PHYSICAL AND MENTAL HEALTH
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EDITORIAL

Wendy Smith, Policy and Research Manager, VICSERV

Just as mental illness has made the shift from being a purely personal problem to become a social issue taken up by politicians of every persuasion, the physical health of people with a mental illness is now gaining attention. The life expectancy of people with a serious mental illness is similar to Indigenous Australians at around 50 to 59 years. The articles in this edition of new paradigm attempt to explain some of the complex reasons why this is so and what can be done to close the gap.

In the lead article, Professor Jayashri Kulkarni considers the impact of social factors, lifestyle issues and the side effects of medication on the physical health of people with a mental illness. She calls on her fellow mental health clinicians to break down the ‘long-held barrier’ between managing mental and physical health. Professor Kulkarni is an advocate for funded exercise, diet and training packages to prevent secondary morbidity, so it seems appropriate follow up with an article by our ‘cover girl’ Elise Dettmann on her fitness goals and the organisations that have enabled her to pursue them. There are a couple of other great articles about the role of physical activity and sporting clubs in improving the health and lives of people with a mental illness.

On a personal note, I am extremely proud to report that this is a smoke-free editorial! Five months ago I kicked a pack-a-day smoking habit. I am already a couple of thousand dollars better off, have greatly increased energy levels and feel an enormous sense of achievement at having freed myself from a powerful addiction. I knew that nicotine interacts with some psychiatric medication but rather than experiencing any problems I was able to reduce the dose of one of mine and may even lose some weight as a result. Finding the right kind of support to help me stop was essential to my success so it is fitting to publish two articles on smoking that emphasise practical ways to support consumers and workers to quit.

Taken together, the articles in this edition create a valuable resource for those wishing to improve the physical health status of people with a mental illness. There are some very strong articles in the research section including one by Neami manager Kirra Yates, which details the results of a study into PDRS staff attitudes to their clients’ physical health needs. I am sure that this edition will be one to regularly get down off the shelf to find the useful facts and figures around the issue and to be inspired to make a difference. As always the editorial team would like to thank everyone who contributed to this edition and helped us meet our deadlines.

Coming up next is the Spring edition, which will present articles from around Australia on what’s happening in the policy and practice environment in each state and territory and what we can learn from each other.
PHYSICAL AND MENTAL HEALTH
Closing the gap – better physical health care for people with major mental illness

Professor Jayashri Kulkarni, Director, Monash Alfred Psychiatry Research Centre

Newer, better antipsychotic medications without the side-effect of weight gain are being developed and some are already available in Australia. However, these medications are expensive because they are not subsidised by our Pharmaceutical Benefits Scheme (PBS). It is imperative that new drugs and other types of treatments are developed and made available to all.

Compared to the general population, people with major mental illnesses such as schizophrenia and bipolar disorder lose 25 to 30 years of normal life span (Colton, 2006). This disturbing fact is not just with us today, but is projected to become a growing trend for the years ahead (Osby, 2000). We need to close this gap in life expectancy between people with mental illnesses and the rest of the population.

There are many big issues facing people with major and persistent mental illnesses including, coping with the social sequelae of major mental illness and the added problems of physical ill health. The social factors include poverty, lack of work, poor or no housing, alcohol and illicit drug abuse, lack of social inclusion and connectedness, lack or difficult family and romantic relationships and dealing with issues of violence. These big factors can overlap with physical health issues and lead to a shortened life-span. Physical health issues include heart disease, obesity, diabetes and smoking, which all lead to premature death.

Increased heart disease risk factors for people with schizophrenia and severe bipolar disorder

The metabolic syndrome is defined as a combination of insulin insensitivity, hypertension, raised blood lipids (high cholesterol and triglycerides – also known as dyslipidemia or hyperlipidemia) and obesity that leads to diabetes and cardiovascular disease. People with severe and persistent mental illness have the following risk factors for developing the metabolic syndrome (also known as Syndrome X).

Table 1 is taken from a study of Morbidity and Mortality in People with Serious Mental Illness, by the National Association of State Mental Health Program Directors Council (July 2006). The combination of the following factors leads to overall greater cardiovascular risks and premature death.
Why do these physical health problems occur more in people with major mental illnesses?

There are really two major areas that explain the cause of these problems. These are lifestyle issues and current available treatments.

Lifestyle issues

Obesity and its sequelae (diabetes, hyperlipidemia) are a problem for Australians in general. As a nation we are eating fatter, more sugary foods and exercising less. Our work and leisure activities generally involve more sitting than running, again leading to further weight gain. Our diets comprise many sugar-rich processed foods, and often without realising it, corn syrup is a common calorie laden ingredient. Fast food is also much cheaper and easier to access. It is little wonder that within this context some people with persistent mental illness who are isolated and financially poor, experience severe weight gain.

<table>
<thead>
<tr>
<th>Modifiable Risk Factors</th>
<th>Estimated Prevalence and Relative Risk (RR)</th>
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<tbody>
<tr>
<td></td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Obesity</td>
<td>45–55%, 1.5–2X RR</td>
</tr>
<tr>
<td>Smoking</td>
<td>50–80%, 2–3X RR</td>
</tr>
<tr>
<td>Diabetes</td>
<td>10–14%, 2X RR</td>
</tr>
<tr>
<td>Hypertension</td>
<td>≥18%</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>Up to 5X RR</td>
</tr>
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Medication induced obesity

A significant cause of weight gain in some people who need antipsychotic medication is the action of some of the antipsychotic medications themselves.

Unfortunately, old antipsychotic drugs such as chlorpromazine, thioridazine and the more recent ones including olanzapine, risperidone, clozapine and quetiapine are all associated with significant weight gain (Allison, 1999). Figure 1 shows this in graph form. The mechanisms for weight gain are complex and involve interplay between the medication and brain chemicals such as serotonin and the fat hormone, leptin. Appetite regulation can also be affected by medication leading to unusual appetite surges and difficulty in stopping eating due to changes in the usual satiety feedback mechanisms. Unfortunately, it is not possible to effectively treat many psychosis symptoms without antipsychotic medications – most of which are implicated in weight gain. Weight gain in turn increases the risk of diabetes, increased cholesterol/triglycerides and hypertension – all leading to increased risk of heart disease and strokes.

Possible solutions

Newer, better antipsychotic medications without the side-effect of weight gain are being developed and some are already available in Australia. However, these medications are expensive because they are not subsidised by our Pharmaceutical Benefits Scheme (PBS). It is imperative that new drugs and other types of treatments are developed and made available to all.

Weight gain in a person who is taking antipsychotic medication needs to be managed as a serious issue. Far too often, mental health clinicians believe their work is done if the person’s
auditory hallucinations or other acute symptoms are settled by taking medication. A common carer comment is ‘but doctor – although the voices have stopped, she has gained 20 kilos and feels so bad about herself that she doesn’t want to go outside or see anybody’.

It is possible to change medications to find one that may suit the individual better. Good dietary advice and exercise plans need to be detailed and tailored to the individual. Mere advice to ‘eat less and move more’ is not good enough. Gym memberships, individual trainers and dietician input all need funding from the government, but in the long-term they may prevent secondary morbidity in this group. Some of these funding packages are available and the use of such health interventions is crucial. Focussing on diet and exercise is vitally important, but if these are reasonably attended to and weight gain is still of concern, then medication change is an important option.

If medication and diet plus exercise strategies are unsuccessful and the person still has significant weight gain, then management may need to include medical treatments such as prescribing weight loss medications or considering gastric banding. Such measures are not to be taken lightly, but the presence of a mental illness should not exclude the person from being considered for such measures if necessary. Far too often, the person with a mental illness is made to feel that they are ‘lazy’ or ‘just not trying enough’ when it may well be the medication that is the real cause of major weight gain. A concerted effort by the person and their treating team needs to examine all aspects of the person’s life and use every possible approach to achieve better mental and physical health outcomes.

Regular visits to a General Practitioner are very important for weight, blood pressure, diabetes and cholesterol testing. Waist circumference measurement is a useful and cheap monitoring tool. Mental health workers and psychiatrists also need to include physical health follow up in their routine assessments of their patients. The long-held barrier between managing a person’s mental health and physical health needs to be broken.

If we can raise the level of concern about a person’s physical health in our mental health teams to the same level as concern about mental state, then the management of weight gain, diabetes, hypertension and high cholesterol levels will not be seen as an afterthought or minor problem. People with mental illness and their carers have a greater awareness of such issues and can hopefully encourage physical matters to be attended to.

**Figure 1**

**MEAN CHANGE IN WEIGHT WITH ANTIPSYCHOTICS**

Estimated Weight Change at 10 Weeks on “Standard” Dose

Smoking

Cigarette smoking is disproportionately high in the population of people with severe mental illness. The reasons for this include some of the biological impact of nicotine, which has an anxiety reduction effect. However, cigarette smoking is associated with both psychological and physiological addiction. Social pressures to smoke in this group are manifold and include the lack of activity and peer group pressure. According to a 2007 SANE access economics study (Access Economics 2007), the financial cost of excessively high smoking by people with mental illnesses is over $3.5 billion each year (health system costs, reduced productivity and money wasted on drug addiction). The cost of premature death and suffering inflicted upon this group because of their excessively high smoking is almost $29.4 billion a year.

