EQUALLY WELL
2022 SYMPOSIUM

Action and collaboration for hope and health

BOOK OF PROCEEDINGS
12-13 April 2022
Griffith University, Gold Coast Campus

EQUALLYWELL

Acknowledgement

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.

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.

Notes

Equally Well 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.

Recommended Citation

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FORWARD

Welcome

It was wonderful to meet face-to-face after a 2-year break due to COVID-19. To come together around a shared purpose and common goal is a joy and privilege, that until recent times we mostly took for granted. As an added bonus, joining the symposium virtually has also become much easier. The theme of the 2022 Equally Well Symposium was Equally Well: Action and collaboration for hope and health. COVID-19 brought restrictions to contact and moving around in the community. Thus, it tested health services' capacity, both in respect to 'action' and 'collaboration'. Providing safe accessible services requires flexibility and a focus on the needs and situations of those we work with.

These challenges provided profound insights into how we should be connecting with community, not only in times of infection control, lockdowns and contact restrictions; but how we should connect at all times. While not all services rose to the challenge of the occasion, those that did, responded with ingenuity and resourcefulness. The result was an enhanced focus on the consumer's needs and situation leading to a variety of service enhancements.

First, services developed ways to get in touch with people to see how they were going, and see what support they needed, and how best it could be provided. Second, they tried to adapt to the preferences of those they were serving. This was in contrast to the previous default position of requiring people to adapt to the preferences and convenience of the service providers. For instance, instead of requiring people to travel to the service, the service providers travelled to the people.

Third, organisations looked for ways to work together with other services and coordinate service delivery across a variety of domains. We saw different services combine, providing home visits to offer routine services, mental health, physical health, and social wellbeing checks and also offer vaccination support. Services also used SMS, phones, and videos to check-in regularly with their clients.

Finally, there was a mutuality, fuelled by the awareness that we were all in this together trying to adapt to a challenging and rapidly evolving situation. This helped us develop an increased sensitivity to the wellbeing of those around us: friends, colleagues, co-workers, collaborators and service recipients.

COVID-19 offered us these and many more lessons on how we could collaborate more effectively and more often. Our 2022 Equally Well Symposium highlighted many brilliant examples of collaboration, co-design and innovation in the face of unforeseen 'disrupters'. Going forward, the question is will we incorporate them into our everyday practice or will we fall back into unhelpful and unresponsive old patterns. We trust this book of proceedings will serve to remind us of how we apply these lessons in 'usual' times and in times of challenge.

Dave Peters
Symposium Co-Chair

Mal Hopwood
Symposium Co-Chair

Russell Roberts
Scientific Committee Chair

Panel: Inclusion as a necessary precursor to wellness
Cliff Lewis, Maggie Toko, Sharnie Roberts, Reza Rostami

Panel: Overcoming implementation barriers - Next steps
Vicki Langan, Fay Jackson, Andrew Watkins & Caroline Johnson

KEYNOTE HIGHLIGHTS

BY CATE CARRIGAN, CROAKEY

Articles from a report compiled by Croakey Conference News Service on their coverage of the Equally Well Symposium.

Equally Well – Progress in the movement by Mal Hopwood

In his opening address to the Symposium, Co-Chair of Equally Well and Ramsay Health Care Professor of Psychiatry, Malcolm Hopwood, spoke of progress in the Equally Well movement over the last five years.

Hopwood said the 2017 Equally Well Consensus Statement of the Mental Health Commission had outlined the need to address the poor physical health of those with mental illness, which significantly reduced their longevity.

The costs of these premature deaths were highlighted in a 2016 Mitchell Institute and Royal Australian and New Zealand College of Psychiatrists study that found the early deaths of those with severe mental illness was costing Australia $15 billion a year, he said.

Hopwood said central to the initial statement was putting in place a holistic, person-centred approach and there had been consensus that the best way to do this was through adapting/ improving existing services rather than creating something new.

Since then, Hopwood was pleased to see a cascade of policies and EW principles being recognised nationally in a number of ways, including in the Productivity Commission Report on mental health, which raised physical health comorbidities as a key issue.

A marker of success of the EW movement is to see initiatives permeating widely, he said.

“I personally feel very proud to be part of an organisation that’s managed to collect people from across the sector in a way that doesn’t always happen in mental health,” he said.

Improving the physical health of people with mental health problems: is there a role for peer workers?

by David Castle

Underlying health susceptibilities coupled with medically-induced weight gain are creating a ‘ticking time bomb’ of health risks for people with schizophrenia spectrum disorders, a conference on the physical health

Malcolm Hopwood (far right) attending the networking function with (left to right) Rosemary Calder, Dave Peters and Russell Roberts.

of people with mental illness has been told.

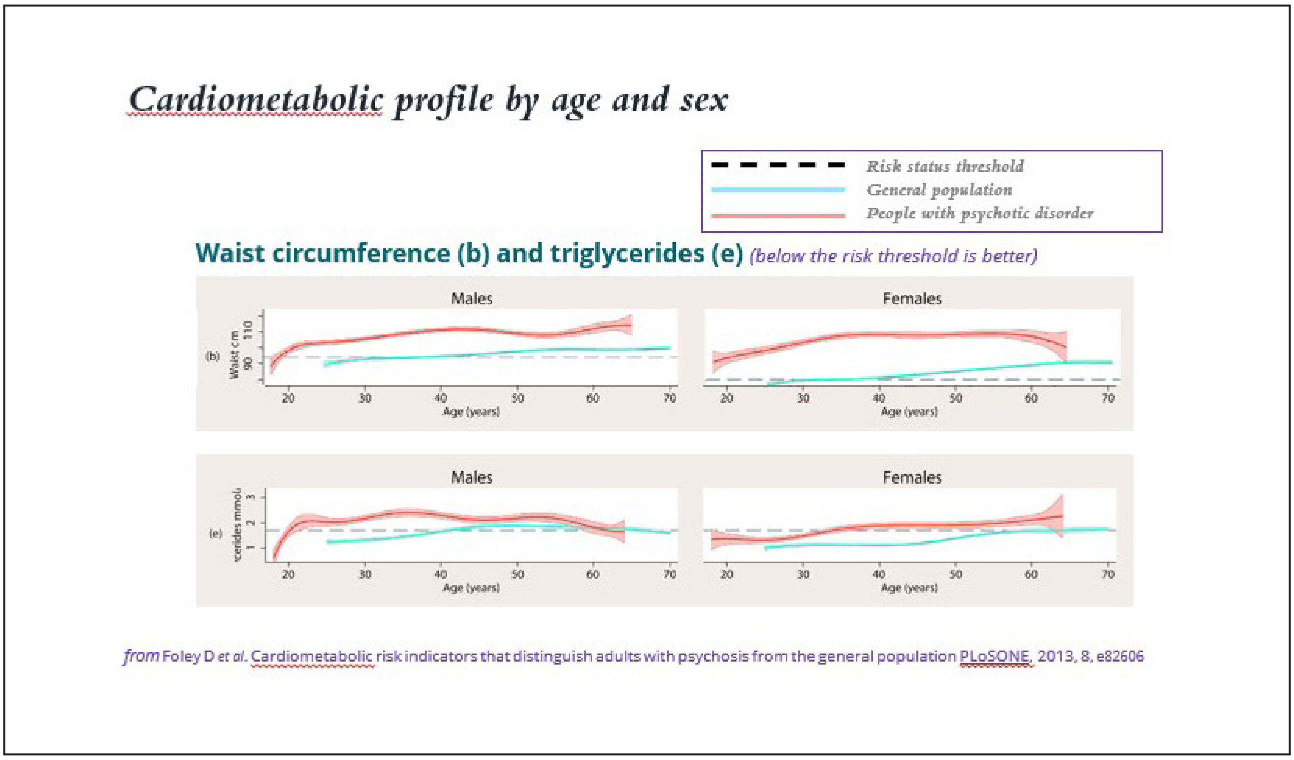
Professor David Castle, scientific director of the Centre for Complex Interventions at the Centre for Addictions and Mental Health (CAMH) at the University of Toronto, told the Equally Well 2022 Symposium that a united effort was needed to tackle the issue, and that peer workers could be central to this.

A keynote speaker at the two-day symposium, being held on the lands of the Yugambeh and Kombumerri peoples at Griffith University, Castle deplored the "appalling inconsistencies" in the provision of care to people with mental health problems.

Individuals with schizophrenia spectrum disorders are disproportionately affected by chronic diseases and physical health problems – such as cardiovascular disease (CVD), obesity, diabetes and hypertension – due to a combination of lifestyle, physiological, and social factors, shortening their life expectancy by 10-25 years, he told the two-day gathering.

People with schizophrenia are at higher risk of chronic metabolic disorders, said Castle, adding that some antipsychotics have a large metabolic footprint, resulting in increased weight gain (and waist circumference), a key risk factor for CVD.

He cited an Australian study that found weight gain happens very early on for those with schizophrenia – even in their teens – when they may have their first episode of psychosis.



Cardiometabolic profile by age and sex

- - - Risk status threshold
General population
People with psychotic disorder

Waist circumference (b) and triglycerides (e) *(below the risk threshold is better)*

from Foley D *et al*. Cardiometabolic risk indicators that distinguish adults with psychosis from the general population PLoSONE, 2013, 8, e82606

"So, we have a ticking time bomb …. that we need to get in and defuse," Castle said.

"One of the things we should not do is use medications that are going to exacerbate the problem."

It wasn't a matter of saying who should or shouldn't be on certain medications, but it was a matter of ensuring there was informed, and personal choice and that the physician needs to be upfront, he said.

"The only way to tackle this is with clinicians of all persuasions working with patients and carers to address the really appalling inconsistencies in the way the care is both provided to and received by patients with mental health problems", he said.

Castle called for a larger role for peer workers, saying he had been privileged to be part of workshops in Australia where there was a strong desire for more peer worker involvement.

These are workers with "experience of mental health issues and metabolic health issues", and their involvement boosted motivation, social support, feelings of control and engagement with health services.

Castle said 12 studies of peer interventions for physical health outcomes in schizophrenia had shown improvements in physical health, BMI, physical activity, and healthy eating.

But he said more research was needed to prove the cost-effectiveness of such interventions and that the

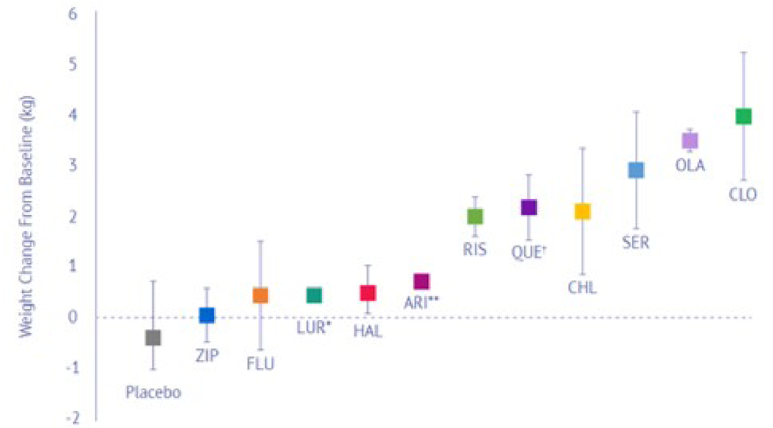
CAHM was working to co-design a trial to measure the long-term improvement in targeted physical health outcomes.

The trial – which is currently in co-design phase and will be implemented in the next couple of months – will involve two part-time appropriately trained individuals with lived experience to act as peer facilitators working closely with the research team to create and plan the intervention.

"We are looking at the peers working alongside clinicians to deliver group-based interventions every week and also to do one-to-one follow-ups to ensure they are on track, and addressing any barriers as they arise," he said.

Castle said it was critical that any peer workers be properly trained and supported, and that any impact of the work on their own physical and mental health be monitored.

Mean change in weight after 10 weeks of antipsychotics



ZIP: Ziprasidone; FLU: Fluphenazine; LUR: Lurasidone; HAL: Haloperidol; ARI: Aripiprazole; RIS: Risperidone; QUE: Quetiapine; CHL: Chlorpromazine; SER: Sertindole; OLA: Olanzapine; CLO: Clozapine.

*Data pooled from short-term, placebo-controlled studies[2]; **4-6 week pooled data[3];†6-week data.

"Something I have seen in my clinical practice is this engagement and human connection can really break the ice in regards to these sorts of care packages," he said.

Equally Well a Family Affair

by Sharon Lawn

Every day in Australia, many more people with mental illness die from often preventable physical illness than as a result of suicide, yet most are still not asked about their physical health when they seek healthcare.

That's a key finding of a soon-to-be-released report from Lived Experience Australia (LEA), which found those with mental illness are missing out on basic health checks, leading to a delay in diagnosis and effective treatment for chronic illness, cancer and other conditions.

Professor Sharon Lawn, Chair and Executive Director of LEA, and a former Mental Health Commissioner for South Australia, will launch the report at the second Equally Well Symposium, held in April as a virtual event as well as in person at the Gold Coast Campus of Griffith University.

She told Croakey of her own experience with clinicians overlooking the physical health of those with mental illness.

Lawn's husband (who helped prepare her talk for the symposium), a former professional Rugby League player, has lived with schizophrenia for decades, for many years undiagnosed and untreated.

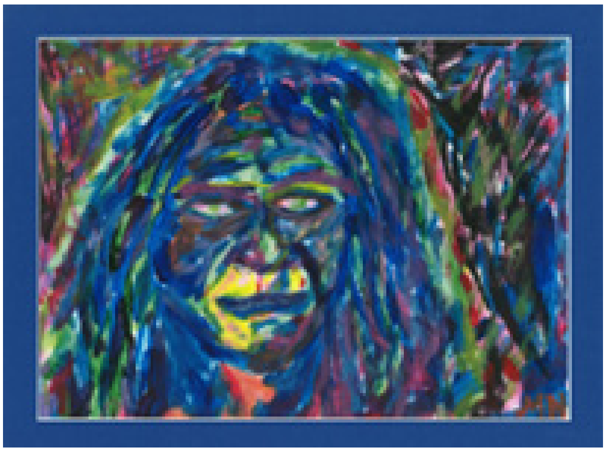
Her husband grew up amidst family violence, poverty, racism, sexual and physical abuse, but also with a culture of strong and fierce commitment to family and football.

While his eventual diagnosis of schizophrenia and treatment with anti-psychotic drugs helped address his mental health, the treatments have also led to much poorer physical health.

The metabolic impact on his weight – he gained 30 kilos in the month following his first admission to hospital – and overall health has been significant.

"Those things chase each other and cause other things. You become more inactive and are likely to

Sharon Lawn and husband.



Self portrait by Professor Sharon Lawn's husband.

put on more weight – it's quite a vicious cycle," Lawn explained.

"He was homeless when we met 20 years ago and the impact of that time living in deprived situations has also left him with other insidious and continuing physical health problems."

Now in his 50s, her husband has had several periods of hospitalisation for mental illness, many medications, and accumulating diagnoses for his physical health.

Lawn, a Professor in the College of Medicine and Public Health at Flinders University in Adelaide, wants clinicians to know that it is not just a matter of telling someone to 'be healthy, eat better and move more' – it's about trying to walk in their shoes.

"It's very hard when you're struggling with trauma and problems with motivation and, like my husband, have trouble initiating, planning and thinking about what to do most days," she said.

Many days are spent rising late or staying in bed, resulting in loss of muscle tone and bone strength, and – like many with schizophrenia – smoking (people with schizophrenia are five times more likely to smoke than the general population).

"Add that to the mix and you have a real problem with the person's ability to walk as far as they used to, be motivated and not spend their day just sitting, smoking and sleeping – losing connection with people and self-esteem," she said.

Lawn wants clinicians to see the whole man – not just the schizophrenia – and tap into her husband's past, what happened in his childhood and his success with rugby, to help him find motivation.

"It's like they are just standing by and watching things move in a particular direction and feel powerless to change anything."

Lawn believes clinicians could be more up-to-date with evidence-based treatments, such as effective smoking cessation programs, and also tap into what gives her husband self-esteem.

She wants consistency and follow-up to ensure there is feedback and motivation to keep going, rather than every contact being an isolated incident.

The impacts of her husband's mental and physical health are there every day and are felt by the whole family, but particularly her husband.

Yet family members are often left out of the discussion. "We're the magic fairy navigator who sits in the waiting room but often doesn't get included," she said.

The message to the conference from her husband will be for clinicians to 'be hopeful' and 'take an interest in more than just compliance with medications', ask more about the patient as a person, and find what motivates them.

He also wants clinicians to work on boosting his self-esteem and make a living plan to measure small steps and progress, using scales and other tools regularly to monitor weight and breathing, and work with the family, rather than leaving them in the waiting room.

Lawn echoes her husband's comments, saying family members are often in the background doing the prompting, supporting and encouraging.

What COVID-19 had taught us about physical health and mental illness

by Russell Roberts

The National Director of Equally Well Australia, Professor Russell Roberts spoke on the lessons learnt from the COVID-19 outbreak, saying people with mental illness were more vulnerable: they were more likely to become infected, suffer serious illness, be hospitalised and die from the virus.

What has happened with COVID-19 is just a reflection of the overall issue of the poor physical health of those with mental illness, said Roberts.

One positive message from the pandemic was that prevention – in the form of vaccination and other public health measures to counter the virus – works.

Roberts used discussion of vaccination to highlight the fact that people with mental health issues are six times more likely to be hospitalised for the common flu than other people in the community.

A flu vaccination that cost just $60 could save a hospital admission costing $2,000 a night, he said, yet many healthcare providers fail to ask mental health patients about their immunisation status.

Roberts added that 16 people with mental illness die every day from a cancer that could have been effectively treated had they been sent for screening.

While EW-informed policies were being put in place, Roberts said there was still much work to do.

"It's great to have the policy but that's just a platform to do something.

Where are the resources? How are we going to do it and coordinate it? All of these things need to happen and it needs to be person-centred not service-centred.

Mental health and primary health services are foreign lands. They are there for the convenience of the service providers – but we need to go to the territory where consumers are comfortable."

Roberts said COVID taught health service providers to reach out to the marginalised or they won't access services and that providers need to be creative and flexible.

Praising those working to implement EW changes, Roberts said all involved are doing a "grand thing" – something variously defined as magnificent, imposing in size, dignified and generational.

"What we are doing is a grand thing. This is a massive issue that we are tackling," he said.

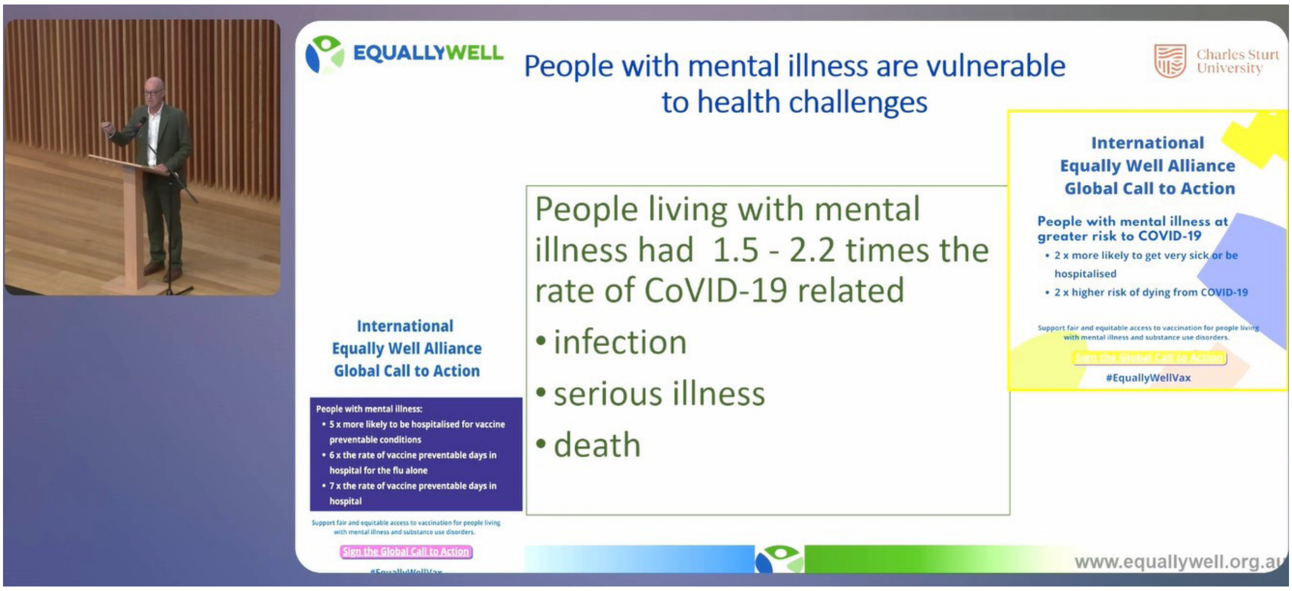
"We are talking 23,000 people per annum who die prematurely, at least half – maybe more – of those deaths are preventable."

Every time we make a difference we change a life, said Roberts, giving the example of a health worker applying EW principles in checking the physical health of a woman with long-term mental illness who was losing her hair.

After ten years of chronic disease, and being seen by mental health services, it turned out "she was malnourished".

A small team changed her life around by referring her to a dietician. "One life with a family and sibling and parents – transformed by that action of an EW practitioner.

"We are doing thousands of these interventions every day. We're having a grand impact. This is a grand, a dignified thing we are doing," he said.



People with mental illness are vulnerable to health challenges

People living with mental illness had 1.5 - 2.2 times the rate of CoVID-19 related

- infection
- serious illness
- death

International Equally Well Alliance Global Call to Action

People with mental illness:

- 5 x more likely to be hospitalised for vaccine preventable conditions
- 6 x the rate of vaccine preventable days in hospital for the flu alone
- 7 x the rate of vaccine preventable days in hospital

Support fair and equitable access to vaccination for people living with mental illness and substance use disorders.

Sign the Global Call to Action

International Equally Well Alliance Global Call to Action

People with mental illness at greater risk to COVID-19

- 2 x more likely to get very sick or be hospitalised
- 2 x higher risk of dying from COVID-19

Support fair and equitable access to vaccination for people living with mental illness and substance use disorders.

Sign the Global Call to Action

#EquallyWellVax

Equally Well and First Nations Australians – Closing the gaps

by Tom Brideson

Aboriginal and Torres Strait Islander peoples' ways of seeing physical and mental health were also highlighted at the symposium, with Tom Brideson, the CEO of Gayaa Dhuwi (Proud Spirit), telling delegates of positive changes in healthcare policy to strengthen First Nations' leadership and input.

Brideson, a Kamilaroi man with 30 years of experience in mental health, said the 2017 Fifth National Mental Health plan had for the first time prioritised Aboriginal and Torres Strait Islander peoples' mental health. Since then, there had been many other policy initiatives which involved growing input from and collaboration with First Nations people.

The narrative in healthcare had changed, with a more strengths-based approach reflected in the latest Close the Gap report, which addressed transforming power and voices for generational change, he said.

One of the Closing the Gap targets – around social and emotional wellbeing – commits governments "to building and supporting structures to empower Aboriginal people to share decision-making" and accelerate policy towards place-based progress.

Brideson told delegates Aboriginal and Torres Strait Islander peoples and their holistic approach to physical and mental health – revolving around the individual, within the family, within the community – had influenced the language of healthcare in Australia.

That language change was reflected in the Equally Well consensus statement, which focused on person-centred, holistic care, prevention and early intervention.

Brideson spoke of the importance of growing the national mental health lived experience workforce.

The lived experience of Aboriginal and Torres Strait Islander people underpinned all the work of Gayaa Dhuwi.

Finally, he stressed inclusion, saying Gayaa Dhuwi ensured many voices were heard, including LGBTQI+ communities, the Stolen Generations, and those of young people, to enhance the expertise of the organisation.

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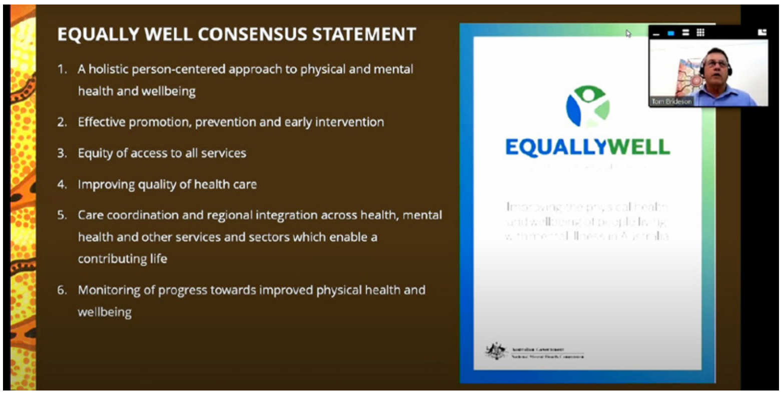


EQUALLY WELL CONSENSUS STATEMENT

1. A holistic person-centered approach to physical and mental health and wellbeing
2. Effective promotion, prevention and early intervention
3. Equity of access to all services
4. Improving quality of health care
5. Care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life
6. Monitoring of progress towards improved physical health and wellbeing

Lifestyle Medicine in Mental and Physical Health by Sam Manger

In dealing with his own mental and physical health issues over the years, Dr Sam Manger, a GP on the Sunshine Coast in Queensland, has found practices such as meditation and regular exercise helpful in keeping himself well.

His lived experience has given him insights that benefit his patients, and he advocates strongly for more people with mental illness to be supported to engage with "lifestyle medicine".

Manger says the lifestyle-based clinical interventions are safe and effective for mental and physical wellbeing, with the 2020 Royal Australian and New Zealand College of Psychiatrists' (RANZCP's) clinical practice guidelines for mood disorders including evidence-based lifestyle interventions as first line recommendations.

The interdisciplinary field uses food, movement, sleep, mind-body practices, social connection, and connection with the natural world, in combination with behaviour change and health coaching approaches along with evolving models of care to improve physical and mental health.

Sam Manger with Dr Linda Barron, Consultant Psychiatrist, Continuing Care Unit, Mountain Creek, QLD Health

While there is some overlap with social prescribing (which enables health professionals to refer people to a range of local, non-clinical services), they are distinct fields, said Manger.

A keynote speaker at the recent Equally Well Symposium, and the President of the Australasian Society of Lifestyle Medicine, Manger wants more clinicians to have lifestyle medicine as a 'go-to' part of their toolbox.

He says there is a strong and growing evidence for 'lifestyle medicine' and says many patients' lives have been transformed by the approach – leaving them healthier, and happier both physically and mentally.

"I went through multiple medical specialists, scans and procedures to only be offered pills at the end of it; a common story," Manger told Croakey.

"This system works well for some …. our healthcare at the moment is not wrong, just incomplete, and lifestyle medicine is that missing pillar of healthcare."

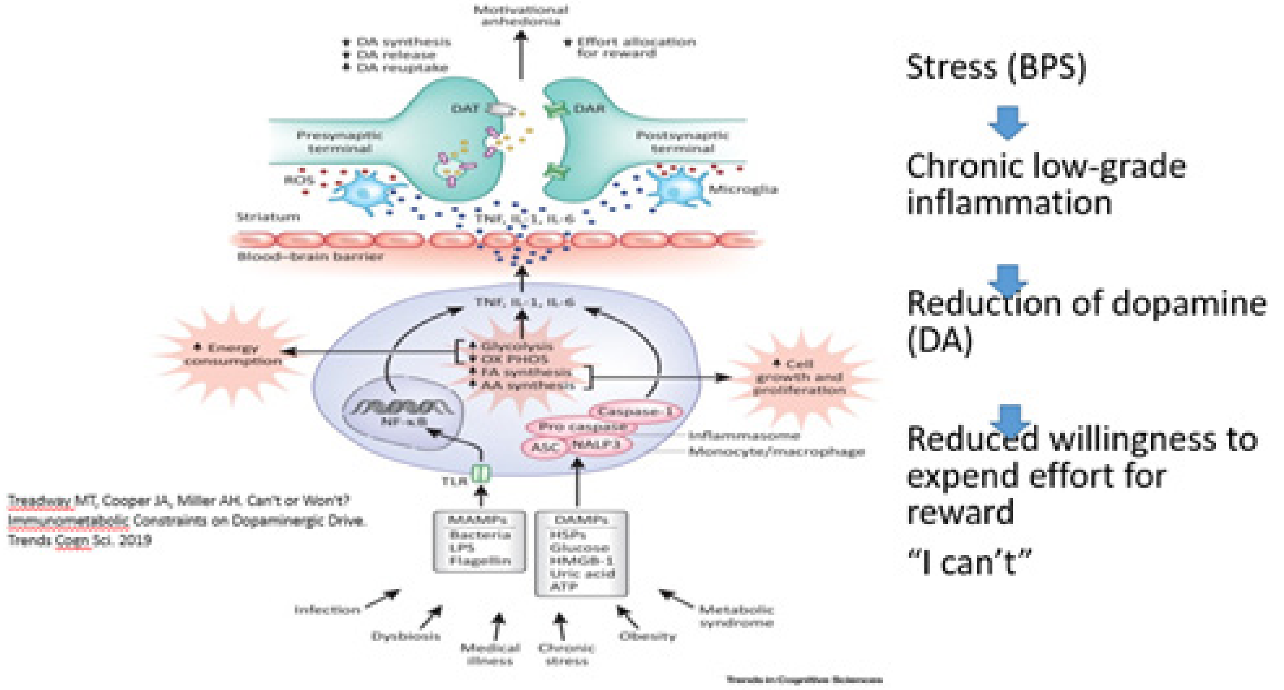
Working as a GPSI (GP Special Interest) with Sunshine Coast public mental health services for the past three and a half years, Manger has run a raft of lifestyle medicine and wellbeing programs, which he has seen change patients' lives.

