental health issues they will generally look for terms such as ‘mental illness’, ‘diagnosis’, ‘schizophrenia’ and ‘bipolar’. However, I believe we should not give people a diagnosis because a diagnosis can limit a person’s life and health purely because of the overshadowing of such a diagnosis and the discrimination that often accompanies it.

We should focus on people as a whole person with a past, present and future, with a mind, body and soul, with experiences of trauma and hope. We should focus on the person, their family and their needs rather than a diagnosis.

This letter is my call to arms; a hopeful challenge and encouragement for all clinical staff to do all they can to improve the physical health of those of us with mental health issues. For far too long too many people operating in clinical settings have seen the poor physical health of those of us with mental illness and trauma as a consequence of the choices we have made in our lives. They often consider our poor physical health is because we eat the wrong foods and drink too much, smoke, use drugs and don’t exercise enough.

However, I like multitudes of people who have been forced onto medications, put on a massive amount of weight within two months of being on medication – 22 kilos; I don’t smoke, don’t take non-prescribed drugs, nor do I drink alcohol often.



My husband and I don't plan for my old age. We plan for his.

flourish AUSTRALIA

Where mental wellbeing thrives

29/03/

Equally Well, 2019

5

I eat healthy diet, don't snack and when I am well enough, exercise every day. I am in a long-term committed relationship with my husband and have not been in poverty for the past 20 years. However, my physical health is extremely compromised. I take 27 medications per day and only two of those are psychiatric medications; the others are medications I need to manage the unwanted side effects of the psychiatric medications.

The psychiatric medications have compromised my weight, liver, kidneys, thyroid and nervous system. I have a neurological disorder caused by lithium that is like a cross between Parkinson's and MS.

My husband and I do not plan for my old age; we plan only for his.

I am writing to ask you not to relegate our poor physical health to being a consequence of our choices. It usually isn't. Please accept that the medications are a major contributor to us having very poor quality of life and causing our early deaths.

Another major contributor to our poor physical health is inequity in our health care. This is discrimination. I refuse to call it 'stigma'. Stigma is a word that has allowed the discrimination towards those of us with mental health issues to continue. Stigma is soft discrimination but it is still discrimination.

Doctors and other clinicians have regularly overlooked our physical health care. My experience in this has meant that I have not been treated until illnesses such as lung clots, pulmonary hypertension, cancer, neurological disorder, hormone imbalances etc. were advanced. However, I am one of the lucky ones; I have at least been treated. Better late than never. I put my luck in this down to the insistence of my husband that tests should be undertaken and treatment given. I must say that during the past seven years, I have seen a marked improvement in attitudes, towards me personally, by young doctors and specialists.

However, only 18 months ago I was treated with discrimination by a gastroenterologist who was extremely disrespectful towards me when he realised I was taking lithium. He pushed his keyboard out of the way, leant back in his chair with his arms folded and said, "So you have bipolar! So, you wouldn't be working then or have private health insurance." When I informed him I was working as a Deputy Commissioner with the NSW Mental Health Commission and as General Manager of Inclusion at Flourish Australia, he leant forward and wrote the word 'Delusional' in my file note. He stood up and showed me the door.

I am not signed up to the eHealth records because I do not want my mental health record to overshadow my physical health needs.

Worse than this, my mental health issues and discrimination by clinical staff towards me led to my younger daughter almost dying from gangrenous appendicitis when she was 13. I took her to the doctor three days in a row, but we were turned away without my daughter even being examined. I was asked, "Have you been taking your medication Fay?" On the third day the woman at the front counter asked me the same question! I called my husband and said, "George, Anna is going to die because I have bipolar and they won't listen to me or even examine her." My husband intervened, Anna was rushed to hospital and emergency surgery was undertaken. It took months for her to recover physically, however, she has never fully recovered mentally from the ordeal. She also had to have three more operations for hernias and has not yet had children. She is now 35.

Intergenerational mental health and physical health issues can and should be considered in the light of intergenerational trauma through human abuse, malpractice or natural disasters and through intergenerational discrimination by medical practitioners.

Granted, Anna's ordeal, our ordeal, was 22 years ago, and my hope is that this sort of discrimination has changed, however, I fear it has not. I say this because of the overshadowing and discrimination that still exists.

A recent report titled *The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness*, recommends changes to health policy to ensure better integration of physical and mental healthcare. "It really is a very severe problem," said Dr Firth, one of the authors of the report. "The extent of the gap in life expectancy between people with mental illness and the general population is actually increasing over time. Protecting the physical health of people with mental illness should be considered an international priority."

The report also found differences in the availability and quality of healthcare were to blame, with some research suggesting people with mental illness were less likely to have physical examinations in primary care, and less likely to receive medical or surgical interventions.

"The issue here is about equality," said co-author Simon Rosenbaum, a research fellow at the University of New South Wales.

Discrimination and inequality are part of the culture in Australian communities more broadly and especially in the medical community. We must eradicate these deeply harmful attitudes from our culture. Please, if you are a medical practitioner:

- Listen to us when we tell you about our health;
- Always check our physical health;
- Recognise that intergenerational trauma, mental health and physical health issues exist;
- When diagnosing us with a mental health issue, consider what the diagnosis and the medications you prescribe may mean to our whole life, our physical health and the inequity felt by us and our families.

Every one of my main previous and current chronic illnesses was relegated by clinicians as being 'all in my mind' until my husband advocated on my behalf. I am a strong advocate myself, however, if clinicians believe you are 'delusional' or 'attention seeking', self-advocacy amounts to naught. None of these illnesses such as lung clots, bowel, thyroid and uterine cancer, a neurological disorder, pulmonary hypertension etc. were in my mind! My Webster pack, shown at the forum, was offered to the audience as proof of my ongoing battle with poor physical health.