Smoking cessation requires ongoing, slow and persistent work. Many people with a mental illness who wish to stop smoking do not receive a proper program of help. Cigarette smoking in this population is often ‘normalised’ and seen as the ‘least of his/her worries’ or ‘the only pleasure he/she has in life’. Mental health case workers often relegate smoking cessation near the bottom of a long list of issues to be dealt with. However, the morbidity related to smoking is very high. Lung and heart disease are clearly correlated with smoking. There are several approaches to smoking cessation, but it is a difficult addiction to cure.

A study being conducted jointly in Newcastle and Melbourne called Healthy Lifestyles (Monash Alfred Psychiatry Research Centre, 2011) has shown that it is possible for people with severe persistent schizophrenia to stop smoking or significantly reduce the number of cigarettes smoked. The key ingredients to this successful program include the combined use of nicotine substitutes plus psychological therapy that is targeted for people with schizophrenia. Persistence by the psychology therapists is very important. This approach is replicable but the greatest step to successful smoking cessation is identifying that smoking is a major concern for the person with a mental illness and their case workers.

A special group

Women with severe mental disorders in their mid-40s need special consideration around the effect that menopause has on their mental health. Estrogen levels (a key female hormone) start to decline with menopause changes that begin ‘typically’ in the mid-40s. Menopause changes impact on brain chemistry several years before the woman experiences physical symptoms such as hot flushes. Estrogen is a ‘neuroprotective’ steroid, meaning it can assist in keeping psychosis or depression symptoms under control. With declining levels at menopause, this ‘protection’ is diminished. It is unfortunately common that women with previously stable mental disorders relapse in their mid to late 40s and early 50s.

In women with mental illness, menopause issues are not often considered as a contributing factor in a worsening mental state (Kulkarni, 2010). It can make a huge difference to the woman’s wellbeing if she is treated with hormone replacement or natural hormone products at this stage of her life. Women also need special attention with respect to having regular breast ultrasound screening and mammograms every two years after age 50. Many women with persistent illness also do not receive regular gynaecological check ups. Breast, uterus, ovarian and cervical cancers are other physical health issues that cut short life spans for women with mental illness.

Conclusion

Improving the physical health of people with severe mental illness needs the combined effort of the person and their carers plus mental health workers (clinical and non-clinical) plus general medical practitioners. Governments need to ensure funding packages for lifestyle programs, education packages and involvement with a range of allied health professionals. The pharmaceutical industry needs to develop effective medications without the current range of side-effects and these drugs need to be accessible to all. This means that an increased subsidy by the government for antipsychosis medication is needed.

Above all, we need a paradigm shift in the current approach by mental health clinicians (especially psychiatrists) to equally manage the mental and physical health of people with severe mental illness. By ‘closing the gap’ that separates the management of people’s mental health and physical health, we can also close the gap between the projected lifespan of people with and without mental illness.

References


Fitness and mental health

Elise Dettmann, Participant at YMCA and Doutta Galla Community Health Service (DGCHS)

Thanks to Doutta Galla Community Health Service (DGCHS) and the YMCA, I am able to walk faster, run for the bus without collapsing in a heap and, best of all, I’m on my way to losing those unwanted kilos that seem to go hand in hand with mental illness.

When you’re unwell, it can be hard to focus on physical health. In the past ten years, I’ve put on 40 kilograms because of mental health issues such as depression, addiction, lethargy, lack of motivation, and medication that lowers my metabolic rate. A couple of years ago, I was going through an ‘unwell’ phase and two doctors suggested that I go for walks. So, taking their advice, I started going for short walks. Over time, I started getting fitter, and more able to walk for longer distances. These days I prefer walking to driving or catching public transport. I’ll regularly walk for 30 minutes to an hour, sometimes walking as far as 10 kilometers. Now, one of the doctors even says, ‘don’t feel you have to walk so far’!

In the past year or two, physical health has become my goal in life. I’ve never been very fit, but a number of opportunities have opened up that allow me to work towards this goal. The first opportunity was through Doutta Galla Community Health Service (DGCHS). They offered free gym sessions once a week and, although nervous at first, I started attending and soon became a regular member. Having people to train with was really encouraging and together we worked towards our gym goals.

The second opportunity was joining the Premier’s Active Families Challenge that took place in October/November 2010. The challenge is to exercise for 30 minutes, 30 times in six weeks. Further, it came with 15 free passes to the local YMCA gym. So I started keeping track of my walking and gym visits and soon I’d successfully completed the challenge.

The next opportunity was the YMCA Open Doors program. This program gives disadvantaged people a chance to join a gym. The YMCA have fundraising days and receive donations in order to offer this service. I collected the application forms, one of which is for my case manager and the other is for me. I did nothing with them for several months as I couldn’t decide whether or not I wanted to join Open Doors. Finally, I filled them out and submitted them. Case managers are involved to the extent that if you become inactive in your membership and the YMCA can’t contact you, they may ring your case manager to find out if anything is wrong. This is a strong motivator for staying active in the program!

Initially, as part of the Open Doors program, I was given a card for ten visits to the gym to use within six weeks. This card was limited in use but I was given the choice of which YMCA
DGCHS...offered free gym sessions once a week and, although nervous at first, I started attending and soon became a regular member. Having people to train with was really encouraging and together we worked towards our gym goals.

facilities I would like to use. I chose gym access over swimming or group classes. After the initial six weeks, I was given a full three-month membership that included full use of the gym, plus group classes and swimming/spa/sauna access. When the three months expired, I was able to continue with yet another three-month membership.

Thanks to Doutta Galla Community Health Service (DGCHS) and the YMCA, I am able to walk faster, run for the bus without collapsing in a heap and, best of all, I’m on my way to losing those unwanted kilos that seem to go hand in hand with mental illness.

FIND OUT MORE: For more information about the Open Doors program, visit the YMCA website: http://victoria.ymca.org.au/cpa/htm/htm_home.asp, Phone 03 9403 5000, or email vicoffice@ymca.org.au.

For more information about the mental health programs at Doutta Galla Community Health Service, visit their website: www.doutta.org.au, or phone 03 8327 1700.
The physical health of the mentally ill: how can we help?

Dr Katherine Sevar, St Vincent’s Hospital Melbourne
Prof David Castle, St Vincent’s Hospital and The University of Melbourne

It has been widely reported that the impact of lifestyle factors on major mental illness and the impact of major mental illness on the ability to make healthy lifestyle choices is a bi-directional issue. The issue of diet is often neglected, but poor dietary habits, with reliance on high fat ‘junk’ foods, is common amongst the mentally ill and is a factor in raising cholesterol and triglycerides, thus worsening cardiovascular risk profile.

People suffering from major mental illnesses such as schizophrenia and bipolar disorder have a high burden of associated physical illnesses, notably cardiovascular disease. Furthermore, it is all too common for cardiovascular risk factors in such individuals to remain undetected and untreated. This article outlines some recent projects that aimed to modify cardiovascular risk factors in individuals with severe mental illness in community mental health services, with a view to informing service provision across general and mental health services, as well as Psychiatric Disability Rehabilitation and Support (PDRS) services.

The problem

The inequity in the provision of physical health services to individuals with major mental illness is worthy of ongoing debate and there is research that suggests individuals with major mental illness experience barriers to accessing adequate services for their physical health, including screening services for common chronic problems including diabetes and cervical cancer. Encouraging links to primary care is extremely important, given the additional screening facilities available in primary care settings that are not as readily accessible in community mental health services – for example, cervical and prostate cancer screening.

Within the Australian medical profession and the general public there has been a rapid increase in the availability of information regarding the impact of lifestyle factors on the physical and mental health of individuals. The proportion of those individuals with severe mental illness who smoke is significantly higher than the general population.1 The percentage of individuals with severe mental illness who exercise regularly is limited, access to a healthy diet is limited by financial constraints, there is limited education regarding healthy
choices and some psychotropic medication can cause individuals to crave carbohydrates and sweet foods. A number of the second generation antipsychotic medications can contribute to the development of metabolic syndrome and specific metabolic parameters require routine monitoring to evaluate the development of diabetes and hypercholesterolaemia.

Diet
It has been widely reported that the impact of lifestyle factors on major mental illness and the impact of major mental illness on the ability to make healthy lifestyle choices is a bi-directional issue. The issue of diet is often neglected, but poor dietary habits, with reliance on high fat ‘junk’ foods, is common amongst the mentally ill and is a factor in raising cholesterol and triglycerides, thus worsening cardiovascular risk profile. Some of the medications prescribed for people with disorders such as schizophrenia can serve to reduce satiety and drive cravings for such unhealthy foods. Also, some antipsychotic medications can directly perturb lipid profiles.