"In my clinical and academic roles I have seen diabetes, heart disease, autoimmune disease, chronic pain, mental illness and many more not only improve, but some remit and always a person's quality of life improves towards genuine wellbeing," he said.

With 90 per cent of diabetes and 80 per cent of heart disease being preventable, these are things that can really make a difference, he said.

Manger says lifestyle medicine is very inclusive of the social determinants of health, pushing back at criticism that it doesn't address the underlying causes of poor health such as poverty, racism and poor housing.

"As a clinician, if I can provide people with food, movement forms, mindfulness practices, encourage social reconnection and social prescribing, this will improve people's lives in ways that are often largely free or cheap … and support vitality in health services, communities, schools and workplaces," says Manger.



Treadway MT, Cooper JA, Miller AH. Can't or Won't? Immunometabolic Constraints on Dopaminergic Drive. Trends Cogn Sci. 2019

Stress (BPS)

Chronic low-grade inflammation

Reduction of dopamine (DA)

Reduced willingness to expend effort for reward

"I can't"

The Sunshine Coast program is just one example of successful and innovative work being done to reverse the poor physical health of those with mental illness highlighted at the two-day Equally Well gathering, which brought together those with lived experience, clinicians, pharmacists, researchers and service providers.

Manger, a senior lecturer at James Cook University (JCU) and Equally Well Ambassador, told the symposium lifestyle medicine had been shown to be just as – and often more – effective than anti-depressants in improving the health of people with mental illness.

Manger cited studies showing the impact of stress on the body and the effectiveness of mind-body practices, such as mindfulness, breath work, relaxation training and exercise, in countering it.

“Good research has shown that regular physical activity can be as effective as anti-depressants and psychotherapy in treating depression – it’s not an optional bonus but fundamentally crucial for mental health care,” Manger said.

“If you’ve got a person you are treating with anti-depressants and psychotherapy, who is under a high level of psychological or physical stress, their brain is inhibited to rewire and refire.”

On diet, Manger told the symposium about evidence of a link between food and mood, with a randomised controlled trial showing 32 per cent of patients with moderate-to-severe major depression disorder going into remission after being put on a Mediterranean diet compared to eight percent in the control group.

“Food can be anti-inflammatory and pro-inflammatory. We take medication all the time to reduce inflammation and yet we are eating food three times a day that is perpetuating inflammation,” he said.

“That doesn’t just make us stiff and sore in the joints, it makes us systemically inflamed and depressed, this really matters,” he said, with a script for lifestyle-based interventions.

Manger highlighted a lack of time as one barrier, explaining that GPs’ 15-minute consultation window was limiting clinicians, and he felt he could only ever be “10 to 20 percent as good as he could be”.

“While there are many amazing GPs, training and practices, systems to genuinely deliver lifestyle medicine are lacking.”

“We need lifestyle medicine embedded at a clinical service level,” he said. “We need health coaching, peer support coaches and link workers, better digital technology and we need proactive models of care that we can deliver to schools, workplaces and civic communities.”

The ASLM wants “to drive and lead and lobby change at the social level as well and help address the social and cultural determinants of health”.

Manger urged delegates to start practising mindfulness themselves – to meditate, do breathing and stretch exercises – and to be leaders and get onboard in implementing lifestyle medicine solutions.

He also urged executives and decision makers to provide their staff with time for their own self-care and time for teams to create local solutions in their services.

One of the best experiences of his life had been incorporating the approach through helping to establish a native, cultural garden at Pangula Mannamurna, an Aboriginal Community Controlled Health Organisation (ACCHO) in Mount Gambier, South Australia.

“We suddenly saw this massive engagement with the health service. It was their service, their story and reconnection was part of it,” he said.

“Sometimes health is not about cells, or receptors, or hormones or pills, it’s about how we reconnect people together.”

Improving the physical health of people living with mental illness - Opportunities for reform

by Ivan Frkovic

Queensland Mental Health Commissioner (QMHC) Ivan Frkovic told the symposium that despite the strong links between physical and mental health, this isn’t yet reflected widely in service delivery.

While there were great pockets of work, such as that being done by Dr Sam Manger on the Sunshine Coast, such initiatives needed to be implemented across the healthcare system in a bid to stop people with mental illness dying – from mainly preventable physical conditions – 15-20 years earlier than the general population.

Frkovic told of a man with a long-standing mental health condition going to a hospital emergency department for a physical condition and being quickly triaged to the mental health unit.

The example showed how a person’s mental health diagnosis often dominated treatment even if they were overweight, had diabetes or a heart condition or other risk factors, he said.

One of the main challenges of getting GPs to check the physical health of those with mental illness was the limited time of consultations, of 12-15 minutes.

Frkovic called for the creation of a healthcare workforce that has the opportunity and time to respond in a holistic way to complex co-morbidities.

“We need to promote a health services culture where mental health and physical health are seen together rather than viewed separately,” he said.

At a systems’ level, Frkovic said there was a need for better integration of services, and the establishment of multi-disciplinary teams to support people and provide the physical and mental health treatment they need.

Frkovic spoke of the need for better partnerships between people with lived experience of mental health conditions, their families and carers, to ensure consumers have more control and input into their own treatment and care.

The QMHC was committed to driving forward the agenda and was working with public and private agencies to ensure the broader implementation of programs boosting the integration of physical and mental health treatment, but there was a long way to go to create systemic change, he said.

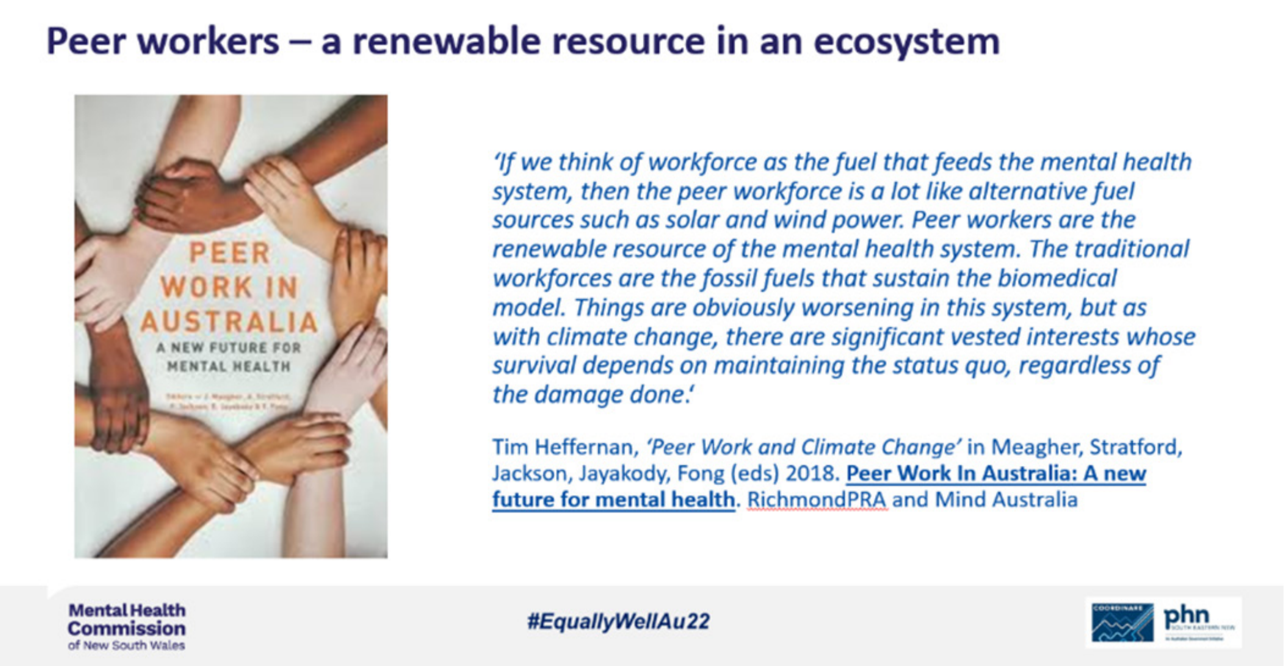
The Lived Experience ‘Peer’ Workforce – being Equally Well by Tim Heffernan

The importance of peer workers was also highlighted by Mental Health Peer Coordinator at COORDINARE, South Eastern NSW PHN, Tim Heffernan, who described the peer workforce as the “renewable resource” of the mental health system.

“The traditional workforces are the fossil fuels that sustain the biomedical model,” he told delegates.

“Things are obviously worsening in this system, but as with climate change, there are significant vested interests whose survival depends on maintaining the status quo, regardless of the damage done.”

Heffernan, Deputy Commissioner with the NSW Mental Health Commission, who has over thirty years



Peer workers – a renewable resource in an ecosystem

‘If we think of workforce as the fuel that feeds the mental health system, then the peer workforce is a lot like alternative fuel sources such as solar and wind power. Peer workers are the renewable resource of the mental health system. The traditional workforces are the fossil fuels that sustain the biomedical model. Things are obviously worsening in this system, but as with climate change, there are significant vested interests whose survival depends on maintaining the status quo, regardless of the damage done.‘

Tim Heffernan, *‘Peer Work and Climate Change’* in Meagher, Stratford, Jackson, Jayakody, Fong (eds) 2018. **Peer Work In Australia: A new future for mental health**. RichmondPRA and Mind Australia

Mental Health Commission of New South Wales

#EquallyWellAu22

of lived experience of mental illness, said while there are good people working across mental health, “we have reached a point where we need new inputs”.

“We need inputs from people who want to help themselves, who want to re-frame their lives from deficit, deficiency and shame, to one of being productive, joyous and happy,” he said.

Heffernan recalled advice relayed by a consumer in a NSW mental health unit that: “You don’t go to the doctor when you are unwell, you go to someone who has recovered from the sickness”.

Investment in peer workers was ‘a must’ and needed to be framed as an urgent human rights and social justice issue. It wasn’t about money – it was about investing in people, he said.

It was about “sharing experiences of recovery , ill-health and getting the vibe back”.

“We have a right to these things because they work. These are the things that keep us physically well yet a lot of the treatment I had as a young man was coercive – it was under the Mental Health Act and I never wanted to go back to hospital,” he said.

In pressing the case for the involvement of more peer workers, Heffernan said: “Most of us want agency in our lives, not agencies in our lives”.

Peer work – despite all the discussion about it – remained a very small part of the mental health workforce, was fragmented and forced to try to fit into often hostile systems.

Heffernan spoke of the evolving role of peer workers, saying when he’d first been employed in such a role he was told “not to talk about medication” with consumers but now the World Health Organization (WHO) had countered such misconceptions, stating that ‘peer-to-peer discussions should not be limited to light topics’.

The WHO document goes on to say peer workers are in an ideal position to use their own personal experiences to talk about complex and distressing issues, such as the benefits and negative effects of medication.

PHOTOS FROM THE SYMPOSIUM


EQUALLYWELL
Quality of Life - Equality in Life
www.equallywell.org.au
Improving the physical health and wellbeing of people living with mental illness in Australia


CHEVRON RENAIS
GCUP
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Q LUX


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Help, hope and purpose
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d support
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Griffith Auditorium
24/7
Market DAY
TOGA PARTY


does the evidence say?
Presented by: Dr Scott Teasdale
On behalf of the Mental Health Working Group
Professor Tracy Burrows, Janice Plain, Deanne Harris, A/Prof Adrienne Forsyth, Georgina Latimer, Michelle Roberton, Tetyana Rocks, Megan Whatnall, Julia Schindlmayr
Acknowledgement: Dietitians Australia
Contact: tracy.burrows@newcastle.edu.au
Dietitians Australia

SYMPOSIUM PAPERS

THEME:
CO-DESIGN

Co-producing assertive cardiac care with and for people with lived experience

Presenters:

Matthew Lewis

Presentation Resources

Matthew is a Research Fellow in the Priority Populations Research Program of the ALIVE national centre for mental health research translation, the Department of General Practice at The University of Melbourne. He is managing the Assertive Cardiac Care Trial, a 5-year randomised controlled trial of an intervention to improve cardiovascular health in people with severe mental illness through primary care. The trial will be complete in December 2023.

Victoria Palmer

Presentation Resources

Victoria is the Director of the ALIVE national centre for mental health research translation. The National Centre aims to implement innovative models of care that are driven by lived-experience to embed prevention across the life course, and mental-physical health tailored approaches in priority populations particularly for reducing the life expectancy gaps seen in people who live with severe mental illness. The Centre's focus is on primary care and the community settings.

Elise Dettman

Presentation Resources

Elise is a casual lived-experience researcher at The University of Melbourne. She has twenty years lived experience of severe mental illness.

Elise studied Computer Science at The University of Melbourne, then gained her MA in 2004. She has worked over the years as a tutor, computer specialist, and more recently in research.

She is excited to be involved in the Assertive Cardiac Care Trial at The University of Melbourne.

ABSTRACT

Introduction: The fact that a possible 25-year gap in life expectancy exists for some people with SMI is a global human rights issue and an unacceptable health inequity that must be addressed. While ways to improve this situation exist, the problem persists. Co-production is essential to addressing this social justice concern. In this paper we reflect on the equitable working relationships, and power disruptions made possible by co-producing an intervention focused on heart health with people who live with SMI.

Method: Iterative co-production cycles were facilitated with people living with SMI. Co-production began through exploring how heart health information was conveyed and what might help to improve heart health. Development and prototype testing was conducted through further coproduction cycles. A final intervention model was co-produced and piloted before wider implementation.

Results and findings: Through the co-production process, core components of the intervention were identified that would not have been possible without bringing people with lived-experience and researchers together to co-create the intervention. These core components include 1) conversation aid supporting heart health discussions and change identification; 2) a take home action plan that was simple, readable

and visually engaging; 3) a heart health information booklet and 4) tailored SMS messaging.

Discussion: The co-produced intervention components are central to engaging with people on their own terms and in a way that enables their experiences to drive changes in how they might address their heart health. The development and final form of study aids were determined by the co-production partners demonstrating the shared power and decision making that underpins co-production. The co-production processes have led to a partnership model of care for delivery in the community setting. Intervention prototypes were further co-produced with healthcare workers and their insights on guidance for improving heart health were integrated for implementation in the trial.

PAPER

Author(s)

Matthew Lewis[1, 2], Emily Knights[1], Victoria Palmer[1, 2], Elise Dettmann[1]

Affiliation(s)

1. The University of Melbourne
2. The Alive National Centre for Mental Health Research Translation

Background

Better preventative care and management of potential heart related health risks through primary care could lead to greater improvement in the lives of people who live with complex mental ill-health. Sadly, while health outcomes have improved for the general population, poorer heart health continues to result in missed life years for people living with complex mental health conditions; in some cases, this is up to 25 years. This indicates that interventions about improving heart and physical health that are provided to the wider community either do not reach or meet the needs of people who live with complex mental ill-health. Our study has worked with people with lived experiences of distress and mental ill-health, health professionals and researchers to co-produce the Healthy Hearts Model of Care which is being delivered in the Assertive Cardiac Care Trial as a national initiative and program.

Who was involved in the Co-production?

A Co-Design Living Labs program was established in 2017 bringing together over 2,000 people from community settings with lived experience of mental ill-health who had previously participated in mental health focused research projects. In the program, co-design and co-production activities are undertaken across the research continuum from priority setting of grant questions, to co-designing models of care, or interventions, to technologies and digital products to sharing information with the public. People can opt-in at their discretion, the program has University ethics approval and there is no obligation to participate. The model of care was co-produced across several years and cycles of co-production.

There were one two-hour co-design sessions held with one to six co-designers (our term for talking about people with lived experience or caregivers of someone living with mental ill-health and distress) to discuss heart health information, ways to connect with people and for co-designers to share their journeys. Sharing experiences has been a key element in the co-design work with the model of care co-designed with people working with prototype examples.

The first co-production cycles resulted in engagement approaches, a conversation aid to prompt discussions of lifestyle areas and a take home goals reminder for the fridge.

Co-designers identified that they wanted:

- simplified materials that were engaging including material objects as reminders
- simple, clear and achievable goals to improve their heart health
- continuing support to reach their goals through regular connection
- peer support, which was outside the capacity of the study
- home based dedicated support, like the hospital outreach Hospital Admission Risk Program (HARP) which is consistent with models of assertive care where the focus is on self-determination, care in community and home, and proactive follow up and support.

This was all prepared ready for delivery in primary care, but then COVID-19 led to major changes and the need for a wider virtual approach. The adaptations were co-designed with two further groups of co-designers. From these sessions, a journey map exploring touchpoints in the cardiac care pathway within primary care was generated and a remote engagement strategy was co-designed. Outcomes of these additional co-design cycles were that:

- allowing participants to be prepared ahead of time for the next step in the study/process of seeking help for heart health was important
- rapport and relationships with clinicians was essential
- aids and barriers to goal setting were identified.

The redesign led to the development of a web-based virtual care platform and co-designers provided feedback on this. The platform was made more friendly and less confronting. For example, instead of opening with risk estimation graphics more neutral opening images were included. People also asked for options for support to be delivered with cameras off, being clear about goal-setting activities and because the SMART acronym was used this needed to be outlined within the platform to help with the goal setting process. Following this co-design work, all information provision to study participants was reviewed and updated by a lived experience researcher in our team (ED).

Critical reflection on the co-design activities and future direction

Integrating co-design into the Assertive Cardiac Care Trial has been important to challenge the ideas and potential pre-conceptions of the researchers and to create a model of care that people connect and engage with. Co-design has directed the intervention and iteratively improved processes and resources, and the co-produced knowledge has involved health professionals and researchers providing input as well. Through ongoing involvement in the Co-Design Living Labs program, co-designers have gained experience in research activities and some have joined the research team as lived experience researchers. Genuine co-design facilitates change and this work has resulted in significant changes to the project and research approaches. While the co-designed and co-produced outcomes benefit the research program, co-designers consistently provide positive feedback about the Co-Design Living Labs. Members enjoy sharing insight into the issues being co-designed from their lived-experience perspectives and seeing the impact of their work on the design and delivery of the intervention and ultimately health care systems improvement.

The Co-Design Living Labs program has evolved and matured and become more embedded in our work and moved from researcher driven approaches to co-partnered and co-convened models. As a program there is a need to create more consistency in feeding back the impact that co-designers have made. There must always be attention to power sharing, active involvement in decisions and creative outcomes (shaping and making) as part of the co-design processes. As researchers, we need to remain open-minded, flexible, and discerning, and continually work to improve and develop the ideas generated from co-design from the earliest possible opportunity. This means acknowledging that the Co-Design Living Labs program is necessarily always evolving.

Co-designing a Physical Health Conversation Guide: Working together for hope and health

Presenters:

Kathryn Thorburn

Presentation Resources

Kathryn has 30 years' experience as a mental health clinician, educator, facilitator, and consultant, and as a family member. Kath is recognised for her work in co-design and co-production, project management, curriculum development and delivery, and curating innovative mental health events and projects. Kath has experience working in public mental health services and educational institutes, and co-founded inside out, a mental health consultancy with a reputation for collaborative and lived experience led approaches. Kath is a PhD candidate at the Centre for Primary Health Care and Equity, UNSW Sydney.

Shifra Waks

Presentation Resources

Shifra has comprehensive research experience at various universities across Australia, experience in co-producing and co-facilitating mental health education and training, and experience in mental health community peer work. Shifra has developed a personal foundation in lived experience/consumer academia, having held lived experience/consumer led researcher roles at the University of Canberra, the University of Newcastle, and the University of Melbourne, and currently with UNSW, Sydney, and the University of Sydney. Shifra has had a significant role influencing the growing recognition of lived experience/consumer academia in Australia.

ABSTRACT

Introduction: Primary care is the main setting in which the physical health needs of people who experience mental health issues are addressed. However, mental health service users and primary care providers report significant barriers to accessing and providing physical healthcare, with obstacles occurring at the individual, practice, and systems levels. Co-design is a process for developing solutions to complex problems that privileges lived expertise, and provides a forum where service users and providers can collaborate to improve healthcare services and relationships.

Method: This research involved co-designing a practical approach to improving mental health service users' physical health care in primary care settings and the research design for testing it. It also explored the co-design process, how outcomes were achieved and the co-designers' experiences. People with lived experience collaborated as co-designers, co-researchers, co-facilitators, and members of the lived experience advisory group.

Records and documents from co-design activities were collected. Co-designers' experiences of the process were obtained via group and individual interviews. Transcribed audio-recordings of individual and group interviews, project documentation and images were coded and analysed thematically.

Results and findings: Six people with lived experience and five service providers (including GPs) participated in the online co-design. Thirty barriers to physical healthcare and 12 potential solutions were identified. The Physical Health Conversation Guide (PHCG) was selected (based on feasibility and impact), developed and prototyped. The research findings emphasise the influence of concurrent dual processes in creating the conditions for new understandings, relationships, and action, with time as a key mediating element.

Discussion: Co-design recognises the value of lived and other expertise in co-creating new knowledge. For its generative potential to be realised, the co-design process needs to create and hold space for emergence, uncertainty and shifts in power. This research has implications for the translation of co-design principles in a range of healthcare settings.

PAPER

Author(s)

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Affiliation(s)

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2. Faculty of Arts and Social Sciences, Social Policy Research Centre, UNSW Sydney, Australia

- This research aimed to identify the key characteristics of co-design and how it achieved its outcomes of a Physical Health Conversation Guide (PHCG) and a process for testing the PHCG. It also aimed to understand the co-designers' experience of the co-design process.
- This is the first stage of a two-stage study. The second stage will test the PHCG based on users' experience. This includes people with lived experience (consumers/carers), people with family experience (carers), mental health staff (peer workers, clinicians) and primary care providers.
- Over 50% of the co-designers had lived/living experience of mental and physical health issues. A lived experience advisory group and lived experience co-researchers helped to ensure the project embedded co-design principles in every stage.
- The structure of the first three online co-design workshops followed this definition: "Define the problem. Identify solutions together. Test solutions" (Roper et al., 2018). Due to the iterative nature of co-design, two additional workshops were held to refine and prototype the PHCG. Almost all co-designers identified the need for this extra time during the co-design experience research.
- The co-designers all agreed that supporting interactions between people with lived experience and GPs and other health workers was key to improving physical health.
- The outcome was a power shifting conversation tool that assists service users/consumers to communicate needs and preferences regarding their physical health care. This includes preferred terminology and communication style, preferred treatments and services, how the person's physical health and mental health interact, and health measures that are important.
- Designed to be accessible, the PHCG underwent a check for usability by people with English literacy challenges, while the website was designed to be visibly and cognitively accessible including text to speech and other accessibility features. The website is also providing a location for resources and a survey to collect demographic data to help understand who is accessing the website and the PHCG. The second stage of the research - testing the PHCG - is now underway.
- Co-designers' experience of the co-design process was obtained via group and individual interviews and an optional brief anonymous survey. Co-design documentation (annotated whiteboards, online chat and workshop summaries) was also collected. Both were coded inductively using NVivo 12. The analysis was framed through Palmer et al.'s explanatory theoretical model of change for co-design (Palmer et al., 2019, p.5). Testing the analysis against existing theory helped to identify any new understandings this research might offer.
- This research confirmed that co-creating knowledge and making decisions to influence change requires space for developing relations and shifting power. Three themes were: Generating Knowledge; Creating Space; and Influencing Change; along with underlying interdependent tensions that support and facilitate each of these themes. Time is a mediating factor.
- Co-design brings people with diverse and complementary perspectives together in a process of collaborative decision-making. This differentiates it from consultation, where diverse perspectives are collected (but not necessarily agreed and adopted). Paying attention to, and allowing time for, collaborative decision-making is important for effective co-design.

THEME:
PREVENTION

I'm NEVER too old to be Asked - Physical and Mental Wellbeing

Presenters:

Vicki Langan

Presentation Resources

With a background in Sports Science and working in ADO, forensic, youth and community services, homelessness and mental health services for over 25 years, Vicki clearly saw the link between mental ill health and the impact on the physical health of individuals living with a mental illness. Moving into Health Promotion, supporting the development of the Peer Work Force and now in her current position as the Health and Wellbeing Manager for Neami National NSW, Vicki has contributed to the development and implementation of several physical health programs, health promotions initiatives and research projects nationally. Vicki is dedicated to helping individuals living with mental illness improve their physical health through collaboration and innovation and as a Mental Health First Aid Instructor supporting attitude change throughout the wider community.

Whitney Lee

Presentation Resources

Whitney completed a Bachelor of Psychology and began her career as a community support worker, where she witnessed the gap in physical health for people living with a mental illness. Having an interest in physical health and being passionate about leading a healthy lifestyle, she undertook a Master of Public Health (Health Promotion), to prevent poor health and promote physically healthy lifestyles for people living with a SMI. 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.

ABSTRACT

Physical health and social isolation have been identified by older people as two important areas of wellbeing that require intervention to improve their quality of life. There can be confusion around who is responsible for assessing and monitoring the physical health of older people accessing mental health services.

Work conducted by Neami's NSW Health and Wellbeing Team in addressing the physical health of individuals living with a mental illness gained interest across the mental health sector, resulting in a request by NSW Health, Older Person Mental Health Services for Neami to partner with them and support implementation of the Physical Health Care Practice Improvement Project.

The Neami Physical Health Prompt was utilised as a resource but required adaptation to cater to people over the age of 60 years. In line with Neami's consumer participation policy and guidelines, a co-design process was used to develop an Older Persons Physical Health Prompt (OPPHP). This changed not only the visual functionality but added another nine essential questions. To support the implementation of the pilot OPPHP, strategies included Neami developing an instructional video to inform staff within five participating Local Health District (LHD) Older Persons Services on the appropriate use of the resource.

At an individual, community and clinical level, the OPPHP supports the person in a variety of ways. Completion of the Health Prompt promotes and empowers them to have regular relevant conversations around their physical health with whomever they choose in a supportive environment, promoting reflection and ensures physical health remains on the agenda.

Responses emphasise the importance of regular physical health checks for older people, while an inpatient in a mental health unit, and/or residential care and the need to build the capacity of age care staff in consumer centred holistic approaches in physical health of older people living with a mental illness.

PAPER

Author(s)

Vicki Langan[1], Whitney Lee[1]

Affiliation(s)

1. Neami National

Introduction

Due to the success of the Neami Physical Health Prompt (NPHP) in addressing physical health for people living with mental illness, Neami National were invited by NSW Older Persons Mental Health to participate in the Physical Health Care Practice Improvement Project and encouraged to utilise their experience of recovery practice in addressing physical health, to develop an Older Person's specific Physical Health Prompt.

As part of this 2-year project, NSW LHDs were invited to choose and invest in resources into the piloting their chosen project. Neami were supported by five LHDs through trialling the co-designed OPPHP within various older persons mental health settings.

The Older Person's Physical Health Prompt

In response to the significant link between mental health and physical health, supported by overwhelming evidence from an international setting, initial discussions regarding the development of a physical health prompt began at Neami National in 2010.

After undertaking a significant amount of research surrounding 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 around physical health and further referrals onto health services.

The Health Prompt includes 28 questions, addressing a set of diverse age and gender related issues. Positive answers to the questions require 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 translated versions into Somali, Mandarin and Auslan.

As part of the Physical Health Care Practice Improvement Project, Neami worked alongside consumers to develop a specific health prompt for people over the age of 60 years, in a co-design process. Considerations from a mix of online and face to face consumer focus groups resulted in changes that reflected the needs of this population including:

- functionality changes such as font size and colour
- wording changes
- relevant additional questions on:
    - cardiovascular health
    - vaccinations
    - muscle strengthening exercise
    - intimacy
- questions around balance, movement and pain were changed for clarity.

Service Improvement Project

The OPPHP is currently being piloted across five NSW LHDs within older person's mental health services; in community, inpatient, and residential care settings. To support the NSW Health Older Person Mental Health Services to implement the OPPHP into the mental health services, Neami also developed an instructional video, and a data reporting process.

Initial findings from the pilot project are showing the need for regular physical health checks for older people, and the need to build the capacity of age care staff in consumer centred holistic approaches to empower older people living with a mental illness to take ownership of their physical health journey.