Please ask yourselves: “What would you want if it were you or someone you love with poor physical and mental health?”

Trauma affects our mental health, which in turn negatively impacts our physical health, and yet people are continuing to be secluded and restrained in hospitals and the justice system. The ‘Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities’ points to the continued abuse of human rights against people forcibly treated in mental health facilities. Although advocates had been calling for the cessation of these practices for decades, it took the death of Miriam Merten in Lismore Base Hospital in 2014 and the leaking of the footage of her demise in 2017 to trigger such a review. Miriam’s mistreatment and death shocked the community, and was the catalyst for establishing this review.

While many of the recommendations from the review were categorised as ‘must do’ actions, half were ‘should do’ actions. In a system that is struggling for funds and enough time to meet all current requirements, I expect that the ‘should do’ recommendations will not be given priority and may not be operationalised until such time as they become ‘must do’ actions.

With this in mind, I want to bring to your attention the International Convention on the Rights of Persons with Disabilities. People with a diagnosis of schizophrenia, bipolar, severe anxiety etc. are seen to have disabilities. The Convention points to “protecting the integrity of the person”. Article 17 of the Convention states that every person with disabilities has a right to respect for his or her (their) physical and mental integrity on an equal basis with others. Article 25 specifies that “persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability”. I argue that every day, in so many ways, hundreds of people in Australia have these human rights violated.

The International Convention on Civil and Political Rights claims: Some human rights are absolute—there is never any justification for violating them. These rights prohibit officials and others from committing genocide, slavery, summary executions, torture and racial discrimination. Also absolute are the personal freedoms of thought, conscience, religion and belief.

Certainly, we no longer commit genocide in Australia, however, history points to the fact that European invaders did commit genocide on Aboriginal people who are still paying the intergenerational price. Aboriginal people were placed into slavery and there were summary executions of Aboriginal people. While these things may no longer happen, the intergenerational effects of these traumas are still being felt today. Racial discrimination is still active today and torture is committed against anyone who is locked in seclusion and restrained. Many would argue that their enforced ECT or other medical treatments that negatively impacted their lives were also a form of torture.

I beseech you to consider that across Australia, public inpatient mental health services and justice health services violate these human rights every day.

I also beseech you to engage in true co-design and co-production of all services with people who have had first person experience of mental and physical illness. Please employ people with an awareness of world views about lived experience, who have strong voices of people with mental health issues, who have good grounding in human rights and the lived experience movement at high levels of your organisations. Be visionary and employ large numbers of peer workers and others with lived experience at all levels of service design, delivery, review and reporting.

Fifteen to 20 years ago, my positions as Consumer Consultant, Peer Worker, Manager Peer Workforce and Director of Consumer, Carer and Community Affairs with South East Sydney, Illawarra Area Mental Health Service were designated lived experience roles. My more recent appointments as Inaugural Deputy Commissioner with the NSW Mental Health Commission and as General Manager of Inclusion with Flourish Australia are designated lived experience positions. I didn't have these positions because I am unique; I had these positions because the boards and CEOs were visionary and sincerely wanted to know how to improve their service delivery, inclusive practices and coproduction.

Lived experience roles work very well if they are appointed by services who sincerely want to engage with lived experience wisdom and practices. Flourish Australia has 280 plus peer workers and we want to grow this workforce because we know it works beautifully for the people we support. Services must be there for the people they support rather than for the sake of the service.

Increasingly we need to see lived experience or peer operated services. We need multidisciplinary teams in which peer workers and other designated lived experience roles are respected partners in all aspects of service delivery and design.

Multidisciplinary teams must include clinical staff who care about and care for our physical health.

We need to be treated holistically and with compassionate understanding about intergenerational trauma, mental health issues and physical health issues. These must be front and centre.

Discrimination against people with mental health issues must stop.

Please see services as orchestras who are there to play the beautiful music of the people's lives the services support; the music they have written. The person must always be the conductor. Every piece of music is unique to each person. Every orchestra has many different instruments playing different parts to produce beautiful harmonies. Multidisciplinary teams are like the musicians in the orchestra. Each team member plays a different role to produce the best outcomes. Orchestras do not consist of only 30 violins or 30 oboes. Embrace the different musicians in a multidisciplinary team including people with lived experience. The person being supported must always be the lead.

We must have person-led services rather than person-centred services. Please recognise that these issues are human rights issues. Please ask yourself what are you going to do to make a difference? Then please take positive action.

Presentation Links

Slides Video

Sincerely Fay

Fay

Fay Jackson
Founder, Vision In Mind
General Manager of Inclusion, Flourish Australia
Inaugural Deputy Commissioner, NSW Mental Health Commission.

Conference Organising Committee

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Thank you to the volunteers who generously gave of their time and experiences to assist this event:

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Notes

Charles Sturt University acknowledges the wide range of terms often used within the field of mental health, such as service user, consumer, patient, client, person with lived experience and psychiatric survivor. These terms reflect local contexts, historical moments, political influences and preferences. We have used the term people living with mental illness. We also acknowledge the critique and limitations of all terms, including people living with mental illness.

We recognise and respect some authors in this book of proceedings have used different terms reflecting their context and situation.

Our sponsors

We gratefully acknowledge the support of our sponsors, whose generous support made this conference possible. It is important to Equally Well that financial cost was not a barrier that excluded people from attending this symposium.

The sponsorship of the organisations below enabled delegates to attend the symposium free of charge.

We wish to thank:

Charles Sturt University

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National Mental Health Commission

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