There is significant potential in this area to investigate the impact of altering an unhealthy diet in people with a major mental illness, especially given the potential physical health benefits of a healthy diet, which have already been widely described in the literature, for example improved diet quality and reduced risk of cardiovascular disease (Michels, 2002)² (Fung, 2001)³ (Hu, 2000)⁴ (Osler, 2001)⁵, type 2 diabetes (Williams, 2000)⁶ and cancer (Michels, 2002)⁷ (Fung, 2006)⁸. Indeed, it appears imperative for services to consider the impact of diet amongst individuals in their care. Underlining this need, and the potential benefits of interventions aimed at healthy eating, is the research published by Jacka et al, 2010,⁹ which described an association between poor diet (such as a Western junk food diet high in saturated fat) and the development of depression. This work was described as ‘both compelling and daunting to consider that dietary intervention at an individual or population level could reduce rates of psychiatric disorders.’

There is also a significant body of evidence for the use of targeted dietary interventions in individuals with major mental illness. The use of omega 3 fatty acids in the treatment of depression has been widely reported and the most recent meta-analysis pointed towards increasing evidence for their efficacy albeit that the studies had been hampered by heterogeneity.¹⁰ From a mechanistic perspective, omega 3 fatty acids are believed to decrease neuro-inflammation as well as oxidative stress,¹¹ which has an impact on the development of the features of major depression. They have also been repeatedly shown to be protective against the development of cardiovascular disease. The Australian Heart Foundation currently recommends that individuals without cardiovascular disease should consume about 500 mg per day of combined docosahexaenoic acid and eicosapentaenoic acid (DHA and EPA) through a combination of the following: two to three serves (150 g serve) of oily fish per week, fish oil capsules or liquid, food and drinks enriched with marine polyunsaturated fatty acids (n-3 PUFA) and individuals with cardiovascular disease should consume twice the amounts stated above¹².

A comprehensive approach
Other major cardiovascular risk factors include lack of exercise and cigarette smoking. As indicated above, these factors are much more prevalent amongst the mentally ill than the general population. It would seem sensible to attempt to address these factors, as well as the dietary issues discussed above, in a comprehensive integrated manner. St Vincent’s Mental Health Service in Melbourne has been engaged in encouraging novel work to develop and evaluate a multi-component risk factor intervention for individuals with psychosis. Specifically, the aim was to reduce the risk of coronary artery disease, smoking and weight gain amongst individuals with schizophrenia, bipolar disorder and related disorders. This pre-post treatment design trial showed that a nine-session program combining motivational interviewing, cognitive behaviour therapy (CBT) and nicotine replacement therapy (NRT) allowed participants to reduce their coronary heart disease (CHD) risk scores, reduce their weight, increase their chance of stopping smoking, increase their physical activity and reduce unhealthy eating.¹³ These encouraging findings are currently being investigated further using a randomised controlled experimental design.

Our research collaborative group has also piloted the use of the nicotinic receptor partial agonist varenicline, instead of NRT, with encouraging results for smoking cessation but with the caveat that some patients experience depression and/or worsening of psychotic symptoms so careful counselling and monitoring systems are required.

Metabolic monitoring and targeted interventions
An increased focus on metabolic monitoring, particularly in individuals taking antipsychotic medication, has continued to evolve over the last three years at St Vincent’s Mental Health Service in Melbourne. Despite significant barriers to the implementation of routine metabolic monitoring from both staff and patient perspectives, the program delivered on around 60 per cent coverage of routine monitoring of blood glucose and lipids and 54 per cent on weight measurement. Compliance with measurement of waist circumference was much lower (seven per cent) and the reported areas that still needed attention include higher rates of weighing and waist measurement and enhanced on-referral to GPs, dieticians and healthy lifestyle groups. From this study it appeared clear that the education regarding lifestyle factors and physical health in general needs to be performed in a timely manner for
individuals with first-episode psychosis, but the information also needs to be provided in a way that resonated with young people who are in the early stages of illness.

During the process of conducting the above study, the investigators also collaborated in a series of healthy lifestyle programs in different areas with the PDRS sector, covering diet and exercise, smoking, medication and changes in lifestyle to promote healthier living. These groups were well received within this environment and many went on to be repeated by staff within the service after the study had been completed. During the study, the service also worked with local gyms to develop and support low-cost gym programs and an exercise program in the inpatient unit.14

The examples above illustrate the opportunities that are present within the PDRS sector to implement programs, which focus on the modifiable lifestyle factors that contribute to poor physical health. Research conducted in the UK that compares patients living in high care, secondary and low care settings found that even those in high care settings – where healthier options were provided – still consumed more junk food than the general population.15 This suggests that more effective interventions are necessary to improve and sustain a healthy diet if the increased mortality of those individuals with schizophrenia is to be effectively addressed.

Research has shown that weight loss programs tailored for this population can be successful, with a group in America reporting that their intervention, which integrated behavioural strategies with a novel food replacement program – as well as practical, community-based teaching of shopping and preparing healthy food – was able to arrest weight gain and that individuals continued to lose weight for six months after completion of the intervention.16

It is necessary to examine the potential barriers to the implementation of programs that encourage healthy eating, reduction in smoking and increased exercise in a psychosocial rehabilitation setting. These barriers may involve practical difficulties in accessing community facilities including local gym membership and there is the potential for stigma to play a role in limiting access to such community facilities. There also needs to be an attitudinal shift when considering resource allocation within psychosocial rehabilitation settings, so that the promotion of physical health and wellbeing are prioritised and part of ‘core business’. Given the potential benefits for the physical health of this population, it is imperative for the sector to continue to advocate for adequate allocation of resources.

References
Smoking and mental illness: attempting to break the cycle

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In Australia in 2000, it was estimated that people with a psychotic illness who smoked and were in receipt of a Disability Support Pension, spent more than one third of their pension on tobacco products. This contributes a total of $111 million each year in tobacco taxes to the Australian government.

Relationship between smoking and mental illness

Tobacco consumption continues to be the leading preventable cause of death in the world (World Health Organisation, 2006). In 1998 an estimated 19,019 people died in Australia as a result of tobacco smoking. Additionally, in 1997-98 a further 142,525 hospital episodes were attributable to smoking (AIHW, 2001). Despite these astounding figures, it has been documented that there has been an overall decline of 40% in smoking rates in Australia since 1985 (AIHW, 2008). The Australian Institute of Health and Welfare’s 2007 National Drug Survey Report highlighted that less than one in six (16.6%) of people aged 14 and over reported daily smoking, declining from 21.8% in 1998. Despite this continual decline in smoking within the general population, smoking rates amongst individuals with a serious mental illness remain extremely high. Across psychiatric diagnoses, smoking was highest among those with schizophrenia, with rates ranging from 50% to 95% (Srinivasan & Thara, 2002). Although other severe psychiatric illnesses such as mood disorders are associated with tobacco smoking, the association between schizophrenia and tobacco smoking appears be stronger (de Leon & Diaz, 2005).

In Australia in 2000, it was estimated that people with a psychotic illness who smoked and were in receipt of a Disability Support Pension, spent more than one third of their pension on tobacco products. This contributes a total of $111 million each year in tobacco taxes to the Australian government. It could be said that smoking contributes to the vicious cycle of poverty and disadvantage in which many people who are living with mental illness are trapped (Lawn, 2001).

Compared with smokers in the general population, smokers with a mental illness also smoke significantly more cigarettes, are likely to be more dependent smokers and have smoked for a longer time (Kumari & Postma, 2005). People with a mental illness who are also smokers are more likely to suffer health problems associated with their tobacco use. They have extremely high rates of morbidity and mortality from smoking related illnesses such as cardiovascular disease, respiratory diseases and cancer (Lawrence et al, 2009). Smoking compounds many of the health problems already experienced by people with mental health issues. Combined with drug therapies that often contribute to weight gain, they are at even greater risk of diabetes, heart attacks and strokes if they smoke. The biggest cause of death among people with mental illness is not suicide, it is cardiovascular disease (Nauert, 2008).
Both physical and social factors are thought to reinforce the use of tobacco in those with a mental illness. For many people with severe mental illness, smoking is a major part of their daily routine. Smoking has historically been a part of the psychiatric culture and is further entrenched by the tobacco industry, which has monitored and directly funded research supporting the idea that individuals with schizophrenia are less susceptible to the harms of tobacco and use tobacco as self-medication (Lawn & Campion, 2010). It is established that smoking increases the metabolism of various antipsychotic medications and therefore smoking by people on these medications may reduce the side-effects. However, people with a mental illness who smoke are then likely to be prescribed higher doses of these medications and as a result, the effects on health overall are negative (Cancer Institute NSW, 2008). Participants of a study designed to determine the motivation for smoking by individuals with schizophrenia reported that smoking assists with the negative effects of schizophrenia, as well as reducing medication side effects. The study also highlighted that the psychological aspects of smoking by people with schizophrenia may be a contributing factor in the high prevalence of smoking. These effects include the use of tobacco as a stimulant, a coping mechanism to deal with stress, an aid to concentration and a facilitator of relaxation (Forchuk et al, 2002).