Opportunities for Conversation

Chronic health issues not being addressed

Table 1. indicates the top "no" responses across 39 completed Health Prompts in older persons mental health services in five LHDs. That is, these areas of concern are where consumers have not had these health issues addressed or have spoken to a health professional about. According to the Australian Institute of Health and Welfare, in 2017-2019 the leading cause of death in ages 65-75 was colorectal cancer, and yet 65% of participants completing the Health Prompt, hadn't spoken to their doctor about bowel cancer. Similarly, coronary heart disease is either the first or second leading cause of deaths in age groups 65yrs –

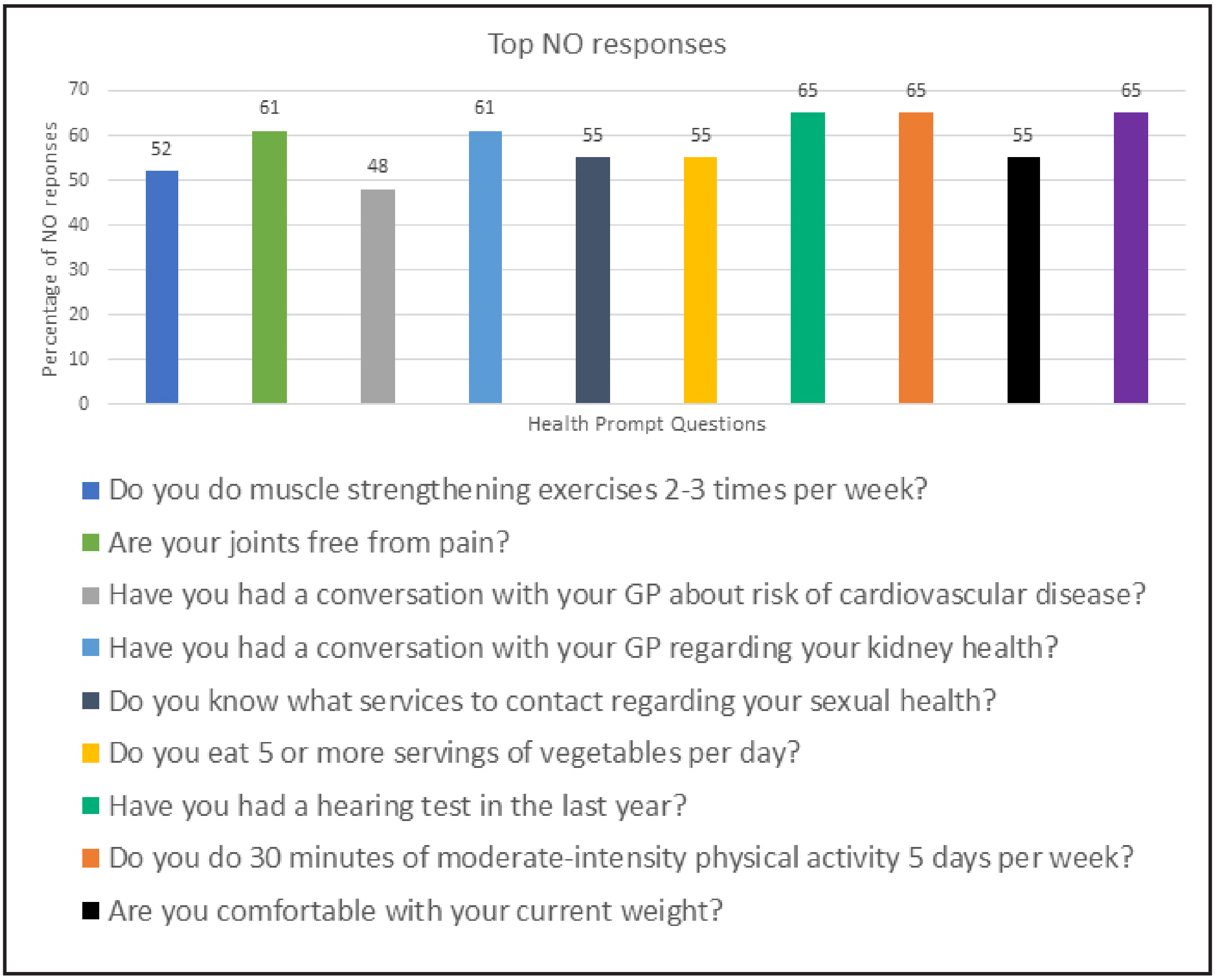

Table 1. Percentages of "Top No" responses on the Health Prompt

85yrs+, and yet 48% of participants had not spoken to their GP about cardiovascular disease.

Opportunities to address health needs

The Health Prompt provides opportunities for writing comments for any additional health concerns that the consumer may be experiencing, and one such comment was:

> *"Diabetes is affecting eyesight and ability to accurately read insulin pens. Homecare staff are unable to check or change if incorrect."*

By completing the health prompt with the consumer, it was discovered through conversation that the consumer's basic health care needs are currently not being met and provides several clear issues that need to be addressed.

Opportunities to improve quality of life

Not only does the Health Prompt provide opportunity for chronic health conditions to be addressed, but also opportunities for conversations about improving quality of life. Hearing difficulties can be extremely isolating, and responses in Table 1. show that 65% people have not had their hearing tests in the last year, indicating that they have not addressed this recently, and may not even realise there could be potential hearing problems. Similarly, conversations around improving lifestyle changes can occur, such as through questions that address muscle strengthening or joint pain.

Never too old to be asked

Using the Health Prompt with consumers within the older person's mental health unit, has highlighted in several ways how assumptions can get in the way of health conversations.

Staff comfort

Staff reflections indicated that some clinicians felt discomfort around asking questions from the Health Prompt when they might not know the answers, or they don't know the topic well enough. This discomfort led to the avoidance of asking these questions, in fear of being asked to answer follow up questions where they may not be able to provide a response.

The Health Prompt is an alternative to clinical assessment or screening, where this is not a checklist, but rather a conversation tool. This allows an opportunity to have strength-based conversations to empower consumers to take ownership of their own physical health and recovery journey. Rather than avoiding questions due to fear of appearing unknowledgeable, this is an opportunity to support the consumer to learn to improve their own health literacy.

Assuming consumer discomfort

It is dangerous to make assumptions in this context and having physical health conversations with older persons living with mental illness has been identified as necessary throughout this process. From Community Mental Health workers, to GPs, to primary health care workers, those working with people living with mental illness have an obligation to ensure the health and wellbeing of consumers. Often it is assumed that older persons do not want to be asked perceived sensitive questions on topics such as: weight, sexual health, prostate, or intimacy. Through the co-design process of the Older Person's Physical Health Prompt, it was identified by the participants that they both want and need to be asked these questions.

Recommendations

This resource is only a small part of a larger initiative, the Physical Health Care Practice Improvement Project; however, initial outcomes have already shown need for practice improvement by service providers. The responses from the Older Person's Health Prompts have shown opportunities, not only to address physical health needs, but also areas for improving quality of life for service users.

Practice improvements include the need for physical health conversations to be made core practise in older persons mental health services, as results indicate there is a gap where service users are not always being asked important questions about their health. Staff need to focus more on recovery coaching practice approaches when having conversations and not make any assumptions around having physical health conversations.

An Endocrinologist-led multidisciplinary clinic for managing metabolic risk factors in case-managed consumers with severe mental illness: A presentation of model of care & service implementation

Presenter:

Presentation Resources

Mridula Kayal

Initially trained as a Psychiatrist in AIIMS, New Delhi, Mridula completed her Fellowship in Australia in 2011. Since then, Mridula has been practicing in the field of Adult Psychiatry, both acute and non-acute. Over time, Mridula has developed a keen interest in Rehabilitation Psychiatry, her current clinical work area with particular interest and commitment in implementing evidence-based psychosocial interventions in the service.

Mridula has worked in, and thoroughly enjoyed the role of Chief Training Supervisor in Cairns from 2014 to 2020, relinquishing this role to dedicate time to research and to widen her clinical experience.

ABSTRACT

People with severe mental illness (SMI) experience a 20-year mortality gap compared to the general population related to the high rate of CVD. Isolated interventions are unlikely to improve cardiovascular fitness or induce weight loss in this population. The Lancet Psychiatry Commission: A Blueprint for Protecting Physical Health in People with Mental Illness, outlines a multidisciplinary approach to a multi-morbidity as an effective method to treat metabolic syndrome in SMI. It recommends implementing the “Diabetes Prevention Program (DPP)”, the gold-standard lifestyle intervention, in people with SMI. To our knowledge, this is yet to be brought into practice in Australia.

We have developed a model of care for implementing the DPP through a multidisciplinary team approach. The team consists of an endocrinologist, psychologist, dietician, exercise physiologist (partnership with PCYC), smoking cessation nurse, and a care coordinator. The program will run as a two-hour 16-week group intervention which includes one hour of education (as per the DPP program manual) and another hour of exercise, under the supervision of an exercise physiologist. The consumers will also have access to three monthly endocrine reviews and three monthly MDT case reviews.

A structured service evaluation will investigate the outcome of metabolic risk factors, diet, physical activity level, and smoking level of the case managed consumers with one or more risk factors for MS in an open-label pre-post design along with the acceptability of the program.

We aim to present the model of care, the information around the implementation and feasibility of this program which started on 02 July 2021.

The importance of the program lies in its ability to showcase work around social and clinical prevention, working in partnerships (with medical colleagues, allied health, and NGOs), converting policy into practice and an example of integrated care.

When successfully implemented, this model has the potential to be replicated in other health care facilities in Australia.

PAPER

Author(s)

Mridula Kayal[1]

Affiliation(s)

1. Cairns Mental Health

- The Multidisciplinary Metabolic Clinic (MMC) based in Cairns, Queensland, is a clinic which aims to improve the cardiovascular outcome in people with serious mental illness. MMC provides specialist services to people over the age of 18 diagnosed with a severe mental illness and at risk of metabolic syndrome, living within the Cairns and Hinterland Hospital and Health Service (CHHHS) catchment area.
- The clinic consists of an endocrinologist, dietician, psychologist, exercise physiologist, smoking cessation clinician, admin officer and care coordinator.

Appointments are made between individual consumers and the endocrinologist, psychologist, exercise physiologist and dietician during the different phases: assessment, treatment and maintenance (weeks 1-2, 12 weeks, 34 and 52).

- The treatment phase is a 12-week group Lifestyle Balance Program which includes weekly education sessions and twice weekly gym sessions at the PCYC.

  The endocrinologist conducts a medical review with the participants and medically manages metabolic parameters in conjunction with their general physician and psychiatric treating team, including diabetes management, blood pressure and weight-loss treatment.

- The administrative office collects demographic data and attendance and organises all appointments for the clinic. The care coordinator triages referrals, oversees organisation of appointments and intervention and engages carers, consumers and relevant stakeholders. The psychologist contributes to the group program with a focus on motivational and recovery.

- The clinic had a high uptake among clinicians, with increased numbers of referrals over time and a good level of acceptance among consumers. The preliminary results are encouraging - they show 61% retention at the end of six months, 72% attended more than half of the group sessions, 72% accepted to take weight loss medication, 63% achieved weight loss of more than five kg (Avg 7kg), 81% achieved reduction in waist circumference by more than five cm and most had improved their fitness level.

- Barriers faced include consumers' motivation to engage and maintain interest for lifestyle changes as well as variable attendance to clinic appointments due to a high level of disorganisation (due to cognitive and negative symptoms of schizophrenia). The roles of care coordinator and admin officer are vital to managing the challenge.

  The medication aspect also needs advocacy – difficulties in reliable medication supply (weight-loss medication) and often this can be patchy and frustrate consumers.

Aligning clinical prevention strategies with consumer goals in concurrent physical & mental health issues; experiences from a pilot evaluation

Presenter:

Presentation Resources

Caroline Johnson

Dr Johnson is a Senior Lecturer at the University of Melbourne in the discipline of General Practice and is in active clinical practice as a General Practitioner. Dr Johnson's research has a strong focus on primary mental health care. She has published on recovery from depression, mental health treatment plans and the role of general practice in providing care for common mental disorders. In 2018 she was a member of both the Mental Health Reference Group and the Psychiatry Clinical Committee of the Medicare Benefits Review Taskforce, where she provided advice to government about modernising the MBS to better align it with evidence-based practice. In 2019 she was called as a witness to the Royal Commission into the Victorian Mental Health System. Dr Johnson represents the Royal Australian College of General Practitioners on the Equally Well Alliance.

ABSTRACT

People who use public mental health services in north-western Melbourne have a life expectancy of 52 years, which is more than 30 years lower than the Australian population. Studies identify the main contributors to early death for this cohort as cardiovascular disease, respiratory conditions and cancers, together responsible for 82% of natural cause early death. In response, North Western Melbourne Primary Health Network funded two organisations to trial a care coordination service for people living with concurrent physical and mental health issues.

In 2020-21, a research team comprising of lived-experience evaluators, a doctor, a nurse, and evaluators from Equally Well, Charles Sturt University, and RMIT University, completed the first stage of an evaluation on both services. Through discussions with consumers and their care teams, we noted that case coordinators, who were in both organisations, registered nurses, were deeply attuned to their consumers' priorities. However, support for consumers' priorities led to a disconnect with clinical priorities and primary prevention strategies. Similarly, within the evaluation team, an ongoing conversation about prioritising clinical needs against both personal needs and preventative strategies occurred between the health and lived-experience evaluators. Interviews with consumers showed that when emotional support needs were met, best practice clinical screening was not prioritised. While rapport building within a re-engagement model is vital, particularly within a cohort that may have disengaged from health services due to negative past experiences, primary and secondary prevention of significant health issues should not be compromised. Though consumers felt heard, often re-engaged in allied health care, and some were able to set, achieve, and self-manage goals after using the case coordination program, the disconnect between clinical and personal priorities remained present throughout consumers' experiences.

In continuing case coordination, how can services stay consumer centred, while meeting clinical needs? What does a best practice collaborative approach look like when personal and clinical goals differ for people with chronic and concurrent physical and mental health issues?

PAPER

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Background and context

In 2019 Neami and cohealth were funded by the Melbourne Primary Care Network (MPCN), trading as NWMPHN, to deliver Integrated Care Coordination (ICC) services from July 2019 to August 2021. Both ICC sites employed one registered nurse and one mental health peer worker, both on fractional appointments.

The overall objective of ICC was: That individuals experiencing severe and persistent mental illnesses who can be or are being appropriately managed in a primary care setting:

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

Evaluation questions

These emerged as the pilot progressed and were expanded after the mid-way interim report:

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

Evaluation method

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

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

This data was used to create 'consumer profiles' (case studies) to illustrate to the reader what the experience of care co-ordination was like from the perspective of those with lived experience.

For this paper, we focus on the file review experience. The data was viewed through a 'clinical' lens according to recommendations from key clinical practice guidelines, alongside an 'intentional peer support' (IPS) lens where the evaluators (a doctor, a nurse and a lived-experience researcher) viewed that data according to IPS principles:

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

Findings

Key findings of the project included positive consumer experiences, predominantly due to the care and compassion experienced in their interactions with the care coordinators, alongside grateful stakeholders, who recognised the high demand for services like this. The file review also revealed the troubling lack of resources to refer people to, with barriers such as access, cost and wait times clearly demonstrated.

There was also a lack of clarity of the role of the peer worker in the pilot as well as a lack of integration with public mental health services. An obvious tension between the priorities of individual consumers and the primary and secondary prevention goals of the clinical guidelines was difficult to resolve for the care coordinators working in the pilot, but also within the multidisciplinary research team. This allowed for rich conversations about how future projects might deliver clinical preventive services while simultaneously drawing on principles of power-sharing, values-based choices and connection.

Discussion

While the program did not demonstrate tangible, measurable health outcomes, there were important intangible benefits that warrant further testing in projects of larger size, longer duration and without the significant barriers crated by the COVID-19 pandemic. Noted benefits included evidence of changing attitudes to health, increased health literacy, better connection to the health care system and some increase in appropriate health screening for participants.

Acknowledgements

The presenter acknowledges colleagues from RMIT, Charles Sturt University and Equally Well who worked together on this evaluation: Chris Maylea, Siobhan Bubner, Matthew Dale, Rory Randall, Robyn Martin, Russell Roberts, Erin Myers, and Lucy Bashfield.

The final evaluation report can be accessed at: Evaluation of Integrated Chronic Care Pilot.

Leadership and collaboration: statewide physical health practice improvement for older people with a mental illness

Presenters:

Presentation Resources

John Stevens

John Stevens is a Policy Officer with the Older People's Mental Health Policy Unit, Mental Health Branch, NSW Ministry of Health. His key areas of policy work include statewide Older People's Mental Health (OPMH) benchmarking, OPMH inpatient models of care, and the statewide OPMH recovery-oriented and physical health practice improvement projects.

Presentation Resources

Kate Jackson

Kate Jackson is the Director, Older People's Mental Health Policy Unit, Mental Health Branch, NSW Ministry of Health. Kate has been in this role since 2004 and has overseen the development and implementation of two statewide older people's mental health service plans. She has been involved in leading 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, and statewide practice improvement initiatives in recovery-oriented practice and physical health of older people with mental illness.

ABSTRACT

Introduction: Both leadership and collaboration are essential in addressing the so-called 'implementation gap' in improving the physical health of people living with mental illness. As part of its commitment to Equally Well, the NSW Ministry of Health has undertaken a statewide practice improvement project to improve the physical health of older people with mental illness. The project has adopted a 'start where you can' approach, leveraging state and local leadership and collaboration. The state project team provides overall guidance and project leadership to local health district (LHD) teams to bring about changes in each LHD that can then inform and give momentum to broader statewide practice change.

Method: Statewide project leadership encourages older people's mental health (OPMH) services across NSW initiate local projects, generating an agenda for change and processes and resources to support it, and promoting collaboration. An expert steering group provides a mechanism for leadership and collaboration, and for local project champions to seek guidance and feedback on their projects and advice on challenges. The overarching project approach is supported through collaboration with targeted external partners depending on the needs of the LHDs and the nature of their projects. Some projects have partnered with international partners, some from the community managed sector and many have partnered with academics to support project design, ethics approval and publication. Establishing and managing these partnerships has been key to shaping projects, making them both more robust and more complex. This presentation will focus on how the project team has maximised engagement by managing these cross-sector and cross-LHD partnerships, encouraging all of the participating services to take a collaborative approach.

Results and findings: Currently the statewide project encompasses 11 LHDs across NSW with eleven projects all at varying stages of completion. Projects have involved collaboration between OPMH services, the university sector, community managed sector and international agencies. Effective collaboration to bring about statewide

practice change is possible. While the projects are in different stages of completion, this presentation will share the journey and the lessons learnt to date from this style of leadership and collaboration.

Discussion: The complexity of managing the establishment of cross-LHD partnerships, external stakeholder partnerships and their varying interests to develop and implement innovative locally grown projects has its challenges but enriches the work significantly. This presentation will outline the statewide model of leadership and collaboration that has been developed and refined over successive practice improvement initiatives, and discuss some of the strengths and challenges of the approach. The presentation will include people involved in the project sharing their experiences of working collaboratively across sectors under the model.

PAPER

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Introduction

Both leadership and collaboration are essential in addressing the so-called ‘implementation gap’ in improving the physical health of people living with mental illness. As part of its commitment to Equally Well, the NSW Ministry of Health has undertaken a statewide practice improvement project to improve the physical health of older people with mental illness. The project supports key directions in the NSW Older People’s Mental Health Service Plan and NSW Health guideline, Physical Health Care for People Living with Mental Health Issues. It has adopted a ‘start where you can’ approach, leveraging state and local leadership and collaboration to support NSW Health Local Health Districts (LHDs) to develop local projects to improve the physical health outcomes of older people accessing their local mental health services. A statewide project team has provided overall guidance and project leadership to LHD older people’s mental health (OPMH) teams and project partners to bring about changes in local services that can then inform and give momentum to broader practice change in NSW OPMH services.

Methodology and findings

The methodology and approach of this project evolved from a previous successful project to support the implementation of recovery-oriented practice across NSW OPMH services. This approach was strengthened by using the framework outlined by Liu et al. a model for interventions addressing the physical health of people with mental illness. For this project, a statewide project leadership team has supported OPMH services across NSW to initiate local practice improvement projects, generating an agenda for change and processes and resources to support it, and promoting collaboration.

The three-person statewide project team in the NSW Ministry of Health has provided leadership, guidance and support for the project, in collaboration with a larger expert reference group. The expert group comprises over 20 people representing a variety of health disciplines and perspectives, including lived experience, carer and peer worker perspectives. This has provided an effective mechanism for leadership and collaboration, and for local project champions to seek guidance and feedback on their projects. The project team and expert group have assisted LHDs in workshopping potential project ideas in line with the ‘start where you can’ approach and in advising on project implementation. This approach has enabled flexibility to take account of variability in local service capacity, priorities and context, and supported adaption of projects in the face of workforce and other challenges presented by the COVID-19 pandemic over the course of the project.

Services have been enabled through the shared leadership structure to start local practice improvement through mobilising available state and local resources, and responding to emerging opportunities. The overarching project approach has been supported through collaboration with targeted external partners depending on the needs of the local health districts and the nature of their projects. About half the projects involve partnerships with the community managed sector and many have involved partnerships with academics to support project design, ethics approval and publication. Establishing and managing these partnerships has been key to shaping local projects, making them both more robust but also more complex. This approach is consistent with complex adaptive systems (CAS) theory that clinical governance models and policymakers must adapt to and seek feedback from different mechanisms and sources. It has enabled the incorporation of lessons learnt through the course of the project into statewide processes and further enhanced the development of distributive leadership capacity.

The COVID-19 pandemic had a significant impact on the overall project, resulting in challenges with LHD resourcing, workforce changes and competing priorities. The shared leadership structure between LHD project leads and managers, the expert reference group and the statewide project team, as well as senior partners in partnering academic and community managed organisations has allowed most projects to continue in the face of these challenges. Where one project partner has had reduced capacity, other partners could progress the projects at some level until the working environment allowed for all project partners to re-engage. This approach has meant that the statewide project team has been successful in keeping LHDs engaged in the statewide project and in supporting them to collaborate on existing projects when staffing and resourcing challenges arising from the pandemic response threatened their exit from the project.

Currently the statewide project encompasses 15 LHDs across NSW, with nine projects all at varying stages of completion. Projects have involved collaboration between OPMH services, the university sector, and the community managed sector. While the projects are in different stages of completion, it is expected that all of the LHD projects will be completed in 2022 and showcased in a statewide project report and forum event later in 2022.

Discussion

In NSW OPMH services, a model of statewide leadership and collaboration to support practice improvement has been developed and refined over successive improvement initiatives. This approach is driving practice improvement in physical health assessment and care for older people with mental illness, even in the context of the COVID-19 pandemic. Establishing and managing partnerships between LHDs, community managed organisations and universities with their varying interests and perspectives has its complexities, but has enriched the work significantly. Collectively, these projects promise progress in addressing the so-called 'implementation gap' in improving the physical health of older people with mental illness.

Some key reflections on this project are that creating the right environment and processes to support collaboration on statewide practice improvement has been important. Policy commitment helped in establishing initial support for the project and has also helped in maintaining support amidst the many challenges it has faced. A distributive leadership approach, involving cross-sector partnerships, has kept the project on track. The project has been ambitious in the number of people it has involved and the scope of collaboration it has promoted, and the pandemic has added complexity. Persistence and adaptability have been critical. The 'start where you can' approach has meant that local projects were more adaptable to change, as the pandemic altered the personnel, workforce and resources available to progress the projects, as well as the ability of older people with mental illness and their families and carers to participate in face-to-face contact. Adding the research partnerships to our previous statewide practice improvement project methodology has added complexity, but should ultimately lead to publication of project outcomes that will in turn build action to improve the physical health of people with mental illness.

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Positively impacting physical health in mental health: Lessons learned for partnerships in regional NSW

Presenter:

Caroline Robertson

Presentation Resources

Caroline is the Senior Strategic Policy and Advocacy Advisor for Exercise and Sports Science Australia (ESSA) and looks after the mental health policy portfolio, advocating for the provision of physical activity to those with a mental illness. She also holds an adjunct Research Fellow position with Charles Sturt University, undertaking research examining the neurophysiological changes that occur as a result of exercise in those with mental illness.

ABSTRACT

Extensive research has demonstrated regular physical activity as key to maintaining physical and mental well-being. Nevertheless, research reporting on the design and delivery of a physical activity program with Older People with lived experience of mental illness is limited. To date, there are no reports describing research undertaken within a regional/rural setting in New South Wales.

In 2020, an interdisciplinary team comprising Occupational Therapists and Accredited Exercise Physiologists (AEP) in partnership with academic researchers tackled the challenge of designing and delivering a physical activity program with older people in the bush. The aim of the project was to deliver a 12-week exercise program consisting of three 60-minute weekly sessions to participants already engaged with case managers from the local Older Persons Mental Health team. The program was to be delivered by an AEP in a fully equipped gym environment accessible to community members with a design informed by research and consisting of a combination of cardio, balance, and resistance training tailored to the identified needs of each participant.

This presentation will reflect on a journey of co-design, adaptation, problem-solving and tenacity leading to delivery of a successful program. It will examine the challenges, benefits and strengths of a partnership incorporating clinicians from a public mental health service, AEPs from a private business and university based academic researchers. The presentation will conclude with an analysis of co-collaboration in practice; the experience of applying research to practice despite a pandemic; and discussion of the implications and lessons learned to inform future research endeavours.

PAPER

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Background

The benefits of exercise in reducing all-cause mortality are well-known in physical disease (Roberts et al., 2018; Vancampfort et al., 2015) but it is also known to improve depressive symptoms and quality of life in those with mental health conditions (Rosenbaum et al., 2014). This is a compounded issue for older adults, with a significant percentage living with complex health needs (NSW ACI, 2014). While research demonstrating the efficacy of exercise programs in improving mental and physical health of those with mental illness exists, there is a gap in implementation and evaluation of pragmatic and sustainable physical activity interventions within existing State Health services (Lederman et al., 2017), particularly in older populations and within regional areas. In 2018 a journey began for an interdisciplinary team that wanted to tackle the challenge of designing and delivering a physical activity program within OPMH in the bush. An AEP-led exercise program for older adults receiving treatment for a diagnosed mental health condition with the community-based OPMH service was implemented in central western New South Wales (NSW). The 9-week multi-modal exercise program consisted of strength, aerobic and balance exercises, with a combination of group and individual exercise tasks graded in intensity to improve overall fitness over the program duration. It comprised a maximum of three, one-hour exercise sessions per week and sessions were designed with participant consultation throughout to encourage maximum engagement and participation. The consultative approach enabled increases in intensity and range of exercises as fitness improved. To further maximise participation a mental health clinician known to participants was present at sessions. This paper reports on the lessons learned from collaborative partnerships through this experience.

Lessons learned

1. Connecting key stakeholders

   The original team that identified the gap in care recognised that they couldn't achieve this work in a silo. To work in collaboration, networks extending from the Local Health District Research team to external organisations including academic researchers and AEPs developed. At the time, the OPMH Policy Unit at a state-level had a key goal of enhancing physical health care in mental health and a partnership with Equally Well which further strengthened local development. Further cross-sector connections were made between Health and Academic staff. This led to project design based on partnerships incorporating public healthcare clinicians, AEPs from a private business, and university-based academic researchers. Research shows value in cross-sector partnerships, incorporating academic knowledge of research design with clinician skill and knowledge of interventions and then implemented this into real-life (Witteman, et al., 2018; Kerkhoff, et al., 2022; Fields, et al., 2021). These partnerships formed around a common vision and goals.

2. Leadership from the ground up

   Common vision, goal and commitment to these, created a united leadership and responsibility to progress this project. Cross-sector governance and leadership is a principle of partnerships and design (NSW ACI, 2014; Naylor, et al., 2016). From our experience, leadership was from two key members from clinical and academic backgrounds who were committed and persevered. It was these attributes that were influential in promoting the project at all levels and maintaining stakeholder engagement. Some studies describe these people as 'champions' (Bonawitz, et al., 2020; Demes, et al., 2020; Naylor, et al., 2016) and a number outline attributes for successful change in healthcare that are similar to the attributes of our leads: responsibility, persuasiveness, tenacity, accountability, dedication and motivation (Bonawitz, et al., 2020; Demes, et al., 2020; The Kings Fund, 2016; Henderson, et al., 2018).

3. Adaptation

   Adaptation became key to this project with the impact of systems, workforce changes, and resource restrictions. These are well-known barriers to partnership success (Ocloo et al., 2021; Henderson et al., 2018). One study argues incentives for individuals to adapt and collaborate are crucial for innovation (Kippin & Fulford 2016). Covid restrictions in particular meant a stop to in-person meetings. A unique advantage of the regional setting had already meant that infrastructure related to virtual platforms was available; however, the pandemic provided the hard stop to make all communication in this manner. This adaptation led to developing a covid-safe program for older people and to rethinking how we engage consumers, carers and the community.

4. Engaging consumers, carers and the community

   Engaging consumers, carers and the community is crucial (NSW ACI, 2014; Witteman et al., 2018; Ocloo, et al., 2021). There was an interest of the team to also understand the participant experience: Acknowledging their feedback and response to the program was important to sustaining interest in physical health as well as adding a narrative to enhance our research and inform further research and design. Although true consumer co-design in the development of the project was constrained, consumer and carer consultation, surveys and informal feedback influenced the project design. Consultation was held with consumers and carers of the OPMH service via an existing group. Survey information was received via existing processes of collecting consumer and carer service experience feedback. A formal process embedded in the project was interviews with consumers before and after the delivery of the intervention program. In two interviews, a carer was present and contributed feedback. Additionally, the AEP encouraged participants to share feedback, and tailored the program to this. Providing participants with an opportunity to individualise their exercise likely had significant benefits, contributing to engagement and the desire to continue physical activity after the program.

5. Achieving more than expected

   Our key driver was to improve physical health, and the project demonstrated that. Participants described improvements in fitness, balance and more awareness of fall-related risks, which converged with their physical test scores. They also reported feeling improvements in mood such as feeling brighter, having a more positive outlook and increased motivation and this was reflected in mental health measures. However, the unexpected learning across all involved was that partnerships had positively impacted physical health in older people experiencing mental health illness in regional NSW and we continue to contribute to the knowledge and research in this area.

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THEME:
PRIMARY CARE

Mental Health Shared Care with Community Mental Health Consumers

Presenter:

Presentation Resources

Andy Simpson

Andy has over 20 years of experience across inpatient and community mental health nursing settings, including two years in education and six years in management roles. For the last 2.5 years he's been the Program Manager with Living Well, Living Longer: Sydney Local Health District's integrated care program aiming to improve the physical health of people with severe mental illness. He's developed a Side Effect & Preventive Health Screening tool (SEPHS) to increase conversations between consumers and clinicians about side effects and physical health. He was recently awarded a translational research grant to enhance Mental Health Shared Care with GPs.

ABSTRACT

People living with severe mental illness have poorer physical health and receive less and lower quality health care than the rest of the population[1]. They experience a significant premature mortality rate, largely from preventable physical health conditions[2]. Immense personal and social costs are incurred.

Sydney Local Health District (SLHD) in partnership with the Central and Eastern Sydney Primary Health Network (CESPHN) has designed and implemented an integrated care strategy to address this: Mental Health Shared Care (MHSC).

MHSC improves communication and care integration between the consumer, GP, and mental health service (MHS), setting clear lines of responsibility. Peer support workers underpin this process, having actively contributed to the model of care from inception. After the provision of consent, the consumer, care coordinator and GP initially meet to review care and goals via a checklist, with the consumer bringing a support person/peer worker as desired. MHSC prompts a GP annual physical health review and agreed escalation points.

Over 700 consumers from 10 mental health teams have MHSC, involving over 329 GPs. To date, 70% of these consumers have received their annual physical health check. Mixed baseline data was gathered from all stakeholders to inform model development. A consumer information sheet was developed using artwork commissioned by an artist and consumer, and an upcoming video is being produced with consumer, peer worker and GP perspectives.

Enablers include a standardised checklist embeddable into GP practice software, three funding streams (Integrated Care, PHN & LHD) and two dedicated shared care clinicians. A widely represented steering committee chaired by the MHS Clinical Director meets bimonthly to provide clinical governance, review performance and plan for growth. Future initiatives include virtual appointments and an online secure accessible shared care plan, formally researched through an awarded Translational Research Grant. We will share our insights, lessons learned and future directions.

PAPER

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SLHD introduced MHSC across community mental health services in 2018 following a successful pilot. MHSC aims to improve working partnerships between the mental health service and an individual consumer's preferred general practitioner (GP) to better integrate physical and mental health care. MHSC is run in partnership with CESPHN and has become a key component of SLHD's Living Well, Living Longer program, an integrated care initiative with a goal to improve the physical health of people living with severe mental illness (PLWSMI).

There are many determinants to the 20 year life expectancy gap that PLWSMI experience, but a key aspect is reduced rates of screening and treatment for comorbidities(1). Contributing factors include lower levels of health literacy in PLWSMI, presenting as challenges with navigating the healthcare system or appraising health information effectively(2). Additionally, there is the impact of diagnostic overshadowing, a subconscious bias in healthcare professionals where presenting physical problems in PLWSMI are more likely to be attributed to mental health symptomatology, leading to a reduction of screening for physical health conditions(3). Other factors that may impact on reduced rates of screening by GPs in particular include patient non-attendance, time constraints in consultations, communication difficulties with both the patient and secondary mental health services, and a lack of clarity for whose responsibility it is to arrange for physical health screening(4).

MHSC addresses this by improving communication and care integration between the consumer, GP, and mental health service, setting clear lines of responsibility. Within 28 days of being allocated a care coordinator, a shared appointment is arranged with the consumer, care coordinator and GP to start the shared relationship, review care and set goals. To assist in the process a standardised MHSC Care Plan is utilised at the appointment, which is embedded within the GPs' practice software. This operates as a checklist to clearly designate care tasks between all parties.

The model is based on an annual cycle of care and the MHSC Care Plan prompts the care coordinator to arrange for an annual fasting blood test and subsequent shared appointment, where the GP conducts a follow up physical health check. This annual review is informed with relevant clinical information from the mental health service, and vital information is shared between both parties including physical and mental health reviews, prescribed medications and metabolic monitoring.

Two senior nurses have been recruited to promote the model within the community mental health teams and form relationships with key GP practices. They play a critical role in orientating care coordinators to the model, monitoring and promoting enrolments within the teams, and prompting annual physical health checks when due. Peer support workers underpin the process and have actively contributed to the model of care from inception.

Since the model was piloted in 2017, over 1,500 unique mental health consumers have engaged in formalised MHSC agreements, many of which have since been discharged from mental health services into GP care. At any single point in time between 2019 and 2022, approximately 700 active community mental health consumers are enrolled in MHSC, representing a third of the total community mental health cohort. Generally, around 70% of these have completed their first annual cycle of care and received a follow up physical health check with their GP. Across the SLHD boundary, over 300 different GPs are involved in providing these agreements.

Challenges have largely centred on time barriers, with in person medical appointments among various parties being difficult to arrange and time intensive. GPs are not incentivised to offer more comprehensive checks during appointments, and care coordinators need to balance the needs of a large number of allocated consumers. Many see reducing mental health relapse and hospitalisation as the priority, so finding the time to set up and attend shared GP appointments can be challenging. Additionally, as no secure communication platform exists between GPs and mental health services, liaison and communication can be time consuming and inefficient, with a reliance on faxing information remaining dominant despite the challenge of integrating faxed updates into electronic records.

Through the award of a translational research grant, the MHSC program is embarking on a new study in collaboration with the University of New South Wales and the University of Sydney to compare the effectiveness of the current model of care with an intervention utilising a web based shared care plan and telehealth reviews. The SHAReD Study (Shared Health Arrangements Research & Development) will evaluate consumer experience, quality of care and impact on quality of life. The study aims to improve consumer engagement in primary care and identify effective, efficient fit for purpose shared care processes.

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Embedding ‘lived experience’ engagement within PHNs

Presenter:

Tim Heffernan

Presentation Resources

Tim is a Deputy Commissioner with the Mental Health Commission of NSW. He is an experienced Consumer Peer Worker and is a past chair and current director of Being Mental Health Consumers. He also works as a Peer Supervisor and as an Official Visitor.

An award-winning poet, Tim co-edits on online space for ‘Mad Poetry’, ‘Clozapine Clinic – The Frater Project’ in the influential Australian journal ‘Verity La’. He has published widely and performed his poetry and facilitated workshops at the Wollongong Writers Festival, the Queensland Poetry Festival, the Big Anxiety Festival and at Mad Pride.

ABSTRACT

In recognition of the contribution of people with a lived experience of mental illness and/or suicide as central to the mental health system, the Department of Health has developed guidelines for Primary Health Networks (PHNs) that set out a clear framework for consumer and carer participation and more recently Peer Workforce.

In June/July 2018, Brisbane North PHN was invited by the Department of Health to chair and provide secretariat support to the newly established National PHN Mental Health Lived Experience Engagement Network (MHLEEN) to assist in improving and embedding ‘lived experience’ engagement within the PHNs, commissioning cycles and commissioned services.

The key purpose of the MHLEEN is to provide support to PHNs in a way that enables them to create an enhanced operational environment that supports not only lived experience and co-design within commissioning mental health and suicide prevention services but also is mobilised from within PHNs themselves. Activities have included:

- Collating and disseminating a stocktake of where PHNs are up to
- Circulating good practice ideas for co-design and commissioning cycles
- Maintaining a MHLEEN website on the National PHN SharePoint
- Attending meetings of the Mental Health Reform Stakeholder
- Have monthly ZOOM meetings and bi-annual planning and
- Presenting to the PHN National Stepped Care Workshops on progress.

Membership is open to all PHNs and relevant staff with responsibility for consumer, carer and lived experience engagement.

This presentation will provide a perspective from two of its members who have a lived experience and are employed by PHNs, Tim Heffernan (Mental Health Peer Coordinator – Coordinare & Assistant Commissioner NSW Mental Health Commission) and Paula Arro (Consumer and Carer Participation Coordinator, Brisbane North PHN).

PAPER

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Understanding the context and system: Regional, State, National

- The role of each PHN is to bring state and national planning together at the regional level.
- This needs to be done with consumers and carers through co-production (co-planning, co-design, co-evaluation and co-delivery).

Consumer Engagement

- doing to – (inform, educate)
- doing for – (consult, involve)
- doing with – (co-design, co-produce)
- doing by – (consumer/carer led)

Practice Principles

- conceptualising participation and engagement as routine practice
- skills and knowledge are recognised and developed (capacity building)
- leadership culture
- dedicated resourcing
- respect, safety and support
- evaluation and quality improvement.

Stages of development model (National Lived Experience (Peer) Workforce Guidelines)

- clarify and commit – preparation
- co-produce – implementation
- continuously learn – transformation

Case Studies – Regional

Peer Participation In Mental Health Service (PPIMS)

Aim and Purpose

‘Work collaboratively to actively participate in mental health systems and reforms in Brisbane North’.

Specifically, the functions of the Network include:

a) Collaborative development of a regional network of peers to provide ‘a voice’ for people with a lived experience as either a consumer or carer to the mental health sector in Brisbane North.

b) Support to other people with a lived experience who want to actively participate in the mental health system reform process and/or are accessing mental health services.

c) An opportunity to have regular updates and input around services, policy, program and system developments.

d) An opportunity to have regular updates and identify strategies to improve engagement, participation, training and employment opportunities.

e) Advice regarding emerging issues faced by consumers and carers in the mental health sector.

f) Participate in the co-design opportunities that evolve either through the PHN or other government and non-government services.

South Eastern NSW Regional Peer Work Framework

- Built on the joint commitment of COORDINARE, Southern NSW Local Health District (SNSWLHD) and Illawarra Shoalhaven Local Health District (ISLHD) to make mental health a joint regional priority, implementation of the South Eastern NSW Regional Mental Health and Suicide Prevention Plan has begun.
- The first action of this plan was to develop a regional Peer Workforce Framework.

Case Study – National

- PHNs engage people with a lived experience (i.e consumers and carers) in the co-design of systems and processes and embed consumer and carer engagement in the co-design throughout the commissioning cycle.
- PHNs to support better outcomes in mental health by promoting and supporting the employment of peer workers as part of multi-disciplinary teams providing person centred support and recovery-oriented and trauma informed care.
- Maintain a National Network of PHNs and other key stakeholders to support, coordinate and collaborate on continuous improvement of person centred, recovery focused planning, implementation and review of primary mental health care.
- Overall, the main aims and objectives of MHLEEN align with the Department's Guidelines for Consumer and Carer Engagement (2016) and Peer Workforce Development (2019) and the Fifth National Plan.
- Embed consumer and carer co-design throughout the commissioning cycle, including in needs assessment; policy development; strategic planning; prioritisation; procurement of services; and monitoring and evaluation.
- In summary, MHLEEN and PHNs have demonstrated a growing awareness, commitment and prioritising of lived experience engagement and peer workforce development. The recent Stocktake Report provides evidence of this and in particular having a central coordinated network which enables a strong collective voice, sharing of resources and support.
- Lived Experience Advocacy Delegates (LEAD) build a collective and independent voice and advisory group to support the work of MHLEEN. Provide support to people with a lived experience to actively participate in mental health reforms. Provide an opportunity to have regular updates on state/territory and national work underway. Provide advice on emerging issues faced by people with a lived experience (consumers and/or carers). Have opportunities to advocate on primary mental health issues. Disseminate information and

updates to local networks and groups.

Recommendations from the Stocktake Report

- Requirements to establish lived experience identified roles within PHNs. The Department and PHNs commit to resourcing and creating lived experience positions. This would require quarantined budget allocations in the Department's funding requirements of PHNs and the PHNs' Mental Health, Alcohol and other Drugs budget.
- Tendering and reporting of lived experience engagement and lived experience workforce. The Department and PHNs to include KPIs around lived experience engagement and lived experience workforce.
- Peer work in commissioned services - MHLEEN to undertake a survey of commissioned services to gather more detailed data on how commissioned services are embedding lived experience engagement and lived experience workforce.
- Collaborative engagement with other stakeholders - PHNs and MHLEEN to formalise partnership agreements with state/territory and national lived experience peak bodies.

Summary Highlights

Since 2018, increases in:

- including people with a lived experience on tender assessment panels, lived experience researchers, educators, trainers and peer workers
- awareness and partnering with the Lived Experience Advocacy Delegates (LEAD) Advisory group
- having policies, procedures and guidelines for engagement (e.g., including sitting fees, terms engagement templates and tools)
- PHNs having KPIs around lived experience engagement in their reporting requirements, and
- collaboration with other key stakeholders such as other PHNs, Mental Health Commissions and other external committees and governance groups.

Lived Experience Leadership in Australia

The National Mental Health Consumer and Carer Forum (NMHCCF) and MHLEEN partnership to co-produce Lived Experience Leadership in Australia.

The three projects have NMHCCF and MHLEEN members on project steering groups. The projects are:

- establishment of a central national repository of mental health consumer and carer leadership-related knowledge and initiatives to be included on the NMHCCF website
- co-design of a mental health lived experience governance framework and toolkit to guide identified priority organisations and jurisdictions when engaging with people with lived experience, and
- review and scoping of formal lived experience leadership education and training.

Foundational resources

Engagement

- Co-production - Putting principles into practice in mental health contexts, Cath Roper, Flick Grey & Emma Cadogan. 2018
- Participation ladder - consumer survivor lens, Indigo Daya. 2020
- NMHC Consumer and Carer Engagement: A practical guide
- NMHC Mental Health Safety and Quality Engagement Guide.

Lived Experience Workforce

- National Lived Experience Workforce Guidelines, Byrne et al., 2021
- QLD Framework for Lived Experience Workforce, Byrne et al., 2019
- Framework for Mental Health Lived Experience (Peer) Work in South Eastern NSW, Craze 2021.

THEME:
MODELS OF CARE ONLINE

The experiences of peer-facilitators delivering a physical activity intervention for emergency service workers and their families

Presenter:

Presentation Resources

Grace McKeon

Grace McKeon is an exercise physiologist and a PhD candidate within the School of Psychiatry at the University of New South Wales, Sydney. Her work focuses on the role of physical activity to protect and improve the mental health of high risk groups including emergency service workers and their families. She is interested in investigating how we can use digital technologies (e-health) to implement novel lifestyle interventions. Grace also works clinically and is leading the new exercise physiology clinic at a mental health medical research institute, the Black Dog Institute.

ABSTRACT

Introduction: Emergency service workers (e.g., police, fire, ambulance officers) are regularly exposed to occupational stressors and potentially traumatic events, resulting in an increased risk of poor mental and physical health. For example, emergency service workers are twice as likely to experience suicidal thoughts compared to the general population and one in ten will develop posttraumatic stress disorder. Despite this, emergency service workers face barriers to accessing traditional mental healthcare. Physical activity is a non-stigmatising, evidence-based strategy for improving mental health; however, novel ways to increase adherence to physical activity interventions are needed. Peers with lived experience may be well-placed to co-deliver physical activity programs alongside health professionals. The aim of this study was to understand the experiences of peer-facilitators in delivering an online mental health informed physical activity intervention for emergency service workers and their families.

Methods: Qualitative interviews were conducted with six peer-facilitators involved in the delivery of a co-designed physical activity intervention. The peers had lived experience of being an emergency service worker/family member and of being through the intervention as a participant previously. Interviews were audio recorded, transcribed, and analysed using exploratory thematic analysis.

Results: Two main themes emerged. The first theme related to the value of lived experience that reflected two subthemes, i) credibility and relatedness by virtue of experience; and ii) knowledge and confidence by virtue of experience. Peers delineated the roles of the study exercise physiologists and themselves, identifying their role as an opportunity to provide emotional support and motivation to exercise, rather than technical exercise prescription. The second theme related to the impact of the role on the peers themselves, whereby peer-facilitators reported feeling an increased sense of purpose and social connection.

Discussion: This qualitative study provides insight and guidance into how peer-facilitators can complement health professionals in the delivery of physical activity interventions for emergency service workers.

PAPER

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Background

- Emergency service workers (e.g., police, fire, ambulance officers) are regularly exposed to occupational stressors and potentially traumatic events. Subsequently, emergency workers experience an increased risk of poor physical health and mental health including posttraumatic stress disorder(1).
- Despite this, emergency service workers face barriers to accessing traditional mental healthcare including stigma, perceived shame, in addition to access and cost barriers(2).
- Physical activity is non-stigmatising and may help improve the mental and physical health of this population; however, novel ways to help people engage are needed(3).
- Peers with lived experience may be well-placed to co-deliver physical activity programs alongside health professionals. While peers working within the mental health system is not a new concept, research involving peers in the delivery of physical activity interventions is in its infancy(4).
- The aim of this study was to understand the experiences of peer-facilitators co-delivering an online physical activity intervention for emergency service workers and their families.

Methods

- Qualitative interviews were conducted with six peer-facilitators who had participated in the 10 week physical activity program(5) themselves and then ‘graduated’ into a peer support role. Interviews were audio recorded, transcribed, and analysed using exploratory thematic analysis.

Results

- Two main themes emerged. The first related to the value of lived experience that reflected two subthemes, i) credibility and relatedness by virtue of experience; and ii) knowledge and confidence by virtue of experience. Peers reported the importance of coming from the ‘blue and red light community’ and the established trust and credibility this brings.
- The second theme related to the impact of the peer-facilitator role on the peers themselves, whereby peer-facilitators reported an increased sense of purpose and social connection. Peers also reported that they were physically active since they felt they had to lead by example.

Conclusion

- This qualitative study provides insights into how peer-facilitators can complement health professionals in the delivery of physical activity interventions for emergency service workers. Further research is needed to elucidate training requirements and safety protocols.

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WellMob: Social and Emotional Wellbeing Online Resources for Indigenous Communities

Presenters:

Heidi Sturk

Presentation Resources

Heidi Sturk is the Director of eMHPrac (e-Mental Health in Practice) at Queensland University of Technology. Heidi develops, delivers and evaluates training and support on digital mental health to health practitioners and service providers nationwide. She holds a Master of Organisational Psychology and has over 25 years' experience working in mental health. Her areas of interest include how to integrate appropriate digital technologies into health care, rural and remote health care practice, and wellbeing of health practitioners.

Sharnie Roberts

Presentation Resources

Sharnie Roberts is a Widjabyl Wia-Bul woman from the Bundjalung Nation with a bachelor's degree in social sciences working on the WellMob project at the University Centre for Rural Health in Training and Navigation.

Sharnie has a wealth of understanding of social and health determinants that impact the mental health well-being of First Nations people in Australia and is passionate about walking alongside First Nation young people to empower the reconnection to their cultural identity for generational healing.

ABSTRACT

Introduction: E-Mental Health in Practice (eMHPrac) is a support service funded by the Australian Government to build digital mental health awareness and skills in primary care practitioners across the country. One of eMHPrac's recent initiatives is the development of WellMob, a website that brings together online social and emotional wellbeing (SEWB) resources for Aboriginal and Torres Strait Islander people. The website design and content reflect that connection to country, culture, community and kin are instrumental in Indigenous wellbeing.

Method: The inspiration for WellMob came from frontline health and wellbeing workers who needed a central place for safe culturally relevant online wellbeing resources. WellMob was developed with a co-design process under the guidance of Indigenous reference groups. As well as giving the website's development Indigenous governance, the project was led by Indigenous staff at the University Centre of Rural Health (part of University of Sydney) under the eMHPrac service in collaboration with the Australian Indigenous HealthInfoNet.

Results and findings: WellMob now has of over 200 videos, apps, podcasts and links to other websites on Indigenous social and emotional wellbeing. Since its launch in July 2020, WellMob has had a strong uptake with an average of 1,000 sessions a week. A culturally-based social media campaign has also directed new traffic to the website and the Facebook page now has over 2,500 followers. User surveys are currently underway.

Discussion: While the primary audience for this website is Indigenous frontline SEWB workers and their clients/communities, the website is helpful for non-Indigenous health practitioners who work with Indigenous clients. Many resources found on WellMob are narrative-style videos, podcasts, social media and story-based content that contribute to a sense of cultural connection and wellbeing. This innovative website is a significant resource to assist with the improvement of physical health of people living with mental illness in Indigenous communities.

PAPER

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E-Mental Health in Practice (eMHPrac) is a support service funded by the Australian Government to build digital mental health awareness and skills in health practitioners across the country. One of eMHPrac's recent initiatives is the development of WellMob, a website that brings together online social and emotional wellbeing (SEWB) resources for Aboriginal and Torres Strait Islander people. The website design and content reflect that connection to country, culture, community and kin are instrumental in Indigenous wellbeing.

The eMHPrac service has been funded by the Australian Department of Health since 2013. eMHPrac undertakes the following activities: development, delivery and evaluation of free training and support on digital mental health for health practitioners around Australia; collection and collation of new registrations and referrals to Australian digital mental health services; and provision of advice to the Australian Government on digital mental health policy. The service is led by Queensland University of Technology in partnership with the Black Dog Institute, Menzies School of Health Research and the University Centre for Rural Health (UCRH) that is a part of the University of Sydney in Northern NSW.

Digital mental health refers to information sites, online programs (self-guided or practitioner supported), apps, moderated online forums, phone lines and online counselling. Considerable research shows that online interventions can be as effective as face-to-face treatment, particularly if there is additional practitioner support. These effects can be strong and well-maintained. Digital mental health services can be used for information/education, self-monitoring, obtaining support from others, prevention, early intervention or treatment. They can also be utilised while waiting for face-to-face support, between sessions or post therapy and can be used for self-help and incorporated into preventive care.

It can be daunting to know where to find helpful online resources, particularly programs or apps. Many are not safe or secure and it is important to find evidence-based services. A good place to start is the Australian Government's digital mental health gateway, Head to Health. It links Australians to a range of free or low-cost government-funded digital mental health services.

eMHPrac also has a website with helpful resources. It is primarily aimed at health practitioners, but anyone can access the site and use the materials. The site has a resource library containing brochures, fact sheets, podcasts and links to webinars. There are also links to newsletters, blogs and research articles.

The eMHPrac team at UCRH established the innovative WellMob website in collaboration with Australian Indigenous HealthInfoNet. The inspiration for the website came from Aboriginal and Torres Strait Islander health workers and communities who wanted one place to find online wellbeing resources that are culturally relevant. WellMob was developed under the guidance of Indigenous reference groups set up across the nation in 2019-2020. Their role was to guide the look, feel and functionality of WellMob. As well as giving the website's development Indigenous governance, the project continues to be led Indigenous staff at UCRH.

The WellMob website is this country's first online library of over 250 videos, apps, podcasts and links to other websites on Indigenous social and emotional wellbeing (SEWB). It's been designed to help our diverse health and wellbeing workforce to find and share online wellbeing resources with Indigenous Australians. This includes school counsellors, youth workers, family support, D&A and NDIS workers, GPs, psychologists and other allied health professionals.

The WellMob website was launched in mid 2020 during the COVID-19 pandemic and associated lockdowns. While the primary audience for this website is Indigenous frontline SEWB workers and their clients/communities, the website has been promoted to non-Indigenous health practitioners who work with Indigenous clients. Anecdotal feedback from non-Indigenous clinicians indicates WellMob is a great cross-cultural and professional development tool to enable them to better engage with their Indigenous clientel.

As an Indigenous specific website, WellMob complements other mental health websites such as Head to Health, Beyond Blue and Black Dog Institute that are targeted for the general population. While many of these traditional/conventional websites focus on 'evidence-based' online mental health resources, WellMob goes beyond typical mental health topics and captures content around a more broad and holistic sense of Indigenous health and wellbeing that centres around culture.

The resources found on the WellMob website are also broader than just links to other websites and conventional mental health apps and online programs. Key resources that are most popular with Indigenous clients include videos, podcasts, social media and story-based content that contributes to their cultural connection and wellbeing as a protective health factor. This user generated content made often by and for Indigenous Australians resonates with their oral traditions and narrative-based cultures. These resources can be found under webpage topics such as culture, keeping safe, healing and our mob that feature alongside more conventional health related content under mind and body webpages. Our diverse workforce can now draw on this wide range of content to support their face-to-face roles, both in and out of session. It can also be used by Indigenous health professionals to support their self-care given the stress and 'lived experience' of health work.

The WellMob team at UCRH have developed some engaging brief videos that demonstrate how frontline workers and other health professionals can use it in their work with our diverse Indigenous communities. These videos can be found on the home page of the website. Since its launch in July 2020, WellMob has had a strong uptake and now averages 1,000 sessions a week. This innovative website is a significant resource to assist with the improvement of the social and emotional wellbeing of our diverse Indigenous communities.

For further information, contact: wellmob.info@sydney.edu.au

THEME:
CHRONIC CARE

Evaluation of Program to Improve Physical Health of People with Mental Illness

Presenter:

Presentation Resources

Andy Simpson

Andy has over 20 years of experience across inpatient and community mental health nursing settings, including two years in education and six years in management roles. For the last 2.5 years he's been the program manager with Living Well, Living Longer: Sydney Local Health District's integrated care program aiming to improve the physical health of people with severe mental illness. He's developed a Side Effect & Preventive Health screening tool (SEPHS) to increase conversations between consumers and clinicians about side effects and physical health. He was recently awarded a translational research grant to enhance Mental Health Shared Care with GPs.

ABSTRACT

People living with severe mental illness live 14-23 years less than the population average due mainly to treatable physical health comorbidities, yet receive poorer quality physical health care. To address this, Sydney Local Health District introduced the Living Well, Living Longer (LWLL) program, which uses a plethora of integrated care initiatives to guide individuals through the four stages of screening, detection, initiation of treatment and ongoing management.

These include:

1. The Collaborative Centre for Cardiometabolic Health in Psychosis (ccCHiP), a one-stop shop multidisciplinary clinic that provides comprehensive assessments of cardiometabolic risk and formulates treatment recommendations.
2. The Mental Health Shared Care (MHSC) program formalises care arrangements between GPs and mental health services guided by the shared care checklist, which defines the responsibilities of the mental health team and the GP while ensuring care reviews and prescribed medications are communicated within a comprehensive annual cycle of care.
3. Community lifestyle clinicians, namely dietitians, exercise physiologists, and smoking cessation officers have been employed to work with consumers to develop individualised achievable and relevant health behaviour change goals and support the practical strategies required to achieve these.

Since the program began in 2014, over 1,100 individuals have been reviewed at ccCHiP, 1,200 enrolled in MHSC, and over 2,100 have engaged with the lifestyle clinicians. A power-calculated sample of 251 consumers, representative of the community mental health population, was compared between 2016 and 2020. Average Body Mass Index improved from 30.6 to 29kg/m2 ($p=0.047$), a shift from the obese range to the overweight range. Low Density Lipoproteins reduced from 2.88 to 2.60 ($p=0.014$) and the proportion of people with elevated blood sugars (HbA1c) reduced from 45% to 30% ($p=0.025$). People who engaged with the LWLL interventions were more likely to show health improvements. These outcomes and future directions of the program will be discussed.

PAPER

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1 Sydney Local Health District

The Living Well, Living Longer program (LWLL) is an integrated care initiative within Sydney Local Health District. It was established in 2013 to provide care pathways to improve the physical health of people living with severe mental illness (PLWSMI). All people receiving care coordination from the Sydney Local Health District Adult Community Mental Health Service (hereafter 'consumers') are eligible.

PLWSMI are six times more likely to die from cardiovascular disease and four times more likely to die from respiratory disease compared to the general population, contributing to a 14-23 year loss of life.(1) This is largely attributed to high rates of modifiable cardiometabolic risk factors such as smoking, obesity, diet and sedentary lifestyle.(2) Additionally there is high prevalence but poor screening and treatment of conditions such as dyslipidaemia, hypertension and type 2 diabetes in PLWSMI.(3)

LWLL has been designed to provide consumers with a seamless, comprehensive care pathway through the four stages of screening, detection, treatment initiation and ongoing management of their coexisting physical health conditions. LWLL employs peer support workers, smoking cessation support, dietitians and exercise physiologists. Additionally, specialist nurses are employed to facilitate and promote the Mental Health Shared Care (MHSC) program, a core component of LWLL. Since LWLL's inception, people with lived experience of mental illness have been consulted on the design and implementation, including peer support worker representation at all levels of governance of the program.

From the outset of the consumer journey through LWLL, a discussion prompt tool is utilised by care coordinators to assist consumers to set goals for improved physical health. Care coordinators and peer support workers are trained to complete metabolic screening which is offered within 28 days, along with a fasting metabolic blood test.

Following this, a shared appointment is set up between the consumer, their care coordinator and general practitioner (GP) to initiate MHSC, where a standardised care plan is used to identify roles and responsibilities. Crucially there is an agreement around exchange of information, ensuring improved communication between all parties. The MHSC care plan includes milestones and target dates, and annual physical health checks are tracked as a key performance indicator.

Consumers have routine access to peer support workers who use their lived experience of mental illness to offer empathic support, empowerment, and validation to inspire healthy lifestyle choices. The peer support workers help facilitate therapeutic groups such as walking, yoga, or 'Gym and Swim', run in collaboration with LWLL exercise physiologists, which meets twice a week at a local aquatic centre. If required, consumers may be referred to credentialed smoking cessation officers who offer psychological support to reduce or quit smoking, and free nicotine replacement therapy. Additionally peer support workers offer a smoking cessation group.

During their engagement with LWLL, consumers are referred to the Collaborative Centre for Cardiometabolic Health in Psychosis (ccCHiP) where they're seen by a range of cardiometabolic health specialists in one afternoon. The LWLL dietitians and exercise physiologists integrate into ccCHiP, helping the multidisciplinary team within the clinic to provide comprehensive cardiometabolic assessments. The ccCHiP team also includes a psychiatrist, cardiologist, endocrinologist, clinical nurse consultant, oral health therapist and sleep specialist.

Following ccCHiP, the consumer's GP is provided with a set of recommendations for treatment options towards improved cardiometabolic health. The LWLL specialist nurses support care coordinators to book shared follow up appointments with consumers' GPs, where the recommendations can be reviewed. This appointment can double up as the annual physical health check as part of MHSC.