Neami substance use research

A study conducted by Neami in 2009 aimed to determine the overall prevalence of alcohol and other drug use amongst consumers accessing the service. As part of the study design, a specific Tobacco Questionnaire was developed to collect information about current smoking patterns, including number of cigarettes smoked each day and amount of money spent on cigarettes each week. The questionnaire also enquired about cessation attempts, motivation and readiness to change smoking behaviour, intention to quit, and whether respondents believe Neami staff should have a role in supporting them to cut down/quit their smoking.

A sample of 489 individuals aged 16-64 participated in the study, recruited from Neami service sites in Victoria, New South Wales, South Australia and Western Australia. The study sample comprised 267 males (54.6%) and 222 females (45.4%). Fifty-six per cent of participants had a diagnosis of schizophrenia, 12.1% depression, 11.5% bipolar disorder and 10.2% schizoaffective disorder. The remaining 10.2% of participant diagnoses included anxiety, post natal depression, personality and eating disorders. Despite the relatively low rates of alcohol and illicit drug use throughout the sample, high rates of problematic tobacco and caffeine use were common. This report will however focus on the results related to tobacco use.

Preliminary data on smoking rates was collected via the Alcohol, Smoking & Substance Involvement Test (ASSIST). Sixty five per cent (317) of participants identified as daily tobacco smokers, with 48.5% (237) of the entire sample meeting ASSIST abuse criteria, and a further 23.7% (116) meeting dependence criteria for their tobacco use. This high rate of smoking replicates the findings from a previous study conducted by Moeller-Saxone in 2007 involving 280 consumers accessing Neami support services in Victoria, in which 62% of study participants were smokers (Moeller-Saxone, 2008). Of the smokers identified in the recent study, those with a psychotic disorder were more likely to be in a moderate or high risk category for their tobacco use. Participants with a diagnosis of schizophrenia and schizo-affective disorder were more likely to be daily smokers and also more likely to smoke the most amount of cigarettes. There were no significant differences in smoking rates between men and women. A statistically significant positive relationship was identified between the frequency of tobacco smoking and high scores on the Kessler-10 (a common outcome measure used for assessing symptoms of anxiety and depression). When asked if their substance use had led to any health, social, legal or financial problems in the past three months, 17.8% (87) participants stated that their tobacco use had caused them problems weekly and 12.7% (62) reported it caused them problems on a daily/almost daily basis.

To further explore individual smoking patterns, smokers were also asked to complete the specific Tobacco Questionnaire developed by Neami. The smoking rates among participants who completed the additional questionnaire were high, 16.9% (54) reporting they smoked 1-10 cigarettes per day, 36.3% (116) reported smoking 11-20 cigarettes per day, 30.9% (99) smoked 21-30 per day, 14.7% (47) reported smoking between 31-50 cigarettes per day and 1.3% (4) smoked more than 50 cigarettes per day. Evidence demonstrates that individuals who smoke ten cigarettes a day reduce their life expectancy by an average of two to three years. Individuals who smoke 20 cigarettes a day reduce their life expectancy by five to seven years, and those choosing to smoke 40 cigarettes a day are reducing their life expectancy by eight to ten years (Forchuk et al, 2002). The average number of cigarettes smoked per day in the sample was about 13, demonstrating a significant amount of potential life years lost.

The amount of money spent each week on cigarettes was extremely high, with 41.4% (132) of smokers spending between $51 and $100 per week on cigarettes. There was also a small percentage (3.8%) of smokers who reported that they spent between $101 and $150 per week on cigarettes. When asked if smoking helps them to cope with life and loneliness, 84% indicated that it helps them cope with life and 80% stated it helped them cope with loneliness (includes
responses for a little, somewhat and extremely). Stress and boredom were identified as the major contributing factors as to why someone smoked. When asked if they wanted to quit or cut down, 46.7% stated they wanted to quit and 46.3% said they wanted to cut down. The majority of respondents (70%) also believed (includes responses for a little, somewhat and extremely) that their Neami support worker should be able to support them to reduce/quit smoking at the same time as supporting them in their recovery. This demonstrates that Neami has a key responsibility in attempting to minimise the significant health risks associated with tobacco use amongst consumers accessing the service. The fact that 65% of respondents stated that others smoking around them makes it difficult for them to quit/cut down, reinforces the findings from various public health interventions which demonstrate that quitting can best be achieved in an environment which is conducive to quitting.

**Neami Smoke-Free Wellness Program initiatives**

In late 2008, in recognition of the serious impact smoking has on the health of its staff and consumers, Neami embarked on a comprehensive Smoke-Free Wellness Program. The program aims to create a supportive environment for those with a mental illness who wish to reduce or quit smoking. The results from the 2009 Neami study further reinforced the importance of the program in supporting staff and consumers with information and education about reducing and quitting smoking. To date, key activities of the Smoke-Free Wellness Program have included:

- dissemination of a Smoke-Free Policy
- health promotion officers being appointed in each state with Smoking Cessation a key portfolio of their role
- the appointment of health promotion site champions to support and further promote the work of the health promotion officers
- administration of a staff survey aimed at assessing staff’s attitudes and beliefs towards smoking
- distribution of resource kits to support workers and consumers in developing action plans, goal setting and identifying resources to assist in reducing/ quitting smoking. These kits also provide essential information for staff members on the relationship between smoking and mental illness
- brief intervention training for staff and the delivery of smoking cessation support groups in New South Wales, Victoria and Queensland (using resources from SANE and QUIT Victoria). The consistent delivery of these groups across Neami commenced in early 2011.

As can be seen, the development of a Smoke-Free Policy is just one of the many strategies Neami has introduced in an attempt to reduce the alarmingly high rates of smoking among consumers accessing its services. However, in order to be effective in becoming a smoke-free organisation, it was acknowledged that the focus of any targeted program initiatives has to be on both staff and consumers. As a result, gathering information on staff attitudes and beliefs towards smoking has also been a key focus of the Smoke-Free Wellness Program at Neami. The administration of an online survey to all staff identified a number of areas that have informed the work of Neami’s health promotion officers, including:

- staff who smoke. There was an underlying current of resistance particularly in regard to staff who are smokers being requested to smoke away from the premises. This was difficult to enforce and it was challenging to make staff aware that it was important to keep smoking as invisible as possible from consumers
- staff who feel it’s a client’s right to smoke. Many staff felt quite passionate that we should provide consumers with the dignity of risk to determine their own smoking habits
- some staff felt uncomfortable asking consumers not to smoke in their presence. They were also requested not to assist in the purchasing of cigarettes or related items. Staff felt this was challenging given it was often at the point of sale when purchasing other items.

The most effective way to overcome the challenges presented by staff has been to ensure the health promotion officers are equipped with a comprehensive level of knowledge about the issues associated with smoking and mental illness, and an awareness of how to best introduce smoking cessation strategies with consumers. Reinforcing the findings of the recent study, which highlighted that the majority of consumers who smoke want to quit/cut down also encourages staff to continue engaging in discussions with consumers about their smoking. This knowledge sets the foundation for why change is so important and lays a solid case for why Neami has made the issue of smoking such a high priority. Neami has also acknowledged that change takes time and that staff need to feel supported, heard and given an opportunity to reflect on their beliefs and attitudes. This is achieved by allowing a space for their reflection within team meetings and supervision.

Evidence clearly demonstrates that people with a mental illness can quit smoking when provided with appropriate support and that the benefits may encompass both physical and mental health (Lawn and Pols, 2005). The World Health Organisation (2006) states that ‘successful long-term cessation rates depend on the implementation of educational programs and supportive resources for those who want to quit’. Understanding the issue of motivation is therefore critical to assisting individuals to quit smoking. Participants of the smoking cessation groups currently being delivered throughout the organisation are encouraged to begin to think about the reasons behind their
smoking and to develop individualised strategies to help make changes to their smoking behaviour. Other consumers who have successfully quit smoking are recruited as guest speakers at the groups to give hope to others who are attempting to quit or cut down. Pre and post questionnaires are also completed by group participants, which aim to measure changes in smoking patterns and behaviour and to also see if there has been any shift in their attitudes, motivation and confidence towards changing their smoking patterns. The information gathered via these questionnaires will be regularly reviewed to determine the effectiveness of the groups in achieving their aims.

Despite the high rates of smoking identified amongst those attending the smoking cessation groups, participants can still be encouraged by the fact that after ten years, a person who quits smoking may be at the same risk for cancer as someone who is a lifelong non-smoker (Forschuk et al, 2002). The key aim for group facilitators is to therefore increase the personal knowledge and confidence levels of participants so they can attempt to break the cycle of smoking.

The success of implementing the Neami Smoke-Free Wellness Program is a result of a combination of the following factors: clear leadership, cohesive teamwork, staff education and training related to smoking and mental illness, and reinforcement of the Smoke-Free Policy to staff. It is hoped that through Neami’s commitment to ensuring staff are continually providing smoking cessation support and encouragement to consumers, the rate of smoking amongst individuals with a mental illness will begin to decline at a similar rate to that in the general population.