During their brief assessment within the ccCHiP clinic, LWLL dietitians and exercise physiologists offer follow up appointments in consumers' homes or a local health centre, where they provide comprehensive diet/exercise review. They work with consumers to develop individualised, achievable health behaviour change goals and provide practical strategies and ongoing support to achieve those goals. Care coordinators can also refer directly to these clinicians, without needing to wait for the ccCHiP review to occur.

The LWLL model is based on an annual cycle of care. Consumers who access the service for longer periods are offered annual ccCHiP reviews and subsequent physical health checks with their GP as part of MHSC. This frequency may be adjusted depending on individual cardiometabolic risk factors.

There have been many individual success stories for consumers who have engaged with LWLL, and the peer support workers regularly share these consumer stories to inspire others. When consumers have the right information and support, they have been able to make positive changes in their health and wellbeing and transform their lives.

There are early indications that LWLL has contributed to preventing deteriorations in physical health. For example, a random sample of 251 consumers, power-calculated to be representative of the community mental health population, was compared between 2016 and 2020. Average Body Mass Index improved from 30.6 to 29kg/m2 ($p=0.047$), a shift from the obese range to the overweight range. Low Density Lipoproteins reduced from 2.88 to 2.60 (p=0.014) and the proportion of people with elevated blood sugars (HbA1c) reduced from 45% to 30% (p=0.025). A multivariate comprehensive analysis of big data sets is underway to validate these early findings.

The Sydney Local Health District Mental Health Service is exploring opportunities for continued investment to further integrate with primary care, including the use of technology to streamline consumer identification and follow up. To this end, the District has started a randomised controlled, translational research trial to introduce a web-based shared care platform. This will investigate the impact on communication between GPs and mental health services, and the quality of primary care received by individuals who are engaged in MHSC. The study is a partnership with University of New South Wales and the University of Sydney.

The take home message from LWLL would be to stay the course, and don't be afraid to challenge the professional nihilism that exists which implies the problem is too hard, or that mental health consumers don't want to be healthier, because this isn't the case. Consumers need information and the tools, coupled with clinical and peer support, to make changes.

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Supporting Healthier Lifestyles: A Role for Community Managed Organisations

Presenter:

Presentation Resources

Jenny Bowman

Professor Jenny Bowman is a health psychologist and researcher at The University of Newcastle. Jenny is passionate about understanding and addressing physical health disparities among people with a mental health condition, and leads the Physical Health in Mental Illness (PHiMI) research team, which addresses preventive care for smoking, nutrition, alcohol use, and physical activity risk factors for people with a mental health condition.

Jenny and the PHIMI research team are undertaking a program of work focusing on strategies to increase the capacity of mental health services and community agencies to provide best practice preventive health care for people with a mental health condition. In partnership with key policy agencies and peak bodies, and undertaken with end-user organisations, this program of work strives for both scientific value and relevance to health policy and practice.

ABSTRACT

Introduction: Community managed organisations (CMOs) may play a valuable role in providing preventive care to people living with a mental health condition (consumers) to improve lifestyle health behaviours (related to smoking, nutrition, alcohol and physical activity). Little research, however, has explored the extent to which this potential is being realised or how the capacity of CMOs to provide preventive care might be increased. This presentation provides an overview of the NSW-wide 'CMO Connect' project; designed to address this gap.

Methods: The project is triangulating data collected from CMO leaders, staff and consumers, using both quantitative and qualitative methods. It is assessing the current provision of preventive care, barriers and facilitators to provision, as well as consumer views of acceptability. Data is informing the conduct of a pilot trial of co-developed strategies to increase the capacity of CMOs and staff to support consumers in improving lifestyle health behaviours.

Results and findings: This presentation will provide an overview of key findings from the project to date. Despite consumer expectation of receiving preventive care from their CMO support workers, such care is infrequently provided systematically, across behaviours, for all consumers. Factors likely to facilitate routine and comprehensive care provision include: staff training and guidelines; the availability of funding at both a service and consumer level; the degree to which the importance of a healthy lifestyle is embedded within organisational culture; and awareness of supports which might be offered by other CMOs and services, and to which consumers might be connected.

Discussion: Tailored strategies are required, co-developed with CMO staff and consumers, to increase the capacity for preventive care provision to consumers. Given diversity across CMOs in care and funding models, and in staff and consumer characteristics, strategies which can be adapted to a range of settings will be especially important.

PAPER

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Community managed organisations (CMOs) are non-government organisations that provide holistic and person-centred support to people with a mental health condition, including support for employment, accommodation, and daily life assistance, as well as peer support. They are an important and growing part of the mental health care system, accounting for a quarter of the mental health workforce in NSW. CMOs may play a valuable role in providing preventive care to people living with a mental health condition (consumers) to improve lifestyle behaviours, including:

smoking, nutrition, alcohol and physical activity. Little research, however, has explored the extent to which this potential is being realised or how the capacity of CMOs to provide preventive care might be increased. The NSW-wide ‘CMO connect’ project was designed to address this gap, involving triangulated data collected from CMO leaders, staff and consumers, using both quantitative and qualitative methods. The overarching aims were: (1) to explore the potential role CMOS might playing in providing preventive care, and (2) identify ways to assist CMOs to adopt and implement evidence-based preventive care to better address the physical health needs of consumers. The project assessed various measures including the current provision of preventive care, barriers and facilitators to provision, as well as consumer views of acceptability. Data were collected via:

- Online survey (n=86) and qualitative interviews (n=12) with CMO managers
- Online survey of staff (199 staff across 11 NSW CMOs)
- Telephone survey of consumers (n=150)
- Findings informed the development and conduct of a pilot trial (in one CMO) of co-developed strategies to increase the capacity of CMOs and staff to support consumers in improving lifestyle behaviours.

Some key findings

Provision of preventive care:

- Preventive care is being provided, but not always in a systematic or comprehensive manner.
- Managers reported less than 50% of CMOs had policies addressing one health behaviours; 80% of managers reported their organisation provided care to address at least one behaviour. Types of support commonly provided included practical education and life skills, referral and local connection, and encouragement.
- The proportion of staff reporting they addressed health behaviours at least once per week ranged from 61% (smoking) - 85% (physical activity).
- While consumers rated their expectation and acceptability of receiving preventive care from their CMO as high (71%+), receipt of care was lower and ranged by behaviour: less frequently for alcohol and most frequently for physical activity.

Barriers and enablers to preventive care (reported by staff and managers):

- Staff training and guidelines
- The availability of funding at a service level
- Perceived ability to influence behaviours
- ‘a healthy lifestyle’ embedded within organisational policy and culture
- Staff awareness of support available within other CMOs and services, to which consumers might be connected.

Pilot trial of co-developed strategies with one CMO:

- Co-development workshops were held with staff & managers of one CMO (n=20 participants)
- Pilot trial of the strategies: analysis is ongoing, preliminary findings regarding the training component indicate staff (n=16) increased ratings of confidence and importance of providing preventive care, as well as increased competence.

Implications

Tailored strategies are required, co-developed with CMO staff and consumers, to increase the capacity for preventive care provision to consumers. Given diversity across CMOs in care and funding models, and in staff and consumer characteristics, strategies which can be adapted to a range of settings will be especially important.

THEME:
CARE COORDINATION

Delivery of a co-designed pharmacist-led service to support physical and mental health

Presenters:

Presentation Resources

Amanda Wheeler

Professor Wheeler is a Professor of Mental Health at Griffith University. She has worked as a health practitioner, educator and researcher in mental health and pharmacy practice for almost 20 years. She is nationally and internationally recognised for her expertise in these areas. Her research focuses on quality improvement, professional practice, workforce development and capacity building. These themes come together with the common goal of improving outcomes for consumers and carers and are integrated across the full scope of her work.

Presentation Resources

Helena Roennfeldt

Helena is a lived experience researcher and PhD candidate. Her research explores the experiences of mental health crisis and formal mental health crisis responses. Helena has researched extensively on the development of the Lived Experience workforce in Australia. She holds a Master's degree in Social Work, Forensic Mental Health, Suicidology and Mental Health Practice. Helena has over 20 years' experience working in the mental health sector and her academic, practical and lived experience informs her knowledge and skills base in qualitative research.

ABSTRACT

Introduction: There is an emerging role for community pharmacists to work in partnership with consumers living with Severe and Persistent Mental Illness (SPMI) to support their physical and mental health. This presentation will provide an overview of the reasons why a pharmacist-led support service for people living with SPMI is needed, using evidence from the literature, consultations with consumers with lived experience, and learnings from the development and delivery of the Bridging the Gap between Physical and Mental Illness in Community Pharmacy (PharMIbridge) Randomised Controlled Trial (RCT).

Methods: Community pharmacies (n=55) in four Australian regions were randomised to either the PharMIbridge Intervention (IG) or Comparator Group (CG). Trained IG pharmacists (n=55 including interns) are working together with consumers living with SPMI over a 6-month period, by supporting their physical and mental health needs, and addressing any medication issues. A pharmacist and a consumer educator with lived experience of mental illness working in partnership as a mentor pair are supporting service implementation in IG pharmacies.

Results: The training framework and its delivery will be described, including the mentoring partnership roles. The experiences of the research team and consumer mentors over the past 18 months will be shared.

Discussion: The PharMIbridge RCT aims to address the physical and mental health needs of consumers living with SPMI and use the medication expertise of community pharmacists to support medication adherence.

This RCT is funded by the Australian Government Department of Health as part of the Sixth Community Pharmacy Agreement. https://www.griffith.edu.au/menzies-health-institute-queensland/our-research/pharmibridge

PAPER

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- There is a significant life expectancy gap for people with severe and persistent mental illness (SPMI) attributable to physical health and comorbidities(1), and urgent attention is needed to address the physical and medication-related needs of people living with SPMI;
- There is a potential role for community pharmacists to work in partnership with consumers living with SPMI to support their physical and mental health. Yet barriers exist, such as stigma, lack of mental health training, and lack of confidence identified by community pharmacists in supporting consumers;
- PharMIbridge is a randomised control trial (RCT) and a partnership between the Pharmacy Guild, Griffith University, Pharmaceutical Society of Australia, and University of Sydney. It was funded under the 6th Community Pharmacy Agreement (CPA) and aimed to address the physical and mental health needs of consumers living with SPMI by evaluating the effectiveness of an individualised pharmacist-led support service (the PharMIbridge intervention) compared to usual care (MedsCheck(2));
- 55 community pharmacies from four Australian regions were trained face-to-face after randomisation to either the PharMIbridge Intervention (IG) or Comparator Group (CG). Both groups completed MHFA and research protocol training. Participants from IG pharmacies received an additional day of training, including role plays, case studies and interactive modules delivered by experts which was facilitated by a consumer and pharmacist mentor pair;
- A novel aspect of the intervention was that pharmacists in each region had access to ongoing support via a co-mentoring model of pharmacist and consumer mentor pairs. This was a collaborative partnership based on mentor pairs sharing, listening, and being willing to learn from each other's expertise. Consumer mentor roles added value by sharing personal and collective experiences of the impact of medication and treatment but also understanding the reasons behind medication non-adherence and broader effects on mental and physical health, including social factors;
- Pharmacies involved in PharMIbridge aimed to provide a mental health-friendly setting; a safe space for consumers in the community, showing warmth, empathy, generosity, listening and respecting consumers' goals, working together with professionals, and seeking supports in the community;
- Pharmacists described getting to know the 'person behind the script' and shared positive stories and experiences of consumers during their participation. Pharmacists reported being surprised by the power of small goals, such as getting up earlier and showering daily, but also the big dreams and the intersection of physical, mental health, and social goals;
- The resilience of all those involved was evident in the high completion rates of pharmacists working with consumers despite multiple barriers, including implementation during the pandemic and pivoting to accommodate the many changes in response to lock-downs, border restrictions and community pharmacy's key role as COVID-19 vaccinators.

Funding: This activity received grant funding from the Australian Government. The researchers were independent from the funder. This article contains the opinions of the authors and does not in any way reflect the views of the Department of Health and Aged Care or the Australian Government. The funding provided must not be taken as endorsement of the contents of this paper.

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Co-developing an intervention to support a community managed organisation to provide preventive care

Presenter:

Presentation Resources

Casey Regan

Miss Regan began her PhD in January 2020 with the School of Psychology, University of Newcastle. Her research aims to reduce chronic disease risk among people with a mental health condition by increasing preventive care delivery in community-based mental health settings through tailored practice change interventions. Miss Regan has contributed to the development, implementation, and evaluation of such interventions across two projects in community-based mental health settings. She completed her Bachelor of Psychology (Honours) at the University of Newcastle in 2019, during which she explored the receipt of smoking cessation care in community mental health services.

ABSTRACT

Introduction: People with a mental health condition are more likely than the general population to engage in poor lifestyle behaviours such as smoking tobacco, being physically inactive, having a poor diet and consuming alcohol at harmful levels. Community managed organisations (CMOs) represent an opportune setting to support mental health consumers in improving their lifestyle behaviours. This study aims to summarise the co-development of a pilot intervention which will build the capacity of staff of a CMO to provide care to support their consumers' in achieving lifestyle behaviour change goals.

Method: Two three-hour workshops will be conducted with staff members (approx. n=15) of one NSW CMO. The aim of the workshops is to lead end-users to put forward potential strategies to support staff in providing care for lifestyle behaviours. A series of activities will gather insights, ideas and set priorities. Qualitative inductive thematic analysis will be conducted on the workshop transcripts. Participants will also complete a survey about their perceptions of the potential support strategies, and an evaluation of the workshops as a co-development process.

Expected findings: Co-development workshops are expected to occur in May 2021. Findings of the workshops will be presented, including: key themes identified from the thematic analysis of the dialogue transcript; perceived feasibility, the acceptability and appropriateness of identified support strategies; and the effectiveness of the workshops as a co-development process.

Discussion: Findings from the workshops will inform the development of a pilot intervention to increase the delivery of support for lifestyle factors among consumers with a mental health condition who access community managed organisations. Using a co-development process to develop intervention support strategies to improve care engages end users. Therefore, co-developed strategies are more likely to be feasible and acceptable to end users, as they are designed to meet the needs of consumers and staff; optimising the likelihood of their potential impact.

PAPER

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Summary

- People with a mental health condition experience poorer physical health than people without a mental health condition including a greater morbidity and mortality from chronic diseases, contributed to by the presence of multiple lifestyle factors.
- A preventive approach can be taken to address chronic disease by supporting people to achieve lifestyle behaviour change goals, such as helping people to quit smoking, reduce alcohol intake, participate in physical activity, and eat nutritious foods.
- People can be supported to achieve lifestyle goals by having conversations about behaviour change,

being provided with education and advice, and getting connected to further support and behaviour changes services.

- Community managed organisations (CMOs) are one setting in which to deliver this support.
- We engaged in co-development with staff of a CMO to develop resources and strategies for staff to assist them to deliver support. Co-development involved a three-hour workshop with CMO staff in a variety of roles and was facilitated by two researchers.
- The workshop was segmented into seven parts: 1) facilitators presented the project overview and proposed ways to deliver lifestyle support; 2) group discussion about ways to deliver lifestyle support; 3) facilitators proposed evidence-based strategies; 4) group discussion about preferred strategies; 5) facilitators documented strategies and input them into a survey; 6) strategy ranking activity and results presented; and 7) group discussion about strategy implementation.
- Preferred strategies across the two workshops included: a) training in having difficult conversations; b) a point of care prompt for staff; and c) a guide for connecting people to behaviour change services.
- The co-development workshops ensured that the strategies that will be developed and trialled as part of a larger intervention trial will be more likely to be fit to practice, and be perceived as feasible, appropriate, and acceptable by staff as the end-users of the strategies.

THEME:
PHYSICAL ACTIVITY AND DIET

Improving access to physical activity interventions for adults with mental health issues

Presenter:

Presentation Resources

Justin Chapman

Dr Chapman completed his doctorate in measuring and positively influencing the physical activity patterns of adults with mental illness in 2016. His work spans research, mental health service and community sectors: He leads a multi-centre randomised controlled trial of interventions to promote physical activity in adults with mental illness, a health service improvement initiative to improve the focus on health and wellbeing of consumers, and implementation of state-wide healthy lifestyle intervention programs for youth and adults recovering from mental illness across Queensland. He has 19 research publications since 2015 (11 as first author) including two health service reports and one conference proceedings paper summarising his implementation projects, and has attracted $1.6M in research and implementation funding from government, philanthropic, and hospital-based schemes.

ABSTRACT

Background: People with mental illnesses are at higher risk of developing preventable physical diseases than the general population. Physical activity (PA) has diverse benefits for physical and mental health; however, people with mental illness face numerous barriers to becoming physically active. Improving access to effective and evidence-based PA programs is an ongoing issue for communities and health services.

Methods: This presentation will describe the evolution of a 5-year body of work to develop, implement and evaluate an evidence-base, collaborative care model for provision of PA programs for people with mental illness. Two randomised controlled trials of different types of exercise interventions have been conducted, and findings translated into community implementation through diverse partnerships with public mental health services and non-government organisations in South East and North Queensland.

Results and findings: Over 500 participants have benefited from the programs over this time, demonstrating improved quality of life, recovery, sense of belonging and self-determined motivation, and reduced distress and depression. The mean rate of completion for these 8-week programs is 60%, and attendance is 58% of group sessions. Incorporating motivational coaching was more effective than only providing exercise instruction and gym membership for facilitating behaviour change. Programs are currently funded by North Queensland Primary Health Network, and implemented by PCYC Queensland co-facilitated by MIND Australia, The Junction, and Cairns & Hinterland Mental Health Alcohol Tobacco and Other Drugs Service, with QIMR Berghofer as the research evaluation lead.

Discussion: A community-based collaborative care model for provision of evidence-based PA support is feasible and associated with improvements in psychosocial outcomes for people with mental illness. A state-wide cluster randomized trial of this model is needed to provide robust evidence on service-level cost-effectiveness and impact on metabolic health outcomes of consumers, and to lobby government for sustainable investment.

PAPER

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- People with mental illnesses are at higher risk of developing preventable physical diseases than the general population. Physical activity (PA) has diverse benefits for physical and mental health; however, people with mental illness face numerous barriers to becoming physically active. Improving access to effective and evidence-based PA programs is an ongoing issue for communities and health services.
- The Healthy Bodies Healthy Minds program was developed and piloted in 2015-2016 to improve access to lifestyle intervention programs in the Metro North region of Brisbane in Queensland.
- Over the past six years, the program has adapted to the changing mental health funding landscape, being supported by Partners in Recovery, Primary Health Networks (PHNs), National Disability Insurance Agency, philanthropic funding, and research grant funding.
- The program has evolved into a service model, being implemented in partnership with non-government organisations and hospital and health services (HHSs). This approach was highlighted as an exemplar in a 2021 Queensland Health publication, "Improving the physical health of consumers of mental health alcohol and other drug services"(1).
- The program is delivered by exercise physiologists. Participation involves individualised gym-based exercise programs delivered in groups of up to 10 participants. Weekly sessions are co-facilitated by peer workers or other clinical staff, and also involve nutrition and health education.
- Participants can remain involved for as long as they like (i.e., there is no 'cut-off' for duration of involvement, with re-assessments completed every 8-10 weeks).
- Over 600 participants have entered the program since 2015. Participants have improved on outcomes of quality of life, recovery, motivation for exercise, sense of belonging, wellbeing, psychological distress, and fitness(2 ,3, 4).
- The North Queensland Primary Health Network commissioned the service 2018-2023. Strategic planning is around investigating the scalability of this approach with different regions and exploring co-commissioning with PHNs and HHSs.

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Effectiveness and cost-effectiveness of dietary interventions in individuals with a mental disorder: The extent of evidence from review studies

Presenter:

Presentation Resources

Scott Teasdale

Scott is an Equally Well Ambassador, Research Fellow and Dietitian with Mindgardens Neuroscience Network, and Vice-Convenor of the Dietitians Australia's Mental Health Interest Group. Scott was the founding Dietitian for the Keeping the Body in Mind lifestyle program which aims to protect the physical health of people utilising the mental health services in South Eastern Sydney. His body of research work focuses on the role of nutrition for both physical and mental health in people living with mental illness.

ABSTRACT

Introduction: Accredited Practising Dietitians (APDs) are health professionals equipped to take a lead role in multidisciplinary teams to provide effective, evidence based dietary interventions for the prevention, treatment and management of mental illness and/or associated physical illness. A body of research work was undertaken with two distinct aims (1) to determine the extent of research undertaken on the effectiveness of dietary interventions for individuals with a mental disorder on dietary intake, mental health symptomatology and physical health outcomes, (2) to explore the extent of the evidence of experimental studies evaluating the cost effectiveness of dietary interventions in individuals with mental disorders.

Methods: Systematic reviews were undertaken for each aim through searching a range of online databases to identify published research studies. Each review was inclusive of a range of mental health conditions including disordered eating, severe mental illness, substance use, depression and anxiety. For each review standardised screening and data extraction was undertaken using recognised international methodology.

Results:

Aim 1: A total of 46 reviews were included across areas of: disordered eating (N=3), severe mental illness (N=31), substance use disorders (N=3), and depression and anxiety (N=9), totalling 46 included systematic reviews within this rapid review. The majority of reviews were published within the last five years (i.e., since 2016) (N=27), and included studies conducted in adult populations (N=28). Most reviews in the areas of severe mental illness and depression and anxiety reported conclusions in support of the positive effects of dietary intervention, including for nutrition education and behaviour change type interventions.

Aim 2: A total of 13 articles reporting on eight studies were included. Seven studies were in community settings (e.g. outpatient clinics), and one study in the community housing setting. All studies were in adults, seven included male and female participants. Defined mental disorder diagnoses included serious/severe mental disorders (n=3), major depression (n=2), schizophrenia, schizoaffective disorder or first-episode psychosis (n=1), any mental disorder (n=1), and bulimia nervosa (n=1). Five interventions were multi-behaviour, two were diet only and one was an eating disorder treatment. Cost analyses included cost-utility (n=3), cost-effectiveness (n=1), cost-utility and cost-effectiveness (n=3), and a costing study (n=1). Two studies (25%) reported positive results in favour of cost effectiveness, and four studies reported a mix of positive and neutral results.

Discussion: Dietitians have a defined role statement for mental health, a position paper, and from the reviews support that dietary interventions show promising results to improve mental health and may be a cost-effective approach.

PAPER

Authors

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10 Dietitians Australia, Australian Capital Territory

Improving the physical health of people living with mental ill-health requires a holistic, multidisciplinary, person-centred approach.[1] Historically, nutrition experts have not typically been considered core clinicians of mental health services. The role of nutrition experts in this multidisciplinary approach for people with mental ill-health is evolving and becoming more established.

Dietitians are tertiary qualified (at least four years of University) allied health professionals and experts in nutrition and dietary advice.[2] Dietitians are trained to engage in food service management, group dietary therapy, individual dietary counselling and medical nutrition therapy. Dietitians Australia, the national governing body for dietetics in Australia, runs a credentialling program for dietitians – the Accredited Practising Dietitian (APD) Program. This requires undertaking continuing professional development, following national professional standards and being subject to Dietitians Australia's audit and complaints processes.[2] Accredited Practising Dietitians are best placed to provide nutrition and dietary advice to people living with mental ill-heath, their carer(s) and their mental health team.[3]

In order to monitor the scientific evidence to inform the role of dietitians in mental health and to advocate for their inclusion in the multidisciplinary team for holistic care in people with mental ill-health, two projects were undertaken. First, four rapid reviews of systematic reviews were conducted to identify the extent of research undertaken on the effectiveness of dietary interventions on the dietary intake, mental health symptomatology and physical health of people living with mental ill-health.[4] Each rapid review focused on a specific diagnostic group: severe mental illness, depression and anxiety, eating disorders and substance use disorders. Four databases were searched for systematic reviews that included experimental studies assessing the effectiveness of dietary interventions on physical or mental health. Forty-six reviews were included, with the majority (67%) focusing on physical health of people with severe mental illness. Most reviews in severe mental illness and depression and anxiety reported favourable results for weight-related and/or mental health outcomes. Dietary interventions delivered by dietitians tended to have more favourable outcomes than those dietary interventions delivered by other professionals. Less evidence was identified for eating disorders and substance use disorders. This rapid review of reviews concluded that dietary interventions should be available to people living with mental ill-health to support their physical and mental health.[4]

Second, a systematic review was conducted to understand the evidence from cost-effectiveness studies; critical evidence for advocating to management and policymakers.[5] Four databases were searched for cost analyses conducted on experimental studies to improve dietary intake in people with mental ill-health. Thirteen scientific publications reporting on eight dietary interventions were identified. These were predominantly delivered to people with schizophrenia spectrum disorders and mood disorders (6 studies), with one study also conducted in people with bulimia nervosa, and one delivered to anyone with mental ill-health. A variety of cost analysis methods were used, from a costing study through to cost-utility and cost-effectiveness studies. These preliminary cost effectiveness studies have found mixed results and more studies are needed to understand health sector and societal costs and subsequently influence decision makers.[5]

The role of Accredited Practising Dietitians has been disseminated to the psychiatry field through a peer reviewed publication detailing the evidence base for dietitians in mental health and how people with mental ill-health can access a dietitian in Australia.[3] In turn, Dietitians Australia is working to ensure Accredited Practising Dietitians are upskilled to be safe and effective when working with people living with mental ill-health. This has included incorporating mental health into dietetics course curriculums and enabling dietetic student placements in mental health services, the development of an online mental health upskilling course for dietitians and a suite of mental and nutrition resources for health professionals, consumers and carers. These are complemented with the Dietitians Australia's Mental Health Role Statement which is updated every few years to translate new evidence into good practice principles.[6]

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Physical Movement: Challenging the medical model of exercise

Presenter:

Bonnie Ratcliff

Presentation Resources

Bonnie is in her final year of the Master of Social Work (Qualifying) at the University of Sydney. In 2021 she completed her student placement with Neami National, where she contributed to research on best practice in physical activity initiatives. Recently, she assisted with a research project to inform practice with parents with intellectual disabilities who are involved in child protection proceedings. Bonnie also works as a Community Support Worker with older people and people with disability.

ABSTRACT

Introduction: The established idea of exercise and physical activity as something that we ‘should’ do is associated with feelings of shame or guilt around any inaction towards set goals and guidelines. What if physical activity could be reframed as an experience that is fluid, accessible and part of daily life?

Method: A literature review that applies an integrative methodology, folding in consumer and stakeholder expertise, to generate critical perspectives.

Results and findings: This literature review shifts the focus away from prescriptive physical activity, towards a concept of movement that sees people doing what feels good and is meaningful. Moving around the home, getting out in nature, spending time with others; these are whole-of-person and whole-of-life experiences that involve movement, but are often overlooked by the medical and individualised model of exercise. Grounded by the Social and Emotional Wellbeing framework, these movements are not only connected to physical and mental wellbeing, but also to the social, emotional, cultural, and spiritual aspects of the individual and collective self.

Discussion: This research challenges how organisations develop and implement physical activity programs. It presents an alternative vision for future practice and research.

PAPER

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I wish to honour the researchers, advocates and consumers whose activism forged the path for this piece. I also pay my respects to the Gadigal, Yugambeh and Kombumerri people upon whose unceded lands this research was inspired, written and presented. It always was, always will be, Aboriginal land.

Introduction

People with lived experience of mental health challenges have a significantly reduced life expectancy that is up to 20 years less than the average Australian[1]. Over the past decade, physical activity has received increasing attention as a preventative strategy to address this gap[2]. However, growing literature points to implementation challenges; we know that physical activity works but we just aren’t doing it effectively[3]. Exercise psychology is yet to produce program methods capable of increasing physical activity behaviour in a sustainable manner across the population[4]. The failure of existing responses signals that we must look to new knowledge[5]. This literature review will consider whether finding a sustainable approach to improving physical health for people with lived experience of emotional distress requires a re-think of how ‘physical activity’ is conceptualised.

This paper will begin by outlining the current definition of physical activity and the dominant discourses that guide program development. This is followed by a critique, drawing on a variety of sources and voices to explore future program directions.

Lived experience perspectives have meaningfully shaped the direction of this research. This literature review was constructed alongside a series of discussions with consumers, peer workers and key stakeholders at Neami National as part of the Physical Movement Project. However, peers were not involved in the literature synthesis and write-up, which is a significant limitation to be addressed in future evolutions of this research. The author also observed a centring of White Western voices across academic spaces, surfacing a pressing need for greater representation of ethnic, cultural and language diversity in the research[6], including Aboriginal and Torres Strait Islander ontologies[7, 8].

Current approaches

The most widely accepted definition of physical activity was published by Caspersen et al. "Physical activity is any bodily movement produced by skeletal muscles that results in energy expenditure”[9].

The biomedical values embedded within this definition have significantly influenced how we have come to understand what ‘works well’ in physical activity spaces[2]. This definition informs national and international health policy, including the World Health Organization Global recommendations on physical activity for health[10], and the Australian Department of Health Physical activity and exercise guidelines[11, 12]. Described below are dominant frameworks accompanying this conceptualisation.

Exercise is medicine

‘Exercise is medicine’ has become a powerful discourse in policy and academia. It sees health providers prescribing exercise for health issues, encouraging individuals to take responsibility for ‘moving more’[13]. Vancampfort et al. argued that this approach is highly relevant for people with significant mental health challenges; however, recommends that guidelines be an aspirational goal with a focus on incremental changes over time[14]. Under this framework, measures of success are predominantly clinical, such as changes to body weight, BMI, waist circumference, cardiovascular fitness, psychological functioning, and self-reported physical activity.