References


Cancer Institute NSW (2008) Literature Review: Smoking and Mental Illness, other drug and alcohol addictions and prisons, Cancer Institute NSW, Sydney


FIND OUT MORE: Further details of Neami’s Smoke-Free Policy and Initiatives, and findings from Neami’s substance use study can be provided upon request. You can visit Neami’s website here: http://www.neami.org.au/
Addressing the physical health needs of people with mental illness: enabling consumers to access smoke-free messages

Judi Brewster, Project Coordinator, Special Settings (Mental Health and Prisons), Quit Victoria

In an ideal world, we envisage every mental health worker possessing skills in basic level brief intervention and being able to offer smoking cessation support to their clients. Every mental health agency would have some key staff skilled in offering extensive quitting support, delivered in group or individual sessions to those who need or desire help to address their smoking.

This paper will discuss some of the smoking related issues amongst people with a mental illness, and how Quit Victoria’s Special Settings Project endeavours to increase the access to smoke-free messages for this population group.

While smoking rates decline in the general population, they remain high amongst those with a mental illness who often also have higher levels of dependency. As a result, people with mental illness have a lower life expectancy and higher rates of lung cancer, cardiovascular disease and respiratory illness than the general population.

Smoking further entrenches inequalities in this population group. For instance, smokers with a mental illness are estimated to spend around one third of their income on smoking. This can impact upon lifestyle, education, employment and recreation factors, and subsequently lead to increased poverty and isolation.

Encouragingly, the physical health needs of people with mental illness are gaining more recognition by health promotion practitioners and policy makers. Research is also emerging that shows people with a mental illness are just as motivated as the general population to make a quit attempt. Quit Victoria has welcomed the recent activities undertaken by agencies such as Neami Limited (see previous article by Adam Zimmermann and Jane Howey) and the Mental Illness Fellowship Victoria.

But where to start? What works? Evidence suggests that just like the general population, people with mental illness benefit from nicotine replacement therapy (NRT, also known as therapeutic nicotine), psychological support (be that via a group, health professional or use of Quitline) and quitting medications.

Earlier this year, Quit Victoria was involved in a successful lobbying activity, which led to a wider range of quitting aids being made available on the Pharmaceutical Benefits Scheme.
Quitting smoking is regarded as the most important thing a person can do to improve their health. For mental health clients, who are often experiencing various forms of disadvantage, access to smoking cessation support is not only a powerful gift but also a right in terms of their future health.

NRT products (such as patches, gum, lozenges, inhalers and microtabs) as well as quitting medications (such as buproprion or varenicline) can double a smoker’s chance of quitting successfully when compared to quitting unaided. For those smokers on medication who want to stop smoking, Quit Victoria recommends incorporating a doctor’s visit as part of the planning process. At this appointment, the smoker and health professional can establish an appropriate quitting method, discuss access to subsidised quitting aids and set in place some ongoing monitoring to avoid adverse mental health symptoms. Many myths exist around the use of NRT, particularly safety and usefulness. NRT is helpful in its ability to temper chemical withdrawal symptoms and should be considered for those consumers who are chemically addicted.

In an ideal world, we envisage every mental health worker possessing skills in basic level brief intervention and being able to offer smoking cessation support to their clients. Every mental health agency would have some key staff skilled in offering extensive quitting support, delivered in group or individual sessions to those who need or desire help to address their smoking.

The Special Settings Project at Quit Victoria aims to increase the access of smoke-free messages to people with mental illness, through the provision of tailored training, support and resources that recognise some of the unique needs of the mental health services sector.

Our training programs are designed to increase the capacity and confidence of mental health staff to be able to deliver group or individual support. Staff may choose to undertake training in motivational interviewing or brief intervention in order to incorporate smoking cessation into their regular practice. For example, the ‘5As’ model of brief intervention is an internationally recognised framework that forms the basis of the Smoking Cessation Guidelines for Australian General Practice. The model involves every consumer being asked about their smoking status, and offers assistance according to their motivation.

One of the simplest ways to support a smoker is to offer a Quitline referral via the referral form on the Quit website.

Quitline advisors are paid health professionals who have skills and experience in facilitating people with mental health conditions to develop skills and strategies for their quitting journey. Quitline staff respectfully work with callers who are at varying stages of the quitting cycle to address their smoking – from those who are calling to get preliminary information, to those who have made multiple attempts.

In addition to training in brief intervention, agencies may choose to have several staff undertake two-day Quit Educator training. This enables staff to undertake extensive smoking cessation support with their clients and be able to run tailored group programs around agency and client parameters.

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►►► FIND OUT MORE: For further information, go to the Quit website: www.quit.org.au.

References

Healthy Bodies Healthy Minds: a community development project

Lucinda Bain, Community Development Officer, YMCA Victoria

Going to a local gym or swimming pool can be a daunting and overwhelming prospect for many. Most people get anxious about trying something new in an unfamiliar environment. Practical and emotional support from friends, family and experts can really help. Healthy Bodies Healthy Minds aims to address some of these issues by working with local aquatic and leisure centres, making them more inclusive and welcoming for people with mental illness as well as encouraging greater collaboration between the recreation and mental health sectors to enhance and provide more inclusive opportunities.

The benefits of physical activity on a person’s mental health is an emerging area of study. Experts believe that exercise releases chemicals in your brain that make you feel good. Regular exercise can also boost your self-esteem and help you concentrate, sleep, look and feel better. As well as releasing natural chemicals that improve your mood and make you feel happier, having an active lifestyle can do more to help your mental health.

Whilst regular exercise is an important part of living a healthy life, for people experiencing mental illness, health and fitness is especially important, as research shows they are at greater risk of physical health problems such as heart disease and diabetes, or being overweight. Gaining the confidence, self-esteem and motivation to attend a recreation centre is a big step for many, so it’s important that welcoming recreation opportunities are readily available in inclusive communities.

Taking part in physical activities offers many opportunities. It’s a great way to meet people. With this in mind YMCA Victoria, in partnership with SANE Australia and Parks and Leisure Australia, applied for funding from the Department of Planning and Community Development’s Building Inclusive Sport fund for Healthy Bodies Healthy Minds. The fund provides grants to support the development of new, inclusive and innovative
Through the increased attendance of participants experiencing mental illness within gyms, other programs and services, and partnership development with local mental health agencies, the overall outcome is to normalise the inclusion of people experiencing mental illness within recreation centres. This will develop a better awareness, understanding and help address the stigma associated with mental illness within the wider community.

sport and recreation opportunities. A key component of the grants is that they aim to develop partnerships and sustainable projects that will continue beyond the life of the two-year funding period, and which are transferable to other places and organisations.

Committed to providing inclusive opportunities for people with mental illness, the initiative is an expansion of YMCA Victoria’s work in this space. In the past, this included working with Mind Victoria and providing subsidised access to Brunswick City Baths and Wodonga Leisure Centre through the ‘Getting Fit and Fitting In’ project that

• promotes health and wellbeing
• encourages healthy habits
• develops self-confidence and esteem
• fosters social networks and community connections
• promotes mental health through the delivery of outdoor adventure camping experiences such as the Steps program.

Partnering with SANE Australia – a mental health organisation skilled in educating people about mental illness, and Parks and Leisure Australia – an association connecting various sectors of the parks and leisure industry, Healthy Bodies Healthy Minds aims to promote and develop inclusive and accessible environments within local government owned recreation centres for people experiencing mental illness. The project focuses on twenty-four recreation centres across North West Metropolitan Melbourne, within the local government areas (LGAs) of Melbourne, Wyndham, Maribyrnong, Darebin, Hume, Moonee Valley, Banyule, Brimbank, and Whittlesea.

Going to a local gym or swimming pool can be a daunting and overwhelming prospect for many. Most people get anxious about trying something new in an unfamiliar environment. Practical and emotional support from friends, family and experts can really help. Healthy Bodies Healthy Minds aims to address some of these issues by working with local aquatic and leisure centres, making them more inclusive and welcoming for people with mental illness as well as encouraging greater collaboration between the recreation and mental health sectors to enhance and provide more inclusive opportunities.

The project involves a number of strategies and phases that are detailed below.

**Education and training for recreation centre staff**

The first phase involves the delivery of specific mental illness awareness workshops for the recreation centre staff involved in the project by SANE Australia. Each session gives an overview of mental illness and the impact that it has on individuals, and also dispels some of the myths surrounding mental illness.

The workshops are interactive and give participants the opportunity to talk about their experiences, issues, concerns and challenges. Participants also get to hear what it’s really like to live with a mental illness from a person with lived experience via the SANE Speakers Program.

**Building the capacity of recreation centres to support systemic change**

The second phase is to work directly with each recreation centre and LGA and use the training received from SANE Australia as a platform to initiate positive change. LGAs and recreation centres are encouraged to review current policies and procedures and adopt more inclusive and accessible practices such as pricing models, concession rates, timetabling, free access for carers, marketing and promotion.
Cross-sector collaboration

Fostering links between mental health agencies and community recreation centres to create referral pathways and potentially new participation opportunities is key to ensuring people are aware and educated about local opportunities that may benefit them. Getting local mental health agencies talking to, and working with providers of recreation is an important step in ensuring the development of sustainable inclusive participation opportunities.

Building the capacity of mental health agencies

Through the planning phase of this project it was recognised that there is often a stilted flow of communication between local recreation opportunities and people accessing local mental health services. Healthy Bodies Healthy Minds endeavours to open up these communication channels via partnership development and by supporting information and education opportunities such as networking sessions and open days at recreation centres. The project also has a blog, which provides regular updates and information about the project and recreation sector developments.

Cultural change

Through the increased attendance of participants experiencing mental illness within gyms, other programs and services, and partnership development with local mental health agencies, the overall outcome is to normalise the inclusion of people experiencing mental illness within recreation centres. This will develop a better awareness, understanding and help address the stigma associated with mental illness within the wider community.

Once the recreation centres involved have been supported and guided through the various phases of the project they will be eligible to become a “Healthy Bodies Healthy Minds” provider. Referral pathways will be created and they will be promoted as a supporter of inclusive opportunities for people living with mental illness.

Healthy Bodies Healthy Minds is supported by a reference group of eleven members, which meets bi-monthly to discuss the project. The group includes representation of people with a lived experience of mental illness, mental health agencies, various peak bodies, recreation centres and local government.

FIND OUT MORE: Contact Lucinda Bain, Healthy Bodies Healthy Minds Community Development Officer, YMCA Victoria by email at: lucinda.bain@ymca.org.au, phone: 03 8736 6521, or check out the Healthy Bodies Healthy Minds blog at: http://healthybodieshealthyminds.wordpress.com

For further information about YMCA Victoria visit: www.victoria.ymca.org.au
Building capacity to improve physical health

Maria Kambourakis, Mind and Body Project Coordinator, SANE Australia

Equipping staff with the knowledge and skills necessary to deliver healthy living support is vital. Are your staff familiar with the concepts of health behaviour change? Do they have health coaching skills? Are they confident in how to approach clients about physical health issues, how to build motivation for health behaviour change, how to integrate healthy living concepts into daily work, and how to use related resources?

Physical wellbeing is important for all of us, impacting on our quality of life, yet people seriously affected by mental illness have some of the poorest health outcomes in the community; higher rates of type 2 diabetes, stroke, heart disease, thyroid problems, feet problems, oral health problems, the list goes on. But the news is not all grim. With the right care and support, people with mental illness can improve their physical health, and Psychiatric Disability Rehabilitation and Support (PDRS) services are well-positioned to bring about this positive change.

By their very nature, PDRS services encompass many of the competencies seen as important to the support of health and health behaviour. They are client-centered, aiming to empower individuals towards adopting self-management strategies and commonly partner with other service providers. The frequency of client contact, context, nature (collaborative versus didactic) and duration of relationship, gives PDRS services the capacity to encourage and support long-term health behaviour change in clients in a way other services in the sector are not set up to do.

Changing the paradigm

It’s not simply a matter of coordinating walking groups and popping up no-smoking signs. Improving the overall wellbeing of clients requires a commitment that is absorbed into every aspect of the organisation, from allocation of funds right through to recruitment processes. It requires a paradigm shift, a cultural change so that each and every manager, team leader, support worker, peer worker and volunteer believes they have a role to play. It requires that physical health support is integrated in a systemic way into service development and delivery, so that it becomes a matter of ‘this is the way we work’ rather than ‘this is an extra task’ to be performed ad-hoc.
Building a good-practice model

To help facilitate this organisational process, SANE Australia is working with Neami Ltd, a large PDRS service operating in five states across Australia, to develop a model that can be adopted sector-wide. The SANE Healthy Minds and Bodies Project aims to develop an evidence-based, good-practice model for creating the best possible health-promoting environments for clients and staff of mental health services. Over the three-year project, SANE and Neami will work collaboratively to guide organisational change, build skills and educational resources and conduct training to support:

1. organisational capacity-building
2. personal change in staff and clients
3. advocacy and system-wide change.

Helping to build ‘Healthy Minds and Bodies’ organisations - resources for the sector

One of the major outcomes of the project will be a suite of resources to facilitate uptake of the model by other PDRS services across the sector, helping them to become Healthy Minds and Bodies organisations. Resources under development include:

- good-practice guidelines outlining how services can integrate physical health in a systemic way into service development and delivery
- good-practice SANE Smoke-free Guidelines for Non-Government Organisations (NGOs), now available via www.sane.org. Many NGOs face challenges in maintaining a smoke-free environment and providing ongoing support for smoking cessation. The Guidelines provide an overview of how organisations can implement a successful smoke-free initiative to improve the health of clients and staff
- an overview of relevant good-practice physical health and service integration projects nationally and internationally
- healthy living training for NGO managers and team leaders.

What does a ‘Healthy Minds and Bodies’ organisation look like?

A Healthy Minds and Bodies organisation is one that:

- integrates physical health into everyday case management practice
- provides staff and clients with information addressing SNAP (Smoking, Nutrition, Alcohol, Physical Activity) behaviour risk factors
- facilitates regular health checks
- offers one-on-one or group healthy living support (incorporating peer and carer support) such as physical activity programs, dietary advice, food budgeting, etc
- provides a smoke-free environment and smoking cessation support
- develops client personal health skills/Chronic Disease Self-Management (CDSM) skills.

Clients of PDRS services can spend anywhere from 30 minutes to three hours a week in direct contact, either via a support worker, a day program or a support group. These hours provide opportunity for integrated health promotion. But what about the remaining hours where the client is out in the community, living their own life? One of the most important roles PDRS services can play in supporting the physical health of their clients is to empower them to be advocates of their own physical health.
One of the major outcomes of the project will be a suite of resources to facilitate uptake of the model by other PDRS services across the sector, helping them to become Healthy Minds and Bodies organisations.

**How? The big Cs**

How can organisations achieve this in a way that is meaningful and, importantly, sustainable? What is good practice when it comes to providing healthy living support?

1. **Commitment**
   
   Absolute commitment by staff at all levels within the organisation, including the Board, CEO, senior managers, field staff and volunteers. Organisation-wide changes that do not have the full support of management are more likely to fail in the long-term. A dedicated Healthy Living Coordinator to oversee development, implementation and evaluation is vital for sustainability of the initiative.

2. **Culture**
   
   Staff culture can make or break any organisation-wide initiative. Organisations need to evaluate staff culture and address attitudes and beliefs that may undermine a healthy living initiative.

3. **Confidence**
   
   Equipping staff with the knowledge and skills necessary to deliver healthy living support is vital. Are your staff familiar with the concepts of health behaviour change? Do they have health coaching skills? Are they confident in how to approach clients about physical health issues, how to build motivation for health behaviour change, how to integrate healthy living concepts into daily work, and how to use related resources?

4. **Connections**
   
   Service coordination is one of the principle factors in quality holistic healthcare. Formal links with community health centres, GPs, public and private clinical services and allied health providers, as well as community health initiatives and programs (not to mention fitness and recreation centres) are vital to facilitate this.

Turning around the alarming figures surrounding the physical wellbeing of people affected by mental illness is possible with dedication and coordination. With the right planning, PDRS services can make a significant contribution.

►►►**FIND OUT MORE:** If your organisation is working towards improving physical health, or you would like to learn more about the SANE Mind and Body Initiative, contact Maria Kambourakis on 03 9682 5933 or email maria.kambourakis@sane.org.

**Healthy Living resources at SANE Australia:**

- Healthy Living Kit (including Guide and DVD)
- SANE Guide to Healthy Living
- Healthy Living factsheet or podcast
- Healthy Living pamphlet
- SANE Smoke-free Kit
- SANE Smoke-free Guidelines
- SANE Guide to a Smoke-free Life
- Smoking and mental illness Factsheet or Podcast
- Type 2 diabetes and mental illness Factsheet or Podcast
- Mind and Body: Checks for your physical health Factsheet

Factsheets, Podcasts and Guidelines can be downloaded from www.sane.org

Also new to the SANE website is Snapshots, a range of personal stories from Australians who reveal what it is like to experience mental illness from the inside. People share their insights into recovery, including the importance of looking after your overall health and having connections with other people.
Data collected to date suggests that the program can result in increased preparedness to talk openly about mental health issues, and for the club environment to respond with support rather than ridicule, and this offers great hope. Many people join sports clubs for the social connection and sense of community that comes within the club environment. However, without education and understanding, mental health issues may in fact be exacerbated through lack of support by other club members.

In regional and rural areas of Australia, awareness of mental health issues can be limited and help-seeking behaviour particularly low. ‘Good Sports, Good Mental Health – Build Your Game’ (GSGMH – Build Your Game) is a pilot program that aims to raise mental health awareness and community capacity in regional and rural areas through working directly with community sport clubs.

Launched in 2009, GSGMH – Build Your Game is a mental health program for community sport clubs. It is delivered by the Australian Drug Foundation (ADF) with funding from beyondblue: the national depression initiative. GSGMH – Build Your Game involves supporting community sports clubs to undertake a number of interventions designed to build awareness of depression and anxiety disorders, then increase capacity to respond to local mental health issues both from an individual perspective and in the club environment. Interventions include making information about mental health readily available, conducting a club-wide awareness raising activity, demonstrating how to access local services and training for key personnel in the club. More information about these four interventions is provided further below. Evaluation is currently being undertaken to determine the effect of GSGMH – Build Your Game on local community capacity to identify and respond to mental health challenges.