Sedentary behaviour

In 2010 the World Health Organization implemented recommendations on sedentary behaviour, in-line with research identifying the elevated health risks of too much sitting[12]. This signalled a change to how the problem was represented: not just about ‘moving more’ but also ‘sitting less’[15]. Australian Department of Health guidelines followed suit, with recommendations currently in place to reduce and break up long periods of sitting[16].

Behavioural lifestyle change

Behavioural lifestyle approaches dominate health policy and practice; endorsed by the World Health Organisation[1], Lancet Psychiatry Commission[17] and the Sax Institute[18]. This approach seeks to modify an individual’s unhealthy lifestyle behaviours such as diet, exercise, smoking, and alcohol consumption. Popular examples include: Keeping the Body in Mind[19]; Achieving Healthy Lifestyles in Psychiatric Rehabilitation[20]; and In SHAPE[21].

Alternate approaches

In 2020, researcher Joe Piggin sought a revised definition of physical activity that moves away from the biomedical model[2]. The definition prioritises people moving over muscles moving and celebrates the messiness, complexity and relationality of lived experience.

"Physical activity involves people moving, acting and performing within culturally specific spaces and contexts, and influenced by a unique array of interests, emotions, ideas, instructions and relationships.” (p. 5)[2]

Building off Piggin's definition, an alternate vision for physical activity programs is proposed below. This is grounded by discussions with Neami National consumers and peers workers, and disruptive voices in academia.

Embracing complexity

Piggin argues that current thinking around physical activity inadequately accounts for complexity[2]. The Eurocentric ‘behavioural lifestyle’ discourse renders invisible the complexity behind health status[22] by compartmentalising aspects of wellbeing and placing responsibility for self-actualisation on the individual[23]. Even when a more holistic approach is intended, many policies and programs fall back into the trap of biomedical values; a process coined as ‘lifestyle drift’[24]. To counter this drift, perhaps a completely different framework is needed.

The Aboriginal and Torres Strait Islander principle of Social and Emotional Wellbeing recognises interconnected and multidimensional aspects of being; including the social, historical, relational, cultural, spiritual, and connection to the land[25]. Here, physical health does not sit in isolation with the individual but is in harmony with community, and a myriad of other life experiences and influences[24].

In practice, this might see a program created by community, that involves family and support networks, values cultural activities as forms of movement, and sees physical activity as part of a larger ongoing meaning-making process[26, 27]. Service providers would account for social and historical contexts: embedding considerations such as poverty, stigma, trauma, racism, and colonisation into their programs to help create safe and supportive environments for change[28].

Valuing lived experience

The VMIAC Declaration states that for too long, governments and organisations have looked to the wrong places for advice on what is in the best interests of people, when in fact, people can and should speak for themselves about what matters[29]. In the VMIAC re-imagining of a wonderful mental health system, the valuing of lived experience and development of peer-led roles emerged as strong themes[29]. While peer-led models are recognised for their unique contributions in the literature, they are yet to be adopted into mainstream physical activity practices[30]. There is a paucity of studies that provide a strong evidence-base, which warrants greater attention and research[31].

The diversity of lived experience must also be acknowledged, including the experiences of those who fall outside of the DSM pathology. Studies that exclude people without a formal diagnosis of mental ill-health risk excluding those without access to the healthcare system[32, 21]. These exclusions can disproportionately affect minority populations, and skew data and representations on what 'works best'. Therefore, accounting for a broader understanding of lived experience is an area for development in future studies.

Decolonising practice

McGuire-Adams and Murrup-stewart et al. speak of decolonising health spaces[33, 25]. Here, Aboriginal and Torres Strait Islander people's voices, ideas and visions are prioritised to create recommendations, rather than looking towards Western-based narratives. Power must be transferred to local community members for this to occur[25]. Indeed, self-determined programs are considered to be more successful as they produce more culturally safe environments[25].

Meaningful and active resistance is integral to decolonisation, focusing energy into the positive rebuilding that is needed by communities[33]. In the physical activity space, recognising moments of resistance might reframe high 'drop out' rates as the outcome of ineffective programs, rather than a problem of devious individuals.

Seeking diverse meanings

In response to the homogeneity of 'exercise is medicine' initiatives in the literature, Williams et al. propose an interpretive approach to physical activity research whereby people are free to construct meaning based their own experiences[13]. Here, there is no singular definition of physical activity, but rather, diverse meanings and lived experiences.

Recent studies with First Nations communities in Australia and internationally have reconceptualised physical activity as: fluid, a part of everyday life and tradition[34]; inherently social[35]; and innately tied to being on Country[7]. Physical activity can create space for decolonisation through purposeful reintegration of movement with the land, ceremony, healing, spirituality, and wellbeing[33]. An open approach to meaning making that de-centres White, Western and medicalised notions of being can therefore produce expansive opportunities to change the way we think about physical movement.

Shifting the lens on sedentary behaviour also opens up diverse meanings. Instead of demonising stillness as a barrier to good health, what if it was appreciated for its potential role in maintaining wellbeing? Sitting can provide opportunities for rest between activities, recalibration, self-care, socialisation, enjoyment, and gathering momentum for the future[36, 37]. For people with chronic illness, studies have observed the measurable health benefits of sedentary behaviour[37]. Weedon et al. suggest taking sedentary activities at face value: as a simple enjoyment of life[37].

Joyful movement

Taking care of health is often framed as a chore, rather than something that brings enjoyment. This misses one of the most potent motivators: having fun[13]. Hunt and Papathomas used life-story interviewing to explore experiences of exercise and arthritis. They found that when participants discovered enjoyment in an activity, it became more sustainable[27]. Joy can also be found in nature. Goldy and Piff explore how awe-inspiring nature can diminish a person's sense of self, reduce day-to-day preoccupations, and shift focus towards the collective. Such intimate experiences can deeply connect people and improve social wellbeing[38]. Yet, joy, pleasure and social engagement are conspicuous in their absence from 'exercise is medicine' discourses[27].

Ingulfsvann et al. unpacked the theory behind joyful movement in children, demonstrating that joy is not equally available to all. Stigma, societal norms and traditions played a significant role in access[39]. Therefore, the concept of joyful movement isn't just about fun or pleasure, but about finding something that allows you to engage with life the way that you want: doing what feels right for you. Programs guided by this value might seek pleasure and joy as conditions for being well; stepping outside the box, listening, exploring fresh ideas, and centring choice in their design.

Shifting language

To invite this critical shift in thinking, an expansion of language is proposed. The concept of 'movement' is introduced, not to replace other terms, but to build out the vocabulary from which meaning is created and communicated. Different to exercise, fitness or physical activity, 'movement' captures an everydayness; the incidental ways people move about their day-to-day lives.

It is not a new term to the literature on physical activity. It has been used to push beyond 'physical' or 'a-physical' bind[40], and signal how people move not just within their bodies, but between places, spaces, ideas and systems[41]. 'Movement' has also helped place emphasis on the whole day mattering, not just isolated physical activities[42]. Importantly, 'movement' folds in the concept of joy, as in 'joyful movement', which seeks delight, pleasure and meaning-making.

The concept of 'movement' therefore has the capacity to shift our thinking beyond bodily experiences, to the ways in which people move through, are connected with, and still within, the world. It presents an opportunity to reframe how we think about physical activity.

Conclusion

This literature review shifts focus away from prescriptive models of physical activity, towards a concept of movement that sees people doing what feels good and is meaningful. It poses physical activity as an experience that is fluid, accessible and part of our day-to-day lives. Moving around the home, getting out in nature, spending time with others; these are whole-of-person and whole-of-life experiences that involve movement, but are often missed by the medical model of 'exercise'. Grounded in the Social and Emotional Wellbeing framework, this literature review has revealed that the conditions for being well, and connecting with the body, are nested in all other things.

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Community Mental Health Gym and Swim Program: Building community, cardio metabolic health and confidence

Presenter:

Katie Thorburn

Presentation Resources

Katie is a Peer Support Worker with Marrickville CORE Mental Health Team. Katie has worked across Acute Care and Assertive Outreach Teams and has nearly a decade of intimate experience with the Mental Health System. Currently studying Sociology with a keen interest in Social Policy at the University of Sydney, Katie is a Dalyell Scholar. Katie's efforts across SLHD include being the current Secretary of the Trauma Informed Care Committee, a member of the Policy and Procedures Committee, and working on the Workplace Competency and Diploma taskforce. Katie is also a Rainbow Ambassador with the Rainbow Embassy, a Raising the Bar initiative to improve mental health care for the LGBTQIA+ Community.

ABSTRACT

For long-term, sustainable lifestyle change it is important to involve the key human need of human connectedness. Severe mental illness has a significant impact on psycho-social functioning, and individuals face considerable barriers to initiating and maintaining behaviour change. Exercise is a tool that can holistically address social functioning, quality of life and the often neglected physical health needs by building community.

A Gym & Swim program was developed with the aim of increasing individual physical activity participation and to support the transition from community mental health services to general community services. The program aims to develop exercise autonomy by supporting self-efficacy, developing exercise skills and confidence and supporting access to sustained community programs. SLHD collaborated with a local community aquatic centre to provide a feasible, cost-effective program that reduces the common barriers faced by this population in attending traditional gyms. The program runs on two days per week and has an open referral policy. Key features include co-facilitation with the peer-support worker, and community exercise physiologist, personalised programming, carer attendance, and low-cost, non-contractual, membership options to work towards.

Since the program started in October 2018, initially with one weekly session, the program has seen 106 participants, with an accumulative 1,323 exercise sessions completed. Approximately 25 participants have attended more than 10 sessions, with 8-12 participants at each session. The success however, of the program is evident in the transition of participants to access community exercise services independently, and the growing confidence of individuals to do this. As a result, participants build a community around them involved in positive lifestyle behaviours. A recent review of past, present and current participants highlighted the barriers and enablers of the group to help shape future programs. Key insights include the importance of collaboration, social health in creating long-term sustainable change, and having relevant health professionals available.

PAPER

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Gym & Swim is a cardiometabolic health targeted initiative run in the community, facilitated by peer support workers (PSW) and exercise physiologists (EP). It is a component of the Living Well, Living Longer program in Sydney Local Health District (SLHD). The Gym & Swim group consists of dual gym and aqua-aerobics sessions, run twice weekly at the Annette Kellerman Aquatic Centre (AKAC). It is open to all SLHD consumers with a care coordinator at a cost of $4.70 per visit, which includes access to both the gym and pool. Underlying the success of the program has been the building of community which has led to improved cardiometabolic health and confidence of participants. By exploring the structure, unique qualities peer support brings to the program, and a case study of a participant, the model can be demonstrated as possible to be reproduced elsewhere.

Consumers are referred to Gym & Swim by care coordinators or PSWs, and posters advertise the group in the waiting areas and clinical rooms of community health centres. People can choose to attend both the gym and swim components, which are run back-to-back for an hour each, or just one. On their first visit to AKAC the EP develops a personalised gym routine for the individual based on current fitness levels and personal goals. The aqua-aerobics session is then facilitated by an EP, PSW or by a confident volunteer from the group.

A feature that has organically developed which demonstrates great community, is that most participants will wait for each other at the entrance to AKAC before walking into the gym together. Participants motivate each other in their individualised gym programs and in the group aqua-aerobics. Surveys have shown that 85% of participants come for the social aspect as well as the benefits of physical activity itself.

Peer support is an integral component of the structure, facilitation and success of the group. PSWs are foundational to the community aspect as they provide lived experience role modelling hope and connect with participants on more equal terms, encouraging capacity building. PSWs are the experts of their own lived experience and use that perspective, insight and knowledge to understand lived experience perspectives generally. While experts in this, PSWs do not act like experts over consumers – rather they walk alongside people on their recovery journey always reinforcing that they themselves are the experts in their own lived experience. PSWs focus on personal recovery rather than clinical recovery, consider what is important to the individual, and believe someone can have a big and meaningful life with or without symptoms. The goal is to make life more worthwhile.

PSWs who co-facilitate Gym & Swim use a strengths based rather than deficit approach, and utilise an internationally recognised framework in facilitating personal recovery called CHIME, which stands for Connection, Hope, Identity, Meaning and Empowerment[1]. PSWs work with consumers to strengthen these areas of their lives, and form a mutual relationship focused on common experiences. When PSWs facilitate Gym & Swim, they take this ethos and these practices with them on the journey of reconnecting people to joyful movement.

Community underpinning the success of the program can be seen in the case study of a participant. Dubbed "The God Father", he has become a pillar of the Gym & Swim community. The God Father has blossomed throughout participating in the group, and has gone on to participate in over 100 sessions. He brings a warm, welcoming and big personality presence to the program. He often offers to drive people to and from AKAC and coordinates people having lunch together afterwards. Of particular note was the motivation and confidence he found through the program, and the way he represented and credited the Gym & Swim community in his winning of a whole of community six week cardio vascular challenge run at AKAC.

By wearing a heart monitor at all times, reaching targeted heart rates would award a participant points. The public leader-board on display at AKAC reflected The God Father in consistent lead. The God Father worked especially hard during these six weeks and became an icon and huge community member of AKAC as a whole. He'd often be seen talking to other gym goers as they all strived for more points. He was always generous with his time, introducing Gym & Swim participants to other AKAC members. When he eventually won the prize, he used his winnings to put on a barbecue in the park for Gym & Swim participants. The program has inspired him to train to be a PSW and he was recently offered a position. The God Father attributes Gym & Swim as helping him have "more control" over his mental health, "reducing anxiety and moving forward and helping [him] recover from [his] illness".

The three main components to recreating the success of this cardiometabolic health program are collaboration, community and promotion. The program should be collaboratively designed and facilitated by traditional physical health disciplines such as EPs and lived experience experts. PSWs use their lived experience to help build the bridge to the service, encouraging participants to engage on their level. This helps to attune traditional physical health workers to the needs of those with lived experience. EPs add expertise and credibility to ensure the tailored programs are appropriately adjusted for ability and safety. The community setting for the program is essential for a couple of reasons. Firstly, it's important not to ostracise mental health consumers from mainstream society. Secondly, so that participants have the confidence to engage with community based exercise resources following discharge from mental health services. Both serve to avoid the risk of mental health consumers becoming entrapped by mental health specific services. Finally, promotion is essential to ensure participants are able to access and be linked with the program. With these three key ingredients, the Gym & Swim program can be replicated across other service settings and locations, enabling more consumers to access its many benefits.

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THEME:
LIFESTYLE

Kick the Habit with Consumer-Centred Tobacco Management

Presenter:

Presentation Resources

Vicki Langan

With background in Sports Science and working in ADO, forensic, youth and community services, homelessness and mental health services for over 25 years, Vicki clearly saw the link between mental ill health and the impact on the physical health of individuals living with a mental illness. Moving into Health Promotion, supporting the development of the Peer Work Force and now in her current position as the Health and Wellbeing Manager for Neami National NSW, Vicki has contributed to the development and implementation of several Physical Health programs, health promotion initiatives and research projects nationally. Vicki is dedicated to supporting individuals living with mental illness improve their physical health through collaboration and innovation and as a Mental Health First Aid Instructor support attitude change throughout the wider community.

ABSTRACT

The aim of the report was to summarise the evidence gathered via evaluations while implementing the ‘Kick the Habit’ Program. Neami utilised a student of public health from the University of Sydney to conduct the evaluation.

The Tobacco Management project, “Kick the Habit”, is a multi-component program that was developed by Neami’s Health Promotion team in response to the high rates of smoking in people living with a mental illness. The program is a combination of one-to-one coaching support alongside the use of NRT products, as evidence found that the golden standard for tobacco management is pharmacotherapy in combination with behavioural support. One-to-one coaching support is offered in order to develop a personalised and tailored smoking management plan for each consumer based on individualised goals for reducing or quitting smoking. Support is given to initiate conversation and build relationships between consumers and their pharmacists, to utilise NRT products so that nicotine withdrawal symptoms are reduced, and mental health symptoms are monitored.

Though smoking rates have declined in the general population due to successful public health strategies, smoking rates remain unchanged in people living with a SMI. These strategies have in fact further disadvantaged vulnerable populations, by exacerbating marginalisation, and additional tobacco taxes have increase financial vulnerability.

Evidence demonstrates that general smoking cessation programs are ineffective in people living with SMI, hence the urgency to co-design a tobacco management program tailored to this population. Notable outcomes from the report found that 100% of consumers had attempted to stop smoking previously, with 86% of consumers reporting that they reduced tobacco use as a result of participating.

Eighty per cent of participants suggested that the program should go on for much longer. This recommendation and others have been implemented in order to ensure that consumers receive appropriate and effective services.

PAPER

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1 Neami National

Introduction

This short paper looks at the approach Neami NSW took as part of a smoking reduction initiative to addressing the higher smoking rates that exist among those living with mental ill health in Southern NSW along with the current approach taken by Neami NSW through provision of ‘Kick the Habit’. There is extensive research demonstrating that smoking contributes to significant health, economic, and social disadvantage. However, despite thirty plus years of increases in tobacco tax levies and public health messaging around tobacco-related harm; smoking rates for people living with mental health illnesses have not been impacted in the same way as for the general Australian population. We know now that 11% of Australian adult GP smoke, in contrast SANE Australia reported in 2017 that 32% of Australian adults with a mental illness smoke and Neami's Physical Health Prompt data indicates an even higher rate of around 48% of consumers identifying as active smokers.

In the mental health services sector, there is an increasing appreciation of the links between physical health and mental health and we believe Equally Well contributes to that. In relation to smoking, mental health service user feedback demonstrates that there is often a desire to quit or cut down and yet mental health care services often appear reluctant or ill equipped to prioritise or provide support for tobacco use behaviour change. There is an urgent need to strengthen knowledge and practices that can reduce the prevalence of smoking behaviours for people living with a mental illness.

The journey

Over the past four years, Neami has been working to address the prevalence of smoking behaviours for our consumers and extended mental health service users.

Neami's Consumer Centred Tobacco Management program 'Kick the Habit' was adapted from Gould's (2012) Patient Centred Tobacco Management approach as it was in line with Neami National's core values, encompassing a whole of the person focus and encouraging consumer driven decision making around the management of their own health. In 2017, 'Kick the Habit' was trialled as a piolet project across identified Neami services in partnership with leading epidemiological researchers from the University of Western Australia, as there was a need for 'evidence based' and 'best practice' information as part of a National approach.

The findings of the study were published and presented at the 2018 Oceanic Tobacco conference in the meantime the NSW Health and Wellbeing team were implementing recommendations and making changes to improve the program for rollout as part of their Health Promotion strategy. In 2019, the Health and Wellbeing Manager was successful in securing funding for a smoking reduction and cessation initiative via Coordinare, Southern NSW PHN.

Over the past two years we have continued to train Neami staff in an adapted version of CCNSW Talking Tobacco program more adhered to mental health participants and our Kick the Habit Program.

Model of practice

The 'Kick the Habit' approach utilises a change management method to address practitioner assumptions, attitudes, knowledge and confidence to undertake conversations with mental health consumers about their smoking behaviours. Consumers are provided with one-to-one coaching support to develop an individualised smoking management and harm minimisation plan based on their own reasons for reducing or quitting. In addition, consumers are supported to GP/prescribing physician and access to use NRT to minimise symptoms associated with nicotine withdrawal and reduce contraindication of mental health symptoms.

Program design

The Smoking Reduction and Cessation Initiative inclusive of 'Kick the Habit', was a multi component initiative that was developed and compiled by the Neami NSW Health and Wellbeing Manager. The initiative delivery setting was across Southern NSW and was based specifically at Neami Wollongong.

The Initiative comprised three components:

1. Providing Community Mental Health workers from various organisations/services with free mental health tailored Tackling Tobacco (TT) training sessions that were delivered by Neami staff trained as TT Trainers. The training courses ensured the mental health workers were equipped with the knowledge and skills to provide tobacco management support.
2. Kick the Habit Program was offered to individuals residing in southern NSW who identified with a mental health issue and were smokers. Referrals were accepted by the Project Coordinator who also delivered the TT training, established partnerships with the local pharmacists to allow for easy access to NRT and was the Kick the Habit coach.
3. Partnership and access to NRT. The Project Coordinator established a partnership with 11 local pharmacists across 8 Southern NSW LGAs. This allowed for those trained community mental health workers to access FREE NRT for interested consumers and participants of the Kick the Habit program to visit their local pharmacists for NRT information, support, and product.

Evaluation of the initiative

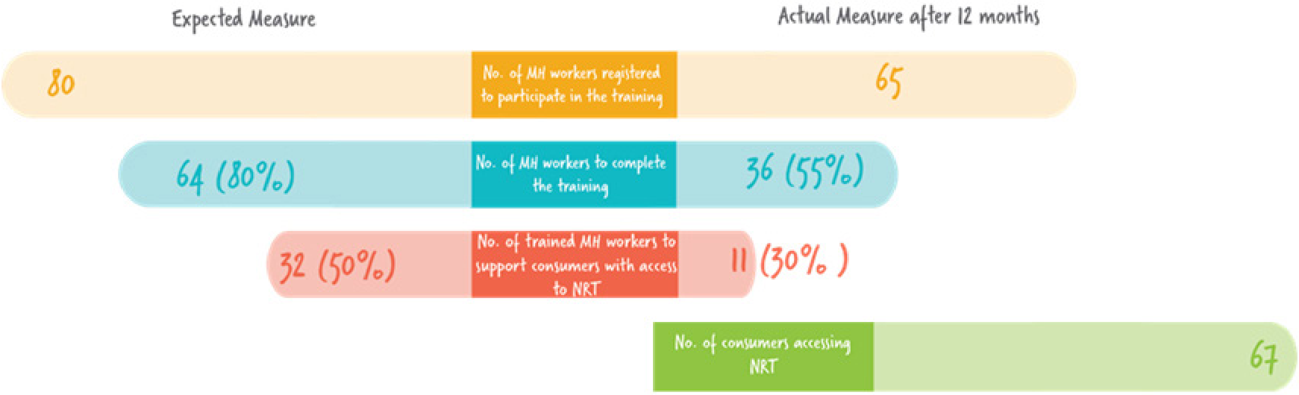
The evaluation report was conducted as part of a 3-month placement requirement of a Master of Public Health student. A combination of qualitative and quantitative data was used to evaluate the impact of the Kick the Habit program. Data was collected by the

Project Coordinator using written forms comprising demographic information, pre and post questionnaires inclusive of Fagerstorm's Nicotine Dependency Test, health literacy questions and smoking behaviours.

Funding requirements obliged us to predict outcome measures but of course this was without foreseeing the natural disasters that took people's homes through bushfires across NSW in the summer of 2019/20 and the onset of a global pandemic in March 2020.

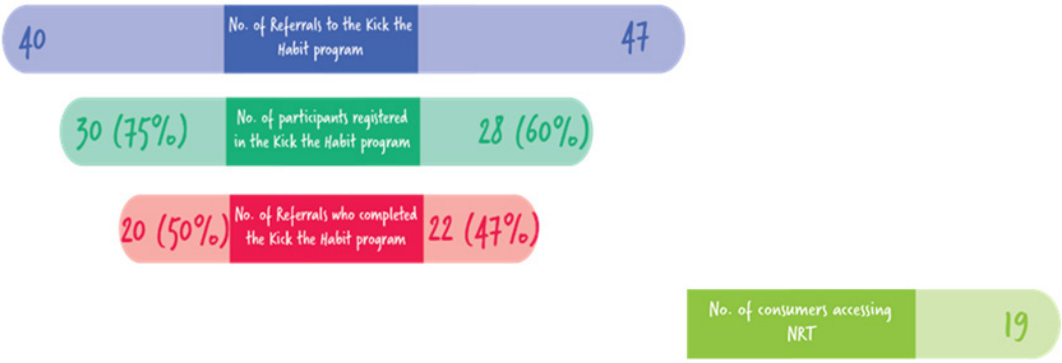
Component 1. Providing training to CMH workers

A key measure was to have 80 mental health workers registered to partake in the training that was offered any time between July 2019 and May 2020. The fundamental objective was to have around 80% (64/80) of the mental health workers complete the training. We achieved 65 workers registering, however, only 55% completed the training and 11 of those workers supported 67 of their consumers to access NRT via local pharmacists.



Component 2. The Kick the Habit Program

The number of expected referrals to the program was 40 people and this objective was achieved with 47 direct referrals into the Kick the Habit program. Predicted registrations were 75% of total referrals and registration achieved 60% (28 people). Overall completion of the program was predicted at 20 people; this rate was achieved with 22 people completing. Of those 22 people, 19 accessed and used NRT to support their tobacco reduction journey.



Physical health and mental health

The mental health and physical illness/diagnosis was recorded for all 22 consumers through the referral form. Overall, when looking at the total listed mental diagnoses that exist for each participant, the most common were found to be:

- depression (73%)
- anxiety (68%)
- PTSD (46%)
- schizophrenia (50%)
- bipolar disorder (18%)

*Other mental health problems included AOD, substance use, claustrophobia and agoraphobia.

As for the physical illnesses reported, the most frequencies related to:

- back pain (36%)
- asthma or lung conditions (32%)
- arthritis and diabetes (23%)
- heart problems (18%)
- cancer (5%)

*As for other physical illnesses, epilepsy, emphysema, hypertension, Parkinson's disease and hearing loss were also reported at low rates.

Reasons for wanting to quit

- ✓ pregnant, protect new family
- ✓ improve personal relationships
- ✓ improve mental health
- ✓ save money
- ✓ improve physical health
- ✓ avoid health risk
- ✓ role model

Change in Tobacco use

Eighty six per cent of participants showed a reduction in their tobacco use on completing the Kick the Habit program.

Dependency measures

When we calculated the dependence rate from pre and post Fagerstorm Nicotine dependency, 50% measured at moderate and 32% high dependence pre the Kick the Habit program.

On completion of the program, 64% of participants showed a change in dependency which reflected a decrease in tobacco dependency.

77% improved their financial situation

Knowledge of existing resources to support tobacco management

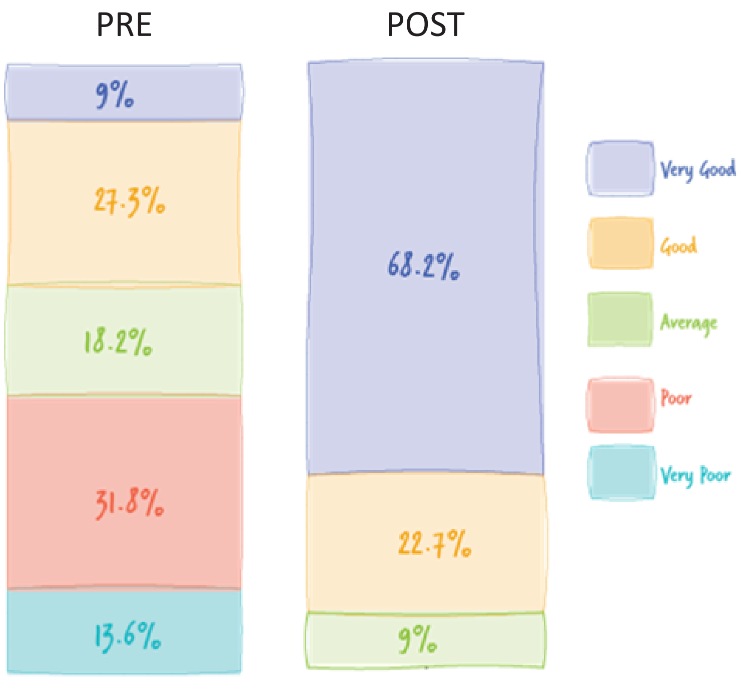
In the prequestionnaire, only 5% of the consumers rated their knowledge of resources available to help reduce or quit smoking as very good and 14% as good. The highest proportion of consumers (36%) reported that they had poor knowledge.

However, after completing the post KTH questionnaire, 46% consumers reported very good knowledge and 27% good. Interestingly, no consumers reported poor or very poor knowledge. This shows a great increase in the level of knowledge as a result of the KTH program.

'I now only smoke 1 cigarette a day'
'I have cut down on smoking and I now know that I can quit'
'I definitely cut back on what I was having originally but I still want to quit'

86% of participants showed a reduction in their tobacco use on completing the Kick the Habit program.

NRT Knowledge Pre and Post



Conclusion – What’s Needed

We continue to explore the outcomes of consumer involvement in the Kick the Habit program through regular one-to-one, face-to-face or phone coaching support given by a health coach, structured appointments, personal individualised tobacco management plans with identified goals, strategies and resources to achieve those goals, GP support and access to free NRT.

In doing so, we discover consumers need longer support time, access to free NRT and ongoing support workers.

It has become evident that this approach is what’s needed to reduce the prevalence of smoking among people living with a mental illness, but we cannot do this alone.

We need more evidence, and this can only be done by investment from government, national bodies and academics.

Healthy Bodies Support Healthy Minds – Equally Well in a Remote Context

Presenter:

Presentation Resources

Nicole Pietsch

Nicole is the Communications and Health Promotion Officer at the Mental Health Association of Central Australia. She has a Bachelor of Arts Degree (Communications Studies) and Certificate IV in Community Services. She has more than 20 years' experience in communications and community engagement. She has a passion for mental health promotion and has lived experience as a carer. Nicole has lived in Alice Springs with her family for 15 years and enjoys its unique environment, culture and community.

ABSTRACT

Introduction: The Mental Health Association of Central Australia (MHACA) is a community managed organisation that provides psychosocial support services, NDIS services, tenancy support, suicide prevention and health promotion programs.

MHACA provides services to participants who predominantly have severe and complex mental health conditions. More than 50% identify as Aboriginal or Torres Strait Islander. Many have chronic health issues, experience homelessness and are considered vulnerable within the community.

MHACA became a signatory to the Equally Well Consensus Statement in 2020. MHACA's presentation demonstrates how an organisation in a remote context can convert policy into practice, working in partnership with consumers and community services.

Method: While MHACA already has a focus on activities that support participant physical wellbeing, the Consensus Statement provides the opportunity to do better.

The Statement is a significant policy document that has many principles to adopt. Rather than feel it is 'too hard', MHACA has assessed the principles and identified what is most feasible in the short to medium term. MHACA has invested in staff health promotion training and has developed the Healthy Bodies Support Healthy Minds (HBSHM) Strategy which provides a whole of organisation approach and builds on community partnerships. It includes:

- introduction of a Health Prompt
- development of a Healthy Eating Policy
- educational campaign on smoking cessation
- ongoing exercise activities
- educational campaign on oral health.

Results and findings: While the implementation of the strategy is in early days, MHACA has been providing introductory activities to participants including a participant pamper day, exercise activities, healthy lunches and smoking cessation education which have been well received. Next steps include working with NAEMI National and participants to develop the Health Prompt.

Discussion: MHACA believes that by sharing our approach to implementing Equally Well principles in a remote context, other organisations will be encouraged to take action.

PAPER

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1 Mental Health Association of Central Australia

The Mental Health Association of Central Australia (MHACA) developed the Healthy Bodies Support Healthy Minds (HBSHM) Strategy as a local response to addressing actions outlined in the Equally Well Consensus Statement.

- MHACA became a signatory to the Consensus Statement in 2020.
- As a remote, not-for-profit community managed organisation, there is no capacity or resources to implement all actions outlined in the Consensus Statement.
- As many MHACA participants have poor physical health, MHACA strongly supports a whole of organisation focus on improving health outcomes.

MHACA developed the Healthy Bodies Support Healthy Minds Strategy to guide organisational initiatives.

Health in a remote context

- Mparntwe (Alice Springs) is a major regional centre in the Northern Territory but a relatively small town, with approximately 28,000 people.
- 20% of people identify as Aboriginal and Torres Strait Islander and just under 25% are from a Culturally and Linguistically Diverse (CALD) background.
- MHACA provides services to approximately 200 participants, of which most experience living with chronic and enduring mental health conditions.
- More than 60% of MHACA participants identify as Aboriginal or Torres Strait Islander.
- Aboriginal Australians have high levels of psychological distress and poorer health outcomes than the rest of the population.
- Central Australia has one of the highest rates of diabetes in the world, and the number of people living with chronic disease is high.

Healthy Bodies Support Healthy Minds Strategy

- MHACA's Health Promotion Team analysed the actions of the Consensus Statement and identified the key action areas that were relevant to the Central Australian context.
- The HBSHM Strategy was developed and adopted to provide a whole of organisation commitment to improving the physical health of MHACA participants.
- The Healthy Bodies Support Healthy Minds Strategy aims to improve the physical health of MHACA participants through five key action areas.

1. Introduction of a Health Prompt

- Neami National developed and trialled Australia's first physical health needs identification tool designed specifically for a community mental health setting.
- The Health Prompt is simple to use and available to other organisations to improve health responses and outcomes for people with complex needs. There is a pictorial version of the Health Prompt and a version developed for Aboriginal participants.
- MHACA has had initial conversations with Neami around tailoring the health prompt for a Central Australian setting. Frontline staff would be trained in how to use the Health Prompt to increase confidence in providing physical health information and interventions.

2. Healthy Eating Policy

- The public dietitians of the Central Australian Health Service (CAHS) have been researching local food security challenges and providing guidance about organisational responsibilities to provide healthy food for consumers.
- A Healthy Eating Policy will provide guidelines around what food MHACA can provide to participants, and what food is appropriate for public events.
- MHACA provides participant education on healthy eating through weekly healthy cooking classes and health promotion activities including special events like Smart Eating Week.

3. Educational Campaign on Smoking Cessation

- A significant proportion of MHACA participants smoke cigarettes.
- People with a mental health condition are more likely to experience greater morbidity and mortality because of smoking-related chronic diseases.
- Early intervention, education and programs can support people to reduce or quit smoking.
- MHACA is providing staff and participant smoking cessation education through a partnership with the Central Australian Aboriginal Congress Tackling Indigenous Tobacco Team.
- Participant education on smoking cessation is being provided though targeted health promotion events.

4. Regular Exercise Activities

- Many MHACA participants have sedentary lifestyles.
- Exercise can improve mood and reduce symptoms of mental illness, including depression and anxiety. Exercise can also improve sleep quality, increase energy levels and reduce stress.
- MHACA includes weekly exercise activities on the monthly participant group activities calendar. This includes swimming, basketball, and Footy 4 Life.
- MHACA provides participant education on exercise including special health promotion events and community outings.

5. Educational Campaign on Oral Health

- Regular dental checks and a good oral hygiene routine are vital to wellbeing and good mental health.

  - People with severe mental illness have 2.7 times the likelihood of losing all their teeth, compared with the general population.
  - MHACA is providing participant education on oral health through targeted health promotion events.

Evaluation

- Evaluation is an important component of health promotion and behaviour change initiatives.
- MHACA is evaluating the HBSHM Strategy with participant surveys/questionnaires and stakeholder surveys.

Conclusion

- Building on the initial success of the HBSHM Strategy, MHACA has secured funding to deliver a Healthy Bodies Support Healthy Minds Program in 2022-2023.
- The Program provides weekly activities for MHACA participants with a focus on exercise and nutrition activities, including education on sugary drinks and increasing water consumption.

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Making an Impact on Smoking for Consumers of Queensland Public Mental Health Services

Peer-reviewed paper

Presenter:

Sally Plever

Presentation Resources

Sally Plever is a Psychologist (MClinPsych) and has worked in mental health for over 20 years in clinical and project roles across inpatient, community and secure services. She currently job-shares the position of Manager of the Queensland Health Mental Health Clinical Collaborative (Qld MHCC), a statewide initiative using collaborative methodology to drive service improvement in adult mental health and addiction services. Through her work with the Qld MHCC, she has developed an interest in the physical health of people with serious mental illness and is undertaking a PhD in the area of smoking and serious mental illness.

ABSTRACT

Aims: Smoking represents one of the leading causes of premature early mortality in people with a serious mental illness (SMI). Healthcare services are key contact points for this priority population and can play a critical role in supporting smoking cessation. However, mental health services have not traditionally prioritised smoking cessation support. Queensland public mental health services (PMHS), through a Mental Health Clinical Collaborative (MHCC), have been working together to prioritise smoking, offer standard and routine smoking cessation care to consumers and support access to an intensive Queensland Quitline smoking cessation program. The following provides an overview of the outcomes from this initiative.

Methods: Since 2015 Queensland PMHS have asked consumers about smoking and provided an evidence-based smoking cessation intervention to smokers (Smoking Cessation Clinical Pathway: SCCP) as part of standard clinical practice across hospital and community services. Queensland PMHS have also partnered with Queensland Quitline to develop a referral pathway to improve access to an evidence-based intensive quit support program providing four support calls and 12 weeks of free NRT for consumers of PMHS. Review of outcomes from this initiative including sustainment of improvement and impact on smoking rates is considered.

Results: Review of outcomes from this initiative have demonstrated positive and continuous improvement. Statewide PMHS have sustained high rates of recording smoking in inpatient 88%-93% (2015-2022) and community services 77%-92% (2017-2020) and in providing the brief intervention (SCCP) to smokers in inpatient 38%-79% (2015-2020) and community services 47%-85% (2017-2020). Referral and engagement with Quitline has been steady with encouraging retention and quit outcomes. The establishment of a statewide reporting process has also enabled reporting of a Queensland public community mental health smoking rate with the 2021 rate of 50.2% showing a promising decline from 51.6% in 2018.

Conclusions: The sad reality is that people with SMI face enormous challenges to achieving smoking cessation. Healthcare services are in a unique position to provide and connect consumers to smoking cessation support. Queensland PMHS have worked together to embed smoking cessation care into standard practice statewide and proactively assist consumers to access ongoing cessation support through an intensive Quitline program with encouraging results.

PAPER

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Introduction

People with serious mental illness (SMI) have been identified as a smoking priority group(1). Smoking represents one of the leading causes of premature early mortality in people with SMI(2). Smoking prevalence for people with SMI is alarmingly high with reports over 60% in people diagnosed with schizophrenia and those treated in inpatient mental health units(3, 4). Unlike the decline in smoking rates evident in the general population, smoking rates for people with SMI have remained consistently high with little indication of change(5). People with SMI are motivated to quit, but have less success, and encounter many barriers including less access to pharmacotherapy and behavioural treatments known to improve quit outcomes(6, 7). One considerable barrier for people with SMI has been the reluctance of health services to treat smoking(8). This has been particularly problematic within mental health services who have a complex history with smoking that includes a permissive culture and at times resistance towards offering smoking cessation(9).

Mental health services are ideally positioned to support smoking cessation and provide evidence-based smoking cessation interventions to this priority population. But the provision of routine smoking cessation care (SCC) within public mental health services (PMHS) is has not been commonplace and when available, is often inadequate(10). To improve delivery of smoking cessation interventions for priority populations, Bonevski et al. (2017) suggest the use of practice and organisational change approaches and highlight the importance of monitoring performance to ensure services achieve goals. Clinical practice change interventions have proven effectiveness in supporting practice change in mental health(11), including smoking cessation(12), and offer an approach that can support the translation of evidence-based practice into everyday care.

In Queensland PMHS, the delivery of evidence-based SCC as standard practice has been in progress since 2015 with services coming together to improve routine reporting of smoking status and the delivery of an evidence-based smoking cessation clinical pathway (SCCP) to people who smoke(13). To support this practice change, PMHS across the state have been assisted by the Mental Health Clinical Collaborative (MHCC) a quality improvement collaborative with demonstrated success in implementing practice change in PMHS(11). Implementation has involved the development of clinical indicators that enable regular monitoring of statewide and service progress and by bringing clinicians and managers together in six monthly statewide forums. During these forums clinicians have had dedicated time to share ideas and experiences, hear from experts in the field, consider individual service goals and progress, and contribute to the setting of statewide targets.

This initiative commenced in 2015, with adult acute inpatient units from 16 PMHS's voluntarily participating. An evaluation of progress in 2017 showed significant improvements statewide and within individual PMHS in the documentation of both smoking status and SCCP(4). In 2017 this initiative was extended to adult community mental health services from each PMHS which included PMHS without attached inpatient adult acute services. The extension to community services was made possible with the addition of a smoking status field to the statewide mental health information system. It was further facilitated through access to a Queensland Health quality improvement financial incentive for PMHS statewide who achieved set and increasing targets. The introduction of required documentation of smoking status within community PMHS also enabled reliable reporting and tracking of smoking rates for people with SMI accessing PMHS.

As part of a system wide approach, and in recognition of the challenges facing people with SMI who smoke, a partnership with Queensland Quitline was established in 2017. This partnership provided a direct referral pathway for clinicians to engage consumers of PMHS who smoke with an intensive Quitline program that included 4 support calls and 12 weeks of free Nicotine Replacement Therapy (NRT). NRT that is free and accessible is an important part of quit assistance for people with SMI. Despite evidence that it can improve and sustain quit rates in this population, people with SMI often do not access this support due to cost and other barriers (7, 14).

The implementation of routine SCC across PMHS, combined with complementary support from Quitline provides a comprehensive approach to smoking cessation in Queensland PMHS. The following provides an overview of some of the collective outcomes from this initiative including changes in reporting of smoking status and SCCP across inpatient and community services, smoking rates for community PMHS consumers and recent Quitline outcomes.

Methods

Sixteen PMHS with adult acute inpatient units introduced routine documentation of smoking status and SCCP for all inpatients 18 years and above, with a length of stay of two or more consecutive nights. The reference period 01 October 2015 to 31 January 2021, and includes all admissions to inpatients wards. A person who smokes is identified as having smoked tobacco within the last 30 days or asked for support to quit. All inpatient smoking information was recorded in the medical record with minimum field requirements for a valid SCCP and the data was entered by hospital coders after discharge. Data was extracted from the Queensland Health Admitted Patient Data Collection (QHAPDC) a statewide repository for inpatient data. Monthly data for all inpatient separations was collected and reported monthly.

For inpatients, the smoking status indicator is calculated as the proportion of inpatient mental health separations where an inpatient had a smoking status recorded during the reference period. The SCCP indicator was calculated as the proportion of inpatient mental health separations where identified smokers had a completed SCCP within the reference period.

Twenty adult community PMHS introduced routine documentation of smoking status and SCCP for all consumers 18 years and above currently open to the service. The time period for this review is 01 July 2017 to June 2021 and includes all service episodes in which a community consumer had at least one service contact. All community data was recorded on the Consumer Integrated Mental Health and Addictions Application (CIMHA) and entered by clinicians. A dedicated field in CIMHA records smoking status with the same definition for a person who smokes as inpatient services. The SCCP is entered separately as a clinical note. Data was extracted from CIMHA and reported six monthly from July 2017 to June 2021.

In PMHS community mental health services, the smoking status indicator is calculated as the proportion of community service episodes where a smoking status was recorded during the six-month reference period. The SCCP indicator was calculated as the proportion of community service episodes where identified smokers had a completed SCCP within the reference period. Smoking status and SCCP documentation across inpatient and community services remain valid for a period of six months.

Data for calculation of the Queensland Community Mental Health smoking rate is sourced from CIMHA and includes all Queensland PMHS community consumers aged 18 years+ and excludes consumers with an unknown smoking status. It is calculated as the proportion of community mental health consumers that are documented as a smoker within the reference period over the total number of open community mental health consumers in the reference period that have a known smoking status.

Queensland Quitline provided program completion rates and 3, 6 and 12-months post program quit rates for the Queensland Quitline Ready to Quit Smoking program for consumers of Queensland PMHS over the period 01 January 2019 to 30 June 2021.

Results

Inpatient PMHS

Figure 1 presents statewide inpatient monthly reporting of smoking status and SCCP from the project commencement. In October 2015 statewide reporting of smoking status for inpatients was 88% increasing to 93% by January 2021. For SCCP documentation, October 2015 was 38% with an increase to 79% in January 2021. Previous evaluation has demonstrated statistically significant improvements in smoking status and SCCP documentation across October 2015 to September 2017(4). As reported in Plever et al . (2020), within individual services there was variation in reporting of smoking status and SCCP and this is still evident following this review.

Community PMHS

Figure 2 presents statewide community PMHS performance for smoking status and SCCP documentation reported six monthly. During the first reference period July to December 2017 smoking status was recorded at 77% and SCCP documentation at 47%. Over the four-year period of this intervention

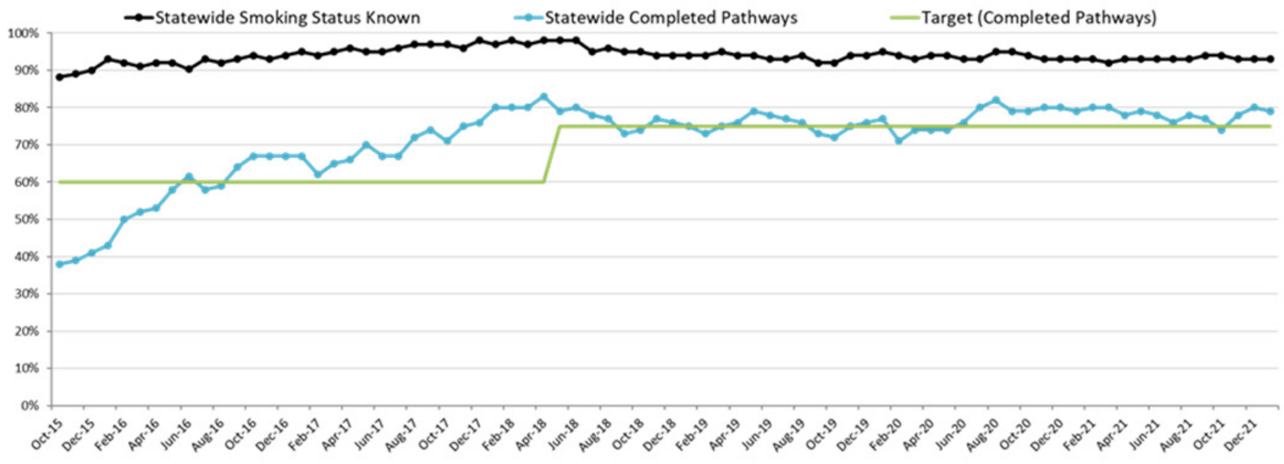

Figure 1: Statewide PMHS adult acute inpatient smoking status and SCCP reporting October 2015 to January 2021.

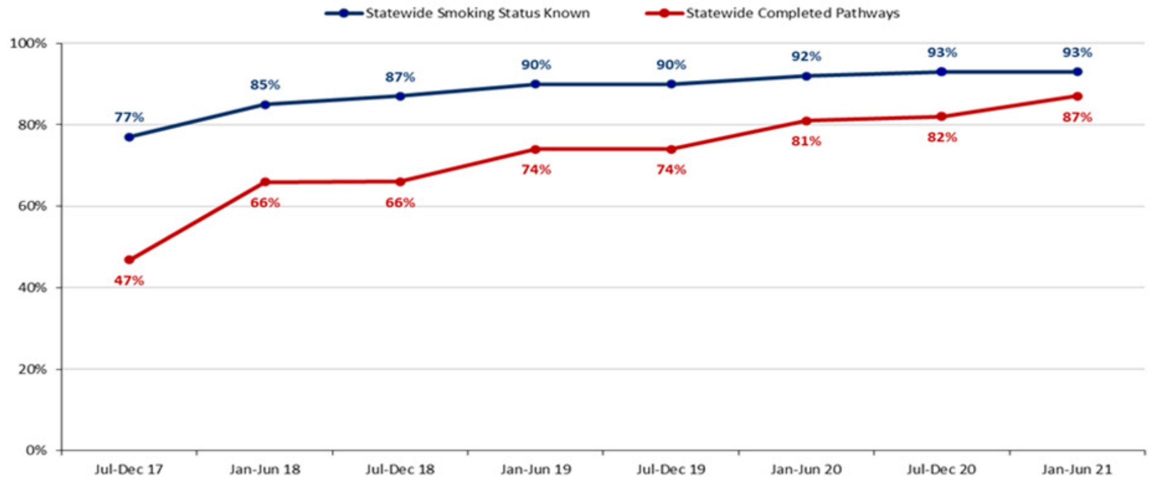

Figure 2: Statewide PMHS adult community smoking status and SCCP reporting July 2017 to June 2021.

smoking status documentation increased to a statewide average of 93% and SCCP documentation to 87% in the final six-month reporting period.

Quitline Queensland

Quitline program completion rates for consumers of Queensland PMHS referred to the Queensland Quitline Ready to Quit Smoking program over the period 01 January 2019 to 30 June 2021 are reported at 42.83%. Post program quit rates are reported as 31.85% at 3 months, 27.44% at 6 months and 26.52% at 12 months.

Queensland Mental Health Smoking Rate

Table 1 provides yearly smoking rates for consumers of PMHS across Queensland as reported by the Queensland Mental Health Clinical Collaborative since 2018(15). Across this four-year period rates have remained above 50%, however in 2021 a 1.4% reduction in this rate occurred from 51.6% in 2018 to 50.2% in 2021.

Year	Smoking Rate
2018	51.6%
2019	51.1%
2020	51.5%
2021	50.2%

Table 1: Queensland Mental Health Smoking Rate for Comunity Consumers 18years+

Discussion

This paper provides a general review of the progress of Queensland PMHS in implementing SCC across statewide PMHS using a quality improvement collaborative. The findings across inpatient and community PMHS suggest that reporting trends for smoking status and SCCP documentation have improved since the commencement of this initiative. Despite variation within individual services, from a statewide perspective, there is evidence to indicate that a clinical practice change intervention has been effective in embedding SCC into routine clinical practice in inpatient and community PMHS.

In 2015 the delivery of smoking cessation was not considered core business within Queensland PMHS. Since this time, across inpatient and community PMHS, there has been an increase in documentation of smoking and SCCP. In inpatient services, significant improvements have been demonstrated in the first two years of implementation and work is currently underway to review data since this time to identify whether these improvements have been sustained. Preliminary results (unpublished) are promising. In community services improvements in reporting of smoking status and SCCP have also been seen and the addition of a quality improvement payment has further supported this practice change. These results contribute to growing evidence supporting the effectiveness of using quality improvement approaches to implement practice change in mental health services(11, 12).

The introduction of statewide documentation of smoking status in community PMHS has created an opportunity to reliably report smoking rates for people with SMI accessing PMHS. It enables tracking over time and provides an indicator of the impact of delivering routine SCC within PMHS. Smoking rates for people with SMI are high with over 60% of inpatient PMHS identified as smoking(4) and over 50% of community PMHS consumers identifying as smoking. It is not possible to draw a direct link from the implementation of routine SCC in PMHS services to the changes in the community PMHS smoking rate reported. However, it is encouraging to see recent change to reported smoking rate and ongoing high levels of delivery of routine SCC in PMHS.

Finally, the partnership with Queensland Quitline to facilitate direct access to an intensive smoking cessation support program with free NRT has been an important addition to the work being undertaking within PMHS. Proactive quit support as part of routine care combined with Quitline engagement to provide ongoing pharmacological and behavioural support is a promising way of tackling smoking in people with SMI. The Quitline service reports that program completion rates for consumers of PMHS are comparable to other Quitline intensive quit support users further reinforcing the fact that people with SMI are capable and motivated to stop smoking and engage with smoking support programs(15-17). Reported quit rates at 12-months of over 26% are also very encouraging when considered in context of unassisted quit rates which can be as low as 3-7%(18).

PMHS are important settings for the delivery of routine, evidence-based, SCC interventions to reduce smoking rates and improve health outcomes in this priority population. Queensland PMHS have made a concerted effort to introduce SCC into routine everyday clinical care with a focus on providing consumers who smoke opportunities to make informed choices about smoking and access evidence-based treatment. The use of a quality improvement collaborative has supported statewide implementation of SCC across diverse services and preliminary results are encouraging for the sustainment of these changes and potential impacts on smoking rates for consumers. Mental health services have a key role in connecting people who smoke to smoking cessation supports such as Quitline and the partnership described here demonstrates how this can work in practice.

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SUMMARY OF ORAL PRESENTATIONS

KEYNOTE SPEAKER SUMAMRY

Symposium opening address

Presentation Resources

David Coleman

The Hon David Coleman MP was sworn in as Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention on 22 December 2020.

Following the swearing in of the second Morrison Ministry in 29 May 2019, Mr Coleman became the Minister for Immigration, Citizenship, Migrant Services and Multicultural Affairs. He was previously Minister for Immigration, Citizenship and Multicultural Affairs from 28 August 2018.

David Coleman was elected to the House of Representatives as the Federal Member for Banks in September 2013. He was re-elected in 2016 and appointed as the Assistant Minister for Finance in 2017.

Prior to entering politics, David worked in the private sector, principally in the media and technology industries. He was Director of Strategy and Digital at Nine Entertainment Co, Chairman of ninemsn, and held board positions with a number of other companies including Sky News and 3P Learning—the operator of Mathletics. He also worked with the management consulting firm McKinsey and Co, and ran his own consulting business.

David completed degrees in Law and Arts from UNSW, and while at UNSW he was elected President of the Student Guild.

Improving the physical health of people with mental health problems: is there a role for peer workers?

Presentation Resources

David Castle

David is currently Inaugural Scientific Director of the Centre for Complex Interventions (CCI) at the Centre for Addictions and Mental Health (CAMH), Toronto, Canada; and Professor, Department of Psychiatry, The University of Toronto.

He has wide clinical and research interests, encompassing schizophrenia and related disorders, bipolar disorder, OCD spectrum disorders and disorders of body image. He has a longstanding interest in the impact of licit and illicit substances on the brain and body, and is actively engaged in programs addressing the physical health of the mentally ill and the mental health of the physically ill.

Equally Well a Family Affair

Presentation Resources

Sharon Lawn

Professor Sharon Lawn is a lived experience researcher at Flinders University, South Australia and Chair and Executive Director of Lived Experience Australia. She was previously Director of the University's Psychiatry Research Unit for five years. Sharon worked in mental health, aged care and disability services for 23 years.

Sharon has led many research projects involving implementation of health system change. Her research has included a focus on self-management, physical health and mental health, veterans and first responders, peer work, service user and family perspectives, and addictions. Sharon has more than 230 publications and has been awarded many grants.

A new vehicle for reform and the road ahead

Dr Vine was unable to attend due to the annoucement of the Federal Election and the Government was in caretaker mode.

Presentation Resources

Ruth Vine

Dr Ruth Vine is Australia's first Deputy Chief Medical Officer for Mental Health. Ruth provides policy advice on critical mental health issues impacting the Australian community due to the COVID-19 pandemic, and champions Commonwealth policy development to better integrate the Australian mental health system.

Ruth is a consultant psychiatrist and has more than 25 years' experience. She has worked for the Victorian Department of Health and Human Services, and has held positions of Deputy Chief Psychiatrist, Chief Psychiatrist and Director of Mental Health. She has chaired the AHMAC National Mental Health Standing Committee, the National Mental Health Workforce Committee, and National Safety and Quality Committee.

Previously, Ruth was the Executive Director of NorthWestern Mental Health.

Ruth is a member of the Board of Forensicare, the Board of Mind, and the Medical Practitioners Board (Victoria).

Ruth holds a Bachelor of Medicine from Melbourne University, a Bachelor of Laws from La Trobe University, and is a Fellow of the Royal Australian and New Zealand College of Psychiatrists.

Abstract

Following a number of key mental health reports and inquiries, a new National Mental Health and Suicide Prevention Agreement has been agreed and will be a vehicle for reform that will listen to and engage with those who have lived experience of mental ill health; and will consider the broader remit of mental health and well-being, not just mental illness. This talk will consider our progress so far and will expand on the priority areas highlighted in the National Agreement. This includes the importance of integration of services providing assessment, treatment and support for physical and mental health, and drug and alcohol misuse.

Lifestyle and cardiology for people with mental illness

Presentation Resources

David Colquhoun

Associate Professor David Colquhoun is a cardiologist in private practice and is actively involved in research and preventative cardiology.

He is a Board Member of the National Heart Foundation of Australia (NHFA); a member of the Scientific Committee of the National Institute of Complementary Medicine (NICM); a member of the Scientific Committee of the Gallipoli Medical Research Foundation; and Co-President of the Clinical and Preventive Cardiology Council of the Cardiac Society of Australia and New Zealand (CSANZ).

He was chief author of the 2008 NHFA Statement on omega-3 fatty acids and heart disease (updated in 2015) and the National Heart Foundation of Australia Statement of Screening and Treatment of Depression 2013.

A consumer perspective

Presentation Resources

Caro Swanson

Caro Swanson 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.

Equally Well in the UK: What we've learnt so far

Presentation Resources

Andy Bell

Andy Bell has been with the Centre for Mental Health UK since 2002. Previously working for the King's Fund, he began as Director of Communications, becoming Deputy Chief Executive in 2009.

He is a member of the Mental Health Policy Group and was chair of the Mental Health Alliance between 2006 and 2008.

Andy has carried out research on the implementation of national mental health policies and on local mental health needs assessments. He writes a regular blog on mental health policy for the Huffington Post.

Symposium welcome

Presentation Resources

Christine Morgan

Ms Christine Morgan is the CEO of the National Mental Health Commission and National Suicide Prevention Adviser to Prime Minister Scott Morrison. Ms Morgan is a passionate leader in mental health care reform, committed to listening and responding to the voice and needs of those with lived experience.

Prior to joining the Commission, Ms Morgan was CEO of the Butterfly Foundation for eating disorders and Director of the National Eating Disorders Collaboration. In the not-for-profit sector, Ms Morgan was General Manager at Wesley Mission, over the areas of Corporate Services and Community & Family Development.

Ms Morgan brings connection and passion to mental health reform, built on the networks she established in the corporate world, her broad legal expertise, her extensive not-for-profit experience and her strong ability to demonstrate to people how their contribution can make a real difference.

Visa status, physical activity and mental health refugees, immigrants and asylum seekers in Sydney, Australia

Presentation Resources

Reza Rostami

Reza is a Research Associate at UNSW Sydney, and a mental health professional. Reza co-ordinated a major research project investigating the physical activity and mental health impacts of Australia's migration policies on Iranian and Afghan asylum seekers and who had arrived in Australia by boat.

He graduated with a Bachelor of Clinical Psychology from the University of Tehran, Iran (accredited by the Australian Psychology Accreditation Council as comparable to a 4-year program of study in psychology).

He also holds a Master of Research from the School of Psychiatry, UNSW Sydney. Reza has published research in the field of psychiatric epidemiology.

Reza was recognised by the 2021 NSW Humanitarian Awards, winning the category of Refugee Community Worker.

Equally Well and First Nations Australians – Closing the gaps

Presentation Resources

Tom Brideson

Tom is a Kamilaroi/Gomeroi man born in Gunnedah north-west NSW. Tom is the Chief Executive Officer of Gayaa Dhuwi (Proud Spirit) Australia, a part time Deputy Commissioner at the Mental Health Commission of NSW and Co-Chair of the National Mental Health Workforce Strategy Taskforce.