**GSGMH – Build Your Game aims to:**

- raise awareness of mental health issues and available support amongst members of rural sports clubs, to reduce the level of mental health issues in those communities
• utilise community partnership networks already developed through BeyondBlue’s rural and drought initiatives in the relevant regions.

• assist rural and regional communities in learning to identify local strengths and services (sports clubs and service systems) and develop the capacity to initiate local partnerships that bring about sustainable change in the understanding and management of depression and anxiety.

GSGMH – Build Your Game was established on the strength of the ADF’s Good Sports program, which is designed to reduce alcohol related harm in community sports clubs. Over 4,000 sports clubs across Australia are registered with Good Sports. Participating clubs progress through an accreditation process, and commit to establishing a club environment that demonstrates responsible use of alcohol. Evaluation of Good Sports suggests that participating clubs have lower levels of alcohol consumption and drink driving than clubs not participating in the program. Moreover, some evidence suggests that as clubs progress through the program, there is an increase in their income, income sources and female membership (Crundall, 2010). These positive outcomes may be considered a consequence of changing the club’s environment through addressing the service and role of alcohol in the club.

GSGMH – Build Your Game is an outcome of the ADF’s engagement with community sports clubs to address alcohol consumption. The ADF has expanded its work to focus on mental health due to the prevalence of mental illness and the fact that alcohol problems and mental health issues often coexist. Mental illness is common in Australia with at least 20 per cent of the population experiencing depression at some stage in their life and 25 per cent experiencing anxiety disorders (ABS, 2006; Todd, 2002). It is proposed that at least 30 per cent of people with a mental illness have a co-existing substance use disorder (Todd, 2002). The ADF has piloted GSGMH – Build Your Game in regional and rural areas, given that the presence of mental illness in non-metropolitan areas tends to be higher than in metropolitan areas. This can be due to greater isolation and stigma presenting barriers to treatment (Pierce, Liaw, Dobell and Anderson, 2010).

It is anticipated that the mix of interventions delivered through GSGMH – Build Your Game will raise awareness and reduce stigma of mental health issues in rural and regional communities. Combined with increased ability to identify and provide initial support by club leaders, a sustained and increased mental health capacity is anticipated.

In Victoria, participating clubs are provided with the support of a project officer from a regional Sports Assembly or Community Health Centre, while in NSW, clubs receive the support of an Australian Drug Foundation Community Development Officer. These officers help clubs to complete the interventions, log their achievements with the ADF, and arrange accreditation for clubs that complete GSGMH – Build Your Game.

BeyondBlue and the ADF committed to engage 400 sports clubs throughout rural and regional Victoria and southern NSW in GSGMH – Build Your Game between 2009 and 2011. A further partnership has since been undertaken, extending the project into Tasmania.

The interventions that make up GSGMH – Build Your Game were designed on the basis of evidence that suggests increasing individual ability to connect with others in their community (Pierce et al, 2010) and training programs in the sport setting (Bapat, Jorm and Lawrence, 2009) may contribute to increasing both the likelihood of seeking assistance and mental health literacy within communities. As mentioned earlier, in addition to a needs assessment, GSGMH – Build Your Game involves four mental health interventions:

• Local service audit
• Information stand
• Mental health awareness training
• ‘Blue’ themed event.

Local service audit

The purpose of the local service audit is to create a link between clubs and local services that provide mental health support. Either a club representative or their project officer creates a poster that provides the contact information of local services. These are displayed in both prominent and discrete locations around participating club rooms. Additionally, contact is made with local services to notify them that the club is working to acknowledge and address mental health issues within their community. Local services are invited to attend the club to present ‘critical facts’ about mental health and to discuss service access pathways. ‘Critical facts’ includes key information on mental health and alcohol and other drugs and is compiled by BeyondBlue and the ADF.
'Bluey' information stand

Beyondblue ‘bluey’ information stands are located in club rooms, providing specific flyers and booklets relating to mental health. Clubs are included on the beyondblue Australian Rural Information Network and identified as community access points for mental health information. The information stand signifies a commitment to mental health by the club and provides ongoing access to information for members and guests.

Mental Health Awareness Training (MHAT)

Two club representatives undertake a three-hour MHAT course designed to enable participants to identify signs and symptoms of depression and anxiety, as well as provide initial contact and referral. The training is provided by beyondblue and is an adaptation of training developed through the National Drought Campaign, with specific information relevant for sports clubs. Ideally, the members selected to take part in the MHAT are well known in their club and respected leaders, who are then identified as key mental health contacts within the club.

‘Blue’ themed event

A ‘blue’ event is held within the club to increase club members’ awareness of depression and anxiety and mental health in general and also improve help seeking behaviour (especially among young men). The nature of the event is established through the needs assessment with some clubs undertaking quite simple activities, while others undertake community-wide events. The ‘blue’ event acts as a launch of the club’s commitment to mental health in a public setting, often receiving local media coverage and in many cases, fundraising for a worthy local cause. The event is also an opportunity to identify the club members who have undertaken mental health training as contact points and highlight the ongoing presence of an information stand in the club rooms.

The combination of awareness raising and capacity building interventions aims to achieve a lasting and sustainable delivery model that ensures ongoing and long-term support to the target audience. GSMGH – Build Your Game interventions are designed to raise awareness and reduce stigma of mental health issues in rural and regional communities, through supporting clubs to be welcoming, inclusive and family friendly environments.

Evaluation

In order to explore the extent to which GSMGH – Build Your Game is achieving its aims, the ADF is undertaking an evaluation of the program that will be completed in October 2011. The evaluation involves both quantitative and qualitative methods.

The quantitative component involves Computer Assisted Telephone Surveys with a total of 500 members drawn from 54 participating clubs. Members were surveyed prior to commencing the program and will be surveyed again following program completion. The majority of questions in the survey were drawn from beyondblue’s National Depression Monitor.

The qualitative component involves interviews with key stakeholders including representatives of clubs participating in the program, project officers, community development officers involved in delivering the program and other key representatives from project partners.

While the evaluation is still in progress, analysis of data collected to date suggests that the program is having a positive impact on participating clubs, and that it is providing them with valuable information, skills and resources. For instance, one club representative indicated that their club was aware of a direct positive outcome from their club’s participation in the MHAT in terms of both increased awareness and increased capacity to provide help:

‘I had one parent go out [of the training] and say, “now I know what’s wrong with my husband”. It was quite amazing… She followed up with it and, sure enough, he was severely depressed, but she was able to do something to help him get back on track. So we had an immediate success following the training – it was really good.’

There are also examples that indicate that GSMGH – Build Your Game has contributed toward club understanding of mental health issues and that this understanding has been translated into greater support for individuals within the club. The following quotes from one of the project officers exemplify this:

[At the club’s ‘blue’ event, a member] ‘got up and said, “I’ve suffered depression for about five years… I needed to do this [get up and tell you all] because it will help me in getting better. I just wanted you to know that… it’s good to have that support, and cycling really helps me as a sport because it’s social and everything like that”’.
While further support may be required to embed sustainable changes in some clubs, GSGMH – Build Your Game has opened a genuine opportunity to facilitate a change in attitudes and culture in the sports club environment. The vision of creating a space where members are able to talk openly about mental health issues and support each other in response to individual issues, appears attainable.

The Project Officer went on to say that having participated in GSGMH – Build your Game, other members now had a better understanding of how they could help this member in the future:

‘Members said, “there were days when he didn’t turn up to racing and we just thought, oh well, he must be busy, but now we know, [it’s] just that phone call to say are you ok? Are you coming out? Do you need us to pick you up?”

Conclusion

While still in its early days, GSGMH – Build Your Game appears to be having a positive impact on awareness and understanding of mental health issues in community sports clubs.

Data collected to date suggests that the program can result in increased preparedness to talk openly about mental health issues, and for the club environment to respond with support rather than ridicule, and this offers great hope. Many people join sports clubs for the social connection and sense of community that comes within the club environment. However, without education and understanding, mental health issues may in fact be exacerbated through lack of support by other club members. While the extent of this change from just the four interventions will vary depending on the extent of mental health capacity that existed prior to the project, it appears a heightened awareness is being achieved.

Even during the roll out of the project, there have been community crises (primarily flooding) which have impacted on local communities. The capacity that has been established within local communities through GSGMH – Build Your Game has already visibly influenced the ability of sports clubs and communities to respond to such issues. Ironically, the crises have also caused new barriers to completion of interventions, due to a considerable number of clubs committed to the program being directly impacted by, and are still dealing with damage from, floods.

Many clubs have found that their participation in GSGMH – Build Your Game has ignited ongoing commitment to building an environment conducive to good mental health. While further support may be required to embed sustainable changes in some clubs, GSGMH – Build Your Game has opened a genuine opportunity to facilitate a change in attitudes and culture in the sports club environment. The vision of creating a space where members are able to talk openly about mental health issues and support each other in response to individual issues, appears attainable.

References


SNAP Connecting To Sport

Cathy Carr, General Manager, SNAP Gippsland Inc.
with contribution from Barry Switzer, Executive Officer, GippSport

SNAP was keen to work more closely with GippSport, as two relatively recent studies involving SNAP participants revealed that our clients’ physical health was a barrier to wellness and we had been looking for a vehicle to utilise this knowledge and move it into a practical and sustainable program.

People with mental health problems desire the same community interaction, connections, and have the same sporting and recreational needs as the rest of the community. A review of current literature indicates that people who participate in sports clubs and organised recreational activity enjoy better mental health, are more alert, and more resilient against the stresses of modern living.

The wider community perception of mental illness presents barriers to participation. The Access For All Abilities program in Gippsland has not actively engaged people with mental health problems and sporting clubs currently do not have the capacity or know how to engage and include these members of our community. It has been our experience that people with mental health problems and their carers are less likely to be involved in sporting clubs and groups. If at all, people living with mental illness are introduced into these groups by a support agency worker and the support is not sustained beyond the introduction.

SNAP Connecting To Sport is a partnership project with GippSport that aims to address barriers to participation in active sport and recreation within local communities in Gippsland. GippSport is the regional sports assembly for Gippsland, which supports grass roots sport and recreation. GippSport encourages participation in active recreation with access for all by supporting welcoming and inclusive clubs and creating health though sport. The Welcoming and Inclusive Club program run by GippSport encourages clubs to become more aware of the barriers that prevent people from joining sporting clubs and provides assistance to clubs to take concrete steps towards improving access for all people.

SNAP Gippsland Inc. (SNAP) is a community managed mental health service that has delivered psychosocial rehabilitation and recovery oriented models of service and care to Gippslanders since 1992. SNAP recognises that recovery is a staged, individual process involving hope, meaning, identity and responsibility. It works with people with mental illness and their families to rekindle hope, set and achieve goals and reconnect with their communities.
In 2009, GippSport approached SNAP to further discuss the development of a project that would fit within the objectives of the State Government’s Building Inclusive Sports Grants 2010 – 2012 application criteria. The objective of the grant was to form a partnership with other key agencies to further develop inclusive and innovative sport and recreation opportunities for people with a disability throughout Victoria. SNAP was keen to work more closely with GippSport, as two relatively recent studies involving SNAP participants revealed that our clients’ physical health was a barrier to wellness and we had been looking for a vehicle to utilise this knowledge and move it into a practical and sustainable program.

The grant was approved in late 2010 and the process of employing a project worker, writing the research brief and getting ethics approval began. As this gained momentum there was, and continues to be, a lot of interest in this project from other areas. The Latrobe Valley and Baw Baw local government areas were not part of the initial application, but it soon became clear that the project would need to extend to these areas. SNAP has managed to find the funds to extend into these areas, thus allowing a whole-of-Gippsland approach.

The submitted project addressed the second target of the application process: to ‘develop new active sport and recreation opportunities for people with a mental illness or Autistic Spectrum Disorder’. It was our hypothesis that the involvement of people with a mental illness in sport and/or active recreation will assist their reconnection with their community and ultimately lead to improved mental health outcomes. An additional focus of our application included carers of people living with a mental illness in an effort to have carers take the opportunity to consider their own mental health and physical wellbeing.

The establishment of a Gippsland-wide Reference Group, with the inclusion of local government, will ensure there is strong support and buy-in for this program. South Gippsland and Bass Coast are identified as growth areas and Wellington, Latrobe, Baw Baw and East Gippsland Shires have been bushfire and flood affected. All six local government areas have pockets of socio-economic disadvantage.

People with mental illness have poor physical health outcomes and their life expectancy is 18-20 years less than the rest of the community. Carers of people with mental illness often express feelings of isolation, loneliness and loss of identity. This project aims to educate individuals and build the capacity of sporting organisations and clubs to be inclusive and provide support and access for people with a mental illness.

Consumers and carers participated in the design of the proposal and will be consulted about the information to be presented to clubs and how it is delivered. When possible, a consumer of mental health services will be involved in the delivery of the information sessions to club members.

All Gippsland sporting clubs have been identified and consultation with consumer groups and carers will determine which clubs will be targeted based on criteria including affordability, appeal and personal preference. Regular consumer input will be sought at monthly consumer forums in all local government areas.

The program will be developed in five locations across Gippsland:

- East Gippsland
- Wellington
- South Gippsland/Bass Coast
- Latrobe Valley
- Baw Baw

Together, SNAP and GippSport will educate and build the capacity of sporting/recreation clubs and groups to enable them to welcome and include people with mental health problems and their carers. GippSport, will deliver Welcome and Inclusive Clubs packages and SNAP will deliver Mental Health First Aid training and provide basic mental health education, thus collaboratively building the capacity of those clubs to welcome people with mental health problems.

This project aims to identify and train facilitators/champions inside the clubs; this is a new and different way of assisted participation. Through training, the roles of facilitators/champions will involve supporting the inclusion of people with mental illness and carers into clubs to reduce the stigma and becoming that point of reference.

Club members will be offered Mental Health First Aid training and basic information sessions about mental illness. This training will inform and educate the members and potentially their families about mental illness, personal awareness and about early warning signs. This will raise community awareness, become a health promoting activity, and also break down stigma by identifying the facts and dispelling the myths about mental illness diagnosis and presentation.
Together, SNAP and GippSport will educate and build the capacity of sporting/recreation clubs and groups to enable them to welcome and include people with mental health problems and their carers. GippSport, will deliver Welcome and Inclusive Clubs packages and SNAP will deliver Mental Health First Aid training and provide basic mental health education, thus collaboratively building the capacity of those clubs to welcome people with mental health problems.

Monash University Department of Rural and Indigenous Health (MUDRIH) will undertake the research and evaluation component of this project and will record and document their findings in relation to the impact on participants and sporting clubs, improvement in health outcomes and the feelings and perceptions of the clients, carers, club members and ‘champions’ before and after the program is implemented. This will include questionnaires, focus groups and interviews.

Consumers and carers will participate in a baseline physical health check by a General Practitioner (GP), which will be repeated at the end of the project. Vital statistics on blood pressure, weight, height, Body Mass Index and blood glucose will be recorded along with the existence of chronic disease and any early indicators of undiagnosed chronic disease.

This project has been informed by two pieces of work in 2008 and 2009 during the time SNAP was reforming its Day Program. A study undertaken by SNAP in the East Gippsland region in 2008 revealed the poor physical health status of adults with mental health problems. It consisted of a physical health check by a GP, followed by a program of physical activity over 12 months. The second piece of work was a small research project conducted in 2009 on behalf of SNAP by Monash Gippsland Community Based Placement medical students in the South Gippsland/Bass Coast area. Both of these projects demonstrated the breadth and depth of physical health issues experienced by SNAP clients. High levels of smoking, alcohol and other drugs intake, low income, poor nutrition, high Body Mass Index, social isolation and low levels of confidence and/or self-esteem were identified as barriers to active participation.

Our hope is that the results of MUDRIH’s research will prove that this new program will enable people with mental health problems to be included in a range of sporting and recreation clubs across Gippsland, achieve improved health outcomes, enjoy their chosen sport and be understood, accepted and valued as a contributing member of the club(s) and community.

FIND OUT MORE: Go to SNAP’s website for more information about their work and programs: www.snap.org.au or contact SNAP Head Office on 03 5153 1823. For more information about GippSport, visit this website: http://gippsland.sportslink.org.au or phone 03 5135 8335.

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Women and suicide

While published suicide statistics indicate that men are most likely to die from suicide, statistically more women engage in non-fatal suicide behaviour. By acknowledging the gender differences in suicidality, addressing risk factors and challenging the negative attitudes, public understanding of suicide and its causes will be enhanced, thus reducing stigma and myths surrounding suicide. The promotion of evidence-based information on suicide that considers gender will contribute to prevention strategies that are targeted, relevant and therefore more effective.

The frequency of suicides and suicide attempts differ significantly between women and men. In Australia, men complete suicide three times more often than women, while women attempt suicide three times more often than men. Much about suicide is gendered; from suicide risk factors, to methods, to the outcome. This is because gender influences the context of people’s lives, including their peer groups, self-expression, help-seeking behaviours, social expectations and access to support. In addition, gender affects other social determinants of mental health, which in turns affects suicidality.

It is generally agreed that the method of suicide is a crucial factor in the differences in women’s and men’s suicide rates. Analyses of suicide over time show the trend of men using more lethal means and women less lethal means is changing. Women are beginning to adopt similar, more lethal methods of suicide to men. In Australia, hanging has become the most common method for suicide in women. In the US, there is an increasing trend in female suicide using firearms, which has been linked to their high availability. It remains unclear as to why this change in trend is occurring. It is possible that...
evolving notions of femininity and masculinity present women with a greater freedom to engage in negative practices traditionally associated with masculinity.

Although the outcome for suicide and suicide attempt differs, the intent is the same. Because suicide attempts do not result in death, people who attempt suicide (the majority of whom are women) are less visible in discussions around suicide prevention. This oversight can lead to women who have attempted suicide not receiving the assistance they urgently need.

The factors, patterns, and behaviours associated with suicide are heavily influenced