Since the early 1990s Tom has worked in Indigenous mental health and health policy; social and emotional wellbeing; clinical mental health care; suicide prevention; education and mental health leadership. Between 2007 and 2020, Tom was the State-wide Coordinator for the NSW Aboriginal Mental Health Workforce Program.

Tom sits on multiple committees to improve the health and mental health of Aboriginal and Torres Strait Islander people. He has many published articles regarding the mental health and related area workforces and advocates for the broad emerging mental health professional workforces across all health and human services.

Improving the physical health of people living with mental illness - Opportunities for reform

Presentation Resources

Ivan Frkovic

Ivan is the Queensland Mental Health Commissioner and brings substantial policy, academic and patient-centred experience to the role, having worked within the mental health system in Queensland for more than 20 years.

With a focus on strengthening partnerships and collaboration, he oversees delivery and implementation of the state’s strategic plan for Mental Health Alcohol and Other Drugs, Shifting Minds.

Ivan has a strong belief in the power of human connection, is a family man with four grown children, and has a great love of music and culture.

The Lived Experience ‘Peer’ Workforce – being Equally Well

Presentation Resources

Tim Heffernan

Tim is a Deputy Commissioner with the Mental Health Commission of NSW. He is an experienced Consumer Peer Worker and is a past chair and current director of Being Mental Health Consumers. He also works as a Peer Supervisor and as an Official Visitor.

An award-winning poet, Tim co-edits on online space for ‘Mad Poetry’, ‘Clozapine Clinic – The Frater Project’ in the influential Australian journal ‘Verity La’. He has published widely and performed his poetry and facilitated workshops at the Wollongong Writers Festival, the Queensland Poetry Festival, the Big Anxiety Festival and at Mad Pride.

Lifestyle Medicine in Mental and Physical Health

Presentation Resources

Sam Manger

Dr Sam Manger is a General Practitioner in clinical practice, Senior Lecturer and Academic Lead for the Master and Graduate Diploma in Lifestyle Medicine, James Cook University College of Medicine and Dentistry and GP Training. He is also an Ambassador for Equally Well Australia, President of the Australasian Society of Lifestyle Medicine (ASLM) and host of The GP Show podcast.

In 2021 he was awarded RACGP General Practitioner of the Year, Queensland, for his commitment to the field of medicine and general practice.

Overcoming implementation barriers

Presentation Resources

Susanna Every-Palmer

Susanna is an academic psychiatrist who is passionate about using multidisciplinary research collaborations to inform the highest quality evidence-based care for people with mental illness.

Alongside her role in the university, Susanna is concurrently employed at the Central Regional and Forensic Services. She has worked in a number of different areas across the mental health sector, including as Clinical Director and Director of Area Mental Health Services (DAMHS) of the Forensic and Rehabilitation Services covering courts, prisons and inpatient and community forensics across New Zealand's lower north island and as New Zealand's Acting Director of Mental Health at the Ministry of Health.

Susanna is the Chair of the New Zealand Committee of the Royal Australian and New Zealand College of Psychiatrists. Susanna obtained RANZCP Fellowship in 2008 and her Advanced Certificate in Forensic Psychiatry in 2010. She has a Masters in Evidence Based Medicine from Oxford University and her PhD focused on mitigating harms in the treatment of serious mental illness.

Launch of Lived Experience Report
What COVID-19 had taught us about physical health and mental illness

Presentation Resources

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 and 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.

CONCURRENT PRESENTATIONS

THEME:
CO-DESIGN

Mental Health Shared Care with Community Mental Health Consumers

Presenter:

Presentation Resources

Chris Maylea

Chris is a social worker, lawyer, an Associate Professor of Law at La Trobe University and a member of the Equally Well Implementation Team. He has practice experience in mental health services as a Social Worker and Manager and is Deputy Chair of the Victorian Mental Illness Awareness Council. Associate Professor Maylea's work sits at the intersections of health, welfare and the law, and is underpinned by human rights and social justice.

Associate Professor Maylea previously managed and evaluated mainstream Aboriginal and child and family community mental health services, rehabilitation units and assertive outreach and support services in regional areas.

Abstract

This paper will report back on preliminary results from an Equally Well – Healthtalk collaborative project being conducted by RMIT University and Charles Sturt University and will discuss how our findings might expand the remit of Equally Well in regards to the range and breadth of physical health challenges faced by our study participants.

The "Physical Wellbeing and Mental Health" research project aims to provide narrative, qualitative data to inform the mortality gap facing persons living with mental health concerns. This presentation will ask by what metrics should we be measuring the mortality gap, and how certain experiences fail to register in Equally Well's current priorities. By elaborating on several case studies, it argues for an expansion of these priorities, and a broader conception of physical health outside the common targets of cancer, cardiovascular diseases and diabetes.

Re-viewing physical health guidelines through a mental health lens

Presenter:

Presentation Resources

Carolynne White

Carolynne is a registered Occupational Therapist and an Adjunct Research Fellow at Swinburne University of Technology. In her current role as Participation and Engagement Advisor at Mind Australia Limited, Carolynne is working to embed a culture of inclusion and participation across the organisation by engaging diverse consumers, family members and carers in activities that influence decision-making.

Abstract

Introduction: Growing recognition of the physical health inequities faced by people living with mental ill-health prompted a review of the Physical Health Guidelines at Mind Australia. The review aimed to ensure that the guidelines were fit for purpose, within staff members' scope of practice, and aligned with recovery-oriented and trauma-informed approaches to care.

Method: The guidelines were reviewed by advisors from the Practice Development and Participation teams over six-months, using an iterative and collaborative process. We began with a workshop with Mind's Lived Experience Advisory Team (LEAT) to understand their experiences and preferences followed by an audit of current policy and practice, and a workshop with Mind staff from across Australia. The findings from the workshops were collated and used to revise the Physical Health checklist and guidelines, with further input from the LEAT and staff to develop practice resources.

Results: The initial workshop with LEAT members highlighted that physical health is important for clients and challenged assumptions that people with mental ill-health lack motivation or knowledge to act on their health. Instead, clients reported numerous barriers including living costs, medication side effects, and difficulties accessing health professionals with appropriate training. In general, staff felt comfortable talking about physical health with clients but were mindful of sensitivities related to age, gender, culture and health conditions such as eating disorders. Staff felt it was important to normalise conversations about physical health but wanted further training to contextualise the relevance of physical health for clients as well as support to integrate physical health guidelines within existing systems and models of practice.

Conclusion: The revised Physical Health Guidelines include resources to start conversations and help with goal setting. Input from people with lived experience and staff was essential to creating guidelines and tools that promote physical health, give hope, and address relevant social determinants of health.

THEME:
PREVENTION

Vaccine preventable hospitalisation in mental health consumers: a booster is needed

Presenter:

Grant Sara

Presentation Resources

Grant is the Director of InforMH, System Information and Analytics Branch, NSW Ministry of Health, and Principal Investigator for the NSW Mental Health Living Longer data linkage project. He is a Clinical Associate Professor in Psychiatry, Faculty of Medicine and Health, University of Sydney, and Honorary Professor, Faculty of Health, Macquarie University.

Abstract

Introduction: COVID-19 has highlighted the essential role of vaccination in preventing serious illness. Mental health service users have low vaccination rates for a range of conditions, but there is little evidence about the impacts of this. Understanding rates of vaccination-preventable illness, and the groups most affected, may help in targeting service and system improvements. Our aim was to describe rates of potentially preventable hospitalisation due to vaccine-preventable conditions in adults using NSW mental health services.

Method: Using linked data from the NSW Mental Health Living Longer Project, we calculated hospitalisation rates for vaccine-preventable conditions, such as hepatitis, influenza and pneumococcal pneumonia. Rates were standardised

for age and socio-economic disadvantage, comparing more than 178,000 mental health service users to the NSW population.

Results and findings: Mental health service users had a more than four-fold increased risk of admission for vaccine-preventable conditions (aIRR 4.7, 95% CI4.5 – 5.0), with even higher risks for consumers aged 40-65. One-quarter of excess potentially preventable bed days in mental health service users were due to vaccine-preventable conditions, including respiratory illness. New data will be presented on specific conditions and groups of consumers with the highest hospitalisation rates.

Discussion: Low vaccination rates have substantial impacts for mental health consumers. Strategies to overcome barriers and support vaccination uptake could have quick and substantial benefits for individuals and health systems. Supporting the uptake of COVID-19 vaccination will be essential to avoid further amplifying health inequalities for people using mental health services.

THEME:
PARTNERSHIPS

Evaluation of an integrated metabolic health clinic embedded in a community mental health service

Presenter:

Dan Siskind

Presentation Resources

Prof Siskind trained as a psychiatrist in Australia and the United States. He works clinically as a psychiatrist in Brisbane, Australia with people with treatment refractory schizophrenia. His research interests include treatment refractory schizophrenia, clozapine and the cardiometabolic comorbidities of schizophrenia. He has over 150 publications and over AU$20million in competitive research grants.

Abstract

Background: Metabolic syndrome is highly prevalent among people with schizophrenia. It is often underdiagnosed and undertreated, with challenges in integrating specialist metabolic and psychiatric services. The aim of this study is to assess the impact of an integrated metabolic clinic embedded within a community mental health service on metabolic health outcomes for people with schizophrenia.

Methods: Metabolic data were collected retrospectively through electronic records from 48 consecutive consumers with schizophrenia reviewed in the integrated metabolic clinic over 12-months. Data from baseline, first follow up and last follow up within 12 months from the initial visit were analysed. Attendance rates at the integrated clinic and those at the general endocrine clinics by a similar mental health patient population were also compared.

Results: The attendance rate was significantly better in the integrated clinic compared to that in the general endocrine clinics for both initial consult (80.0% vs 51.2%, p<0.001) and review appointment (64.3% vs 47.6%, p<0.001).

Conclusions: The integration of a specialist metabolic clinic within a mental health service resulted in better patient engagement for people with schizophrenia.

Published Paper: Outcomes of a co-located approach for metabolic health care for people with schizophrenia

Breast Screen participation rates in mental health consumers

Presenter:

Chris Lambeth

Presentation Resources

Chris is a biostatistician at InforMH, a unit of the System Information and Analytics branch at the NSW Ministry of Health. Originally trained in veterinary science, he has experience in the research and public health sectors. After developing a keen interest in statistical analysis of sleep and respiratory physiology data, Chris was accepted into the NSW Health Biostatistics Training Program in 2020 and has since gained experience in analysis of large linked public health datasets across a number of teams within the Ministry and has also worked on the public health response to COVID-19.

Abstract

Introduction: Mental health consumers have increased cancer mortality, due primarily to increased fatality rates. The disparity in fatality rates is associated with health care factors including lower participation rates in screening programs. Quantifying the scale of the problem in NSW and identifying groups or communities most affected is an important foundation for system improvements. Our aim is to examine the rate of participation in breast cancer screening for female mental health consumers aged 50-74 years in NSW compared to other women in NSW.

Method: Using linked data from the NSW Mental Health Living Longer Project, we calculated breast cancer screening participation rates for women in NSW aged 50-74 years, who are the target group of the BreastScreen NSW program. Biennial screening participation rates were calculated for mental health consumers and compared to rates for the NSW population.

Results and findings: Mental health consumers were less likely to undergo breast cancer screening, with a crude screening rate of 29.2% compared to 52.5% for the NSW population (IRR 0.56; 95%CI 0.55-0.57). Rates standardised for age and socio-economic disadvantage will be presented in addition to rates by region, key demographics and type of mental health condition or care.

Discussion: Breast cancer screening rates for women using NSW mental health services are more than 40% lower than women of the same age in the NSW population. Lower screening rates may contribute to later breast cancer detection and increased breast cancer mortality among female mental health consumers.

THEME:
PRIMARY CARE

Improving access to quality shared care for people with severe mental illness

Presenters:

Presentation Resources

Catherine Spooner

Catherine is a Senior Research Fellow at the UNSW Centre for Primary Health Care and Equity in Sydney. She leads a program of inclusive research at the Centre that aims to identify and trial interventions that can improve the physical health of people with severe mental illness.

Presentation Resources

Peri O'Shea

Peri is a Lived Experience Academic who specialises in qualitative, participative research aimed at improving the health and lives of people with mental health challenges. Her research work draws on academic skills and her own life experiences as a consumer and a carer.

Abstract

Introduction: People with severe mental illness (PWSMI) have a life expectancy 13 to 30 years shorter than the general population. This mortality gap has been increasing. The majority of deaths are due to preventable conditions such as cardiovascular disease and diabetes. There is a need to improve the accessibility and quality of preventive health care for PWSMI to improve their physical health outcomes. Aims: 1. To identify what helps PWSMI establish and maintain a positive relationship with their GP to prevent, detect and manage long-term physical conditions. 2. Trial an intervention based upon the findings.

Method: Semi-structured qualitative interviews and focus group with PWSMI; knowledge exchange workshop with PWSMI, service providers and other stakeholders. A lived experience researcher (PO) was involved in planning and conducting the research.

Results: Participants and stakeholders identified a need for navigation support, GP capacity building to be more accommodating and appropriate for patients with SMI, and improved shared care between the GP and mental health service, with the GP coordinating comprehensive care.

Discussion: Multiple interventions are needed to improve access to good shared health care for PWSMI. We have partnered with two local health districts to obtain funding to trial new web-based systems to facilitate shared care, coordinated by a GP. Working with consumers and health service partners has been essential for us to progress this agenda.

Local Partnership Pilot - a General Practitioner co-located at Community Mental Health Service

Presenter:

Presentation Resources

Nada Andric

Nada is a GP working in Sydney. She is interested in improving the health of people who are marginalised in the community and their access to healthcare. She has worked in primary health in a variety of hospital and community settings and her research interests are in viral hepatitis.

Abstract

Inpatients with serious mental illness often have high and unmet physical health needs. There is much variation in follow up healthcare with community GP services for people on discharge while community mental health follow up is more consistent. We speculated that people would find it easier to attend a GP clinic in parallel with their psychiatrist appointment, rather than attending a GP clinic at a separate site.

In a pilot project with a community mental health clinic, we co-located an independent GP clinic each fortnight to begin to address this service gap. The scope of practice was directed toward common primary care issues- blood pressure, weight and glucose monitoring, chronic disease monitoring, and physical health changes associated with medication side effects, and was limited to the hours of service that the clinic is open.

This presentation will focus on the feedback, successes and challenges in starting this service, and propose some solutions to ensuring that these co-located services are provided and supported in the future.

THEME:

MODELS OF CARE ONLINE

Examining service participation and outcomes from a population-level telephone-coaching service for people with a mental health condition

Presenter:

Presentation Resources

Tegan Bradley

Tegan Bradley is a PhD candidate within the Physical Health in Mental Illness research team based at the University of Newcastle, Australia. Her research focuses on identifying the current efficacy of lifestyle interventions to improve physical activity, weight and diet among people with a mental health condition, with a focus on population level telephone services as a means of providing support. Her experience includes analysis of population level datasets collected as part of routine delivery, as well as qualitative research, in order to evaluate current service delivery outcomes and explore areas for future direction.

Abstract

Introduction: Population-level telephone coaching services provide accessible behaviour change support for modifiable health risk behaviours. The NSW Get Healthy Service® is a free telephone-based coaching service in Australia, supporting improvements in healthy eating, physical activity and achieving or maintaining a healthy weight. This study aimed to examine the

engagement and immediate post-program outcomes of the NSW Get Healthy Service® for participants with a mental health condition enrolled in a 6-month coaching program in terms of program retention and changes in health measures at program completion.

Methods: Secondary data analysis was conducted on service data collected at program intake and completion for individuals who enrolled in a coaching program between January 2018 and October 2019 (n=5,629).

Results and findings: Thirty-three pre cent of coaching participants identified as having had a significant mental health condition that required treatment from a health professional. Approximately a third of participants with a mental health condition completed a coaching program, with most completers utilising the full 10-13 calls available as a part of the coaching program. Participants with a mental health condition made significant positive changes to their daily fruit and vegetable consumption, physical activity (walking and moderate exercise), weight and BMI, but not to waist circumference or vigorous physical activity.

Discussion: The NSW Get Healthy Service® is an effective means of providing behaviour change support for people with a mental health condition. Further research should consider means of improving retention rates.

Published Paper: Examining service participation and outcomes from a population-level telephone-coaching service supporting changes to healthy eating, physical activity and weight: A comparison of participants with and without a mental health condition

Population-level telephone coaching for improving health behaviours in mental illness: an RCT

Presenter:

Caitlin Fehily

Presentation Resources

Dr Caitlin Fehily is an early career postdoctoral researcher working within the School of Psychology at the University of Newcastle. Her research interests include addressing the inequitable chronic disease burden experienced by people with a mental health condition. In particular, Caitlin's research has focused on building the capacity of mental health services to provide preventive care to address their clients' health and lifestyle factors, including tobacco smoking, nutrition, alcohol, physical inactivity and overweight/obesity. Caitlin is involved in a number of research projects across local and national community mental health services, community managed organisations, telephone-based support services, and other health service settings.

Abstract

Introduction: People with a mental illness experience higher morbidity and mortality, consistently reported as linked to higher rates of chronic disease and engagement in health risk behaviours, including poor nutrition, and physical inactivity. Telephone support services offer a means of improving access to support services, though previous research investigating services for reducing health risk behaviours other than smoking in people with a mental illness has been limited. The current trial aims to evaluate the effectiveness of an existing population-level telephone support service in reducing health risk behaviours in people with a mental illness.

Methods: A randomised controlled trial is being conducted in partnership with the NSW Get Healthy Information and Coaching Service (GHS): a free, population-level telephone coaching service to support clients to lead a healthy lifestyle, including improving nutrition, physical activity, weight management, or reducing alcohol consumption. Clients of mental health services across NSW have been recruited via telephone interview, with data collection at baseline and six months post-recruitment. Participants are then randomly allocated to receive either a self-help information pack (control), or the information pack and an active referral to GHS (intervention). Primary outcomes include fruit and vegetable consumption, physical activity (SIMPAQ), and attempts to change these behaviours over the past six months. Secondary outcomes include change in weight, waist circumference, Body Mass Index (BMI), and attempts to change any behaviours addressed by the service in the past six months. Process outcomes such as intervention uptake, engagement, and completion will also be assessed.

Results: 682 participants were recruited (intervention: 547; control: 135). Follow-up data collection is underway, with completion expected by July 2021. Study methodology and planned analyses will be presented.

Conclusions: Results will provide valuable evidence of the potential for an existing population-level, telephone-based support service to deliver preventive care for chronic disease to this priority population.

Published Paper: Effectiveness of referral to a population-level telephone coaching service for improving health risk behaviours in people with a mental health condition: study protocol for a randomised controlled trial

THEME:
CHRONIC CARE

Vaccine preventable conditions and severe mental illness: how much do we know?

Presenter:

Michael Lau

Presentation Resources

Michael is a psychiatrist from Sydney with interest in the treatment of severe mental health conditions, Addiction Psychiatry and research in new treatment modalities for treatment-resistant mental illnesses. The review was conducted in collaboration with the NSW Mental Health Living Longer data linkage project.

Abstract

Introduction: Primary prevention strategies such as vaccination must be part of the complex response to premature mortality in people living with mental illness. However, there is limited evidence on the impacts of this issue, or on strategies for improving vaccination. Our aim was to review the literature on vaccine-preventable conditions in people living with mental illness.

Method: We conducted a systematic review and narrative synthesis of peer-reviewed literature published between 1980 and 2020. We included all studies examining vaccine preventable conditions in people with serious mental illness. We summarised information on (i) prevalence of vaccine-preventable conditions (ii) vaccination rates, (iii) barriers to vaccination and (iv) strategies to increase vaccination rates in people living with mental illness.

Results and findings: Many studies have found a higher prevalence of hepatitis B in people living with mental illness, partly associated with past intravenous substance use. There are fewer studies on other conditions. There is evidence of reduced vaccination rates and increased prevalence of other vaccine-preventable conditions such as influenza, pneumococcal pneumonia and herpes zoster. People living with mental illness have increased rates of hospitalisation for vaccine-preventable respiratory infections such as influenza and pneumococcal pneumonia. Integrated care models have been shown to enhance health care and increase vaccination rates in people with chronic illness.

Discussion: Vaccine preventable conditions are an under-recognised physical comorbidity in mental health and have significant impacts on people living with mental illness. COVID-19 underlines the health impacts of vaccine-preventable conditions, and the risks of unequal outcomes and increasing gaps for people not accessing vaccination. A greater focus on this issue in research and service improvement may be one strategy for reducing mortality and morbidity in this group.

A qualitative investigation of support provided by Community Managed Organisations to address chronic disease risk behaviours in consumers with mental illness

Presenter:

Presentation Resources

Lauren Gibson

Lauren is a PhD candidate at the University of Newcastle and a member of Professor Jenny Bowman's 'Physical Health in Mental Illness' research group. Her PhD research topic is exploring the potential role of community managed organisations and peer-workers in delivering chronic disease preventive care to people with mental health conditions. She has a particular interest in exploring the unique role peer workers may have in providing physical health support to this population; and the barriers and facilitators to doing so as part of routine practice.

Abstract

Introduction: People with mental illness experience significantly higher morbidity and mortality compared to people without. This is consistently reported as linked to increased chronic disease health risk behaviours (smoking, poor nutrition, harmful alcohol consumption, and inadequate physical activity; SNAP) in this priority population. Community Managed Organisations (CMOs) have ongoing contact with consumers, deliver a diverse range of services, and are a potentially important setting to address health risk behaviours for people with mental illness. A qualitative study was conducted to explore: 1) the type of support provided to address five key health risk behaviours (smoking, poor nutrition, alcohol consumption, inadequate physical activity, and poor sleep) of consumers with a mental health condition; and, 2) organisational and staff level barriers and facilitators to providing this support.

Method: One-on-one, semi-structured telephone interviews with standardised open-ended questions were conducted with a purposive sample of 12 senior management staff, across CMOs, NSW, Australia. Three independent coders analysed transcribed interviews. Inductive thematic analysis was used to guide theme generation.

Results and findings: Qualitative analysis generated three major themes, the first being types of SNAPS support that CMOs provided. Under this theme, differences in types of support were evident by SNAP factor, with support largely dependent on available service and client level funding, or client-activation/personalised care plans. The second and third themes related to barriers (a lack of funding; a lack of consistency in SNAPS support provided) and facilitators (workplace culture; collaboration with available supports; staff education and training) experienced when providing SNAPS support.

Discussion: This study found that support strategies offered by CMOs differed by physical health risk behaviours, models of care and funding at both a service and consumer level. Much care provided in this context is patient led, being dependent on funding and inclusion of the health risk behaviours in consumer care plans, particularly when linked to provision of NDIS support.

Published Paper: Exploring Support Provided by Community Managed Organisations to Address Health Risk Behaviours Associated with Chronic Disease among People with Mental Health Conditions: A Qualitative Study with Organisational Leaders

THEME:
CARE COORDINATION

Do consumers of mental health services recall receiving information about physical health?

Presenter:

Sarah Kelshaw

Presentation Resources

Sarah is the Experience and Outcome Measurement Project Manager at InforMH, System Information and Analytics Branch, NSW Ministry of Health.

Abstract

Introduction: The physical health of people using mental health services is a critical priority. Services should provide consumers with information about physical health, lifestyle and medication side effects. However, even when this information is provided, how do we know that it is remembered? Our aim was to explore the proportion of consumers who recalled receiving information about physical health in NSW public mental health services.

Method: The NSW version of the national Your Experience of Service (YES) questionnaire includes six additional questions based on the Healthy Active Lives (HeAL) declaration. They ask whether consumers recall being provided with information on diet, smoking, substance use, sexual health, exercise and possible physical side effects of medications.

Results and findings: In 2019-20 more than 60% of people recalled receiving physical health information, but with lower rates for specific domains of drugs and alcohol (57%) and sexual health (32%). Aboriginal consumers reported recalling more information about physical health than non-Aboriginal consumers. Young people are less likely to recall information on all issues, suggesting that services need to make health information more relevant and memorable for young people. People who reported a more positive experience in developing a care plan were more likely to recall information about physical health.

Discussion: If, how and when information is provided has a large impact on people's overall experience of services. People might not recall receiving information for many reasons. If information is not provided at the right time or in the right way for that individual, it may not be remembered and acted on. Our findings suggest that when information on physical health care is included as part of comprehensive care planning it is more likely to be provided or recalled. Monitoring this through regular surveys might help services to improve their information and support on these issues.

Mental health consumers' access to planned and emergency surgery in NSW

Presenter:

Julia Hamer

Presentation Resources

Julia is a final stage medical student at the University of Sydney and working with the NSW Health Mental Health Living Longer project to complete her MD dissertation. Prior to studying medicine, Julia graduated from the University of Toronto and worked as a neuroscientist studying concussion and mood disorders. Julia is very passionate about brain health and is an aspiring psychiatrist-scientist. Alongside her research pursuits, Julia is a yoga teacher and is highly involved in mental health advocacy work.

Abstract

Introduction: Effective health systems provide timely access to planned surgery when needed. Different rates of surgery between groups may reflect differences in disease prevalence, primary health care, or access to specialist care. High rates of emergency surgery may reflect reduced access to planned care. Our aim was to describe rates of planned and emergency surgery for NSW mental health service users.

Methods: Using the NSW Mental Health Living Longer linked dataset, we calculated surgery procedure rates in NSW public and private hospitals in 2018-19. We compared rates for mental health service users to other NSW residents using incidence rate ratios adjusted for age, sex, disadvantage and rurality. We examined planned and emergency procedures separately, and compared different procedure types.

Results and findings: We identified 2.1 million in-scope surgical procedures and approximately 256,000 mental health service users; 83% of procedures were planned. Compared to the matched NSW population, mental health service users had nearly one fifth more planned surgical procedures (aIRR 1.18, 95% CI 1.17-1.19) and more than three times as many emergency surgical procedures (aIRR 3.42, 95% CI 3:38 -3:46). Subgroup analyses will be presented on specific procedure types, AIHW access-sensitive procedures and different subgroups of mental health consumers.

Discussion: People who use mental health services have a slightly increased rate of planned surgical procedures and a more than three-fold increase in emergency surgical procedures. These findings are not accounted for by social disadvantage. They may reflect greater prevalence of acute and chronic medical conditions requiring surgery, or barriers in access to primary care or planned surgery when and where it is needed. Access to planned surgical care may be an overlooked factor contributing to unequal health outcomes in people living with a mental illness.

THEME:
LIFESTYLE

Unintentional Drug-Related Deaths for people with mental illness in NSW Australia, 2012-2016

Presenter:

Jennifer Smith-Merry

Presentation Resources

Dr Smith-Merry is Associate Professor in the Sydney School of Health Sciences within the Faculty of Medicine and Health at the University of Sydney. Jen is Director of the Centre for Disability Research and Policy (CDRP), a multi-disciplinary centre whose mission is to make life better for people with disability in Australia by translating research to policy and practice.

Jen is chief investigator on multiple grants which evaluate or develop policy and services in disability and mental health. She works closely with people with lived experience of disability and has a strong interest in lived experience-informed policy and service design.

Abstract

Introduction: People with serious mental illness are a vulnerable and stigmatised group who generally receive poorer healthcare and have worse health outcomes including greater premature mortality. Drug-related deaths are a significant cause of death in people with serious mental illness, but drug and alcohol strategies are often disconnected from our thinking about the health and wellbeing of people with mental illness. The aims of this study were to understand drug-related premature death in people with mental illness, investigate trends and rate of changes in unintentional drug-related deaths, describe types of medicines involved, and identify populations at risk. In this paper we explain the data and then outline the policy and practice related solutions needed to address this situation.

Methods: Unintentional drug-related deaths for people with mental illness between 2012 and 2016 were identified in the National Coronial Information System. Data regarding age, gender, marital status, year of death, and substances contributing to death were extracted from the retrieved cases. Descriptive statistics were computed for the results of the present study based on counts and proportions where relevant.

Results: A total of 495 unintentional drug-related deaths were identified (1.6 deaths/100,000 population), showing an upward trend ($p<0.01$). Males (rate ratio, RR: 1.8, 95% confidence intervals, CI: 1.5-2.2), people aged 35-44 (RR: 1.7, CI: 1.3-2.2) were more likely to die from unintentional drug-related deaths compared with the reference (female and people aged 25-34 respectively). The median number of drugs involved per death was 5.0 while the most frequent number of drugs involved (i.e. mode) was one (97/495 cases, 20%). The most common substance involved among 495 cases was diazepam in both genders (males: 135/319, 42%, female: 76/176, 43%). Alcohol and heroin were predominantly involved in deaths among males (both $p<0.05$). During the study period, amphetamine showed the highest increase (3.2-fold), followed by codeine (2.5-fold), quetiapine (2.5-fold) and morphine (2.2-fold).

Discussion: This study identified differences between gender, age group and marital status in trends and rates of unintentional drug-related deaths for people with mental illness. Differences in demographic characteristics imply that a multifaceted and structured approach is required to inform intervention and prevention strategies. Physical health promotion for people with mental illness must include a consideration of drug and alcohol use. The results in this study point towards the importance of renewed efforts around prescribing awareness and medication monitoring practices, as well as medicines-related education for people with mental illness. The number of overall deaths (n=398, 80%) involving polypharmacy or interactions between illicit, over the counter and prescribed medications also necessitates a strategy that brings together cohesive prescribing, mental health and drug and alcohol strategies as part of our overall consideration of the health of people with mental illness.

Published Paper: Unintentional drug-related deaths in people with mental illness in NSW Australia, 2012-2016: a retrospective cohort study

THANK YOU

Thank you to everyone who contributed their time and expert advice to the event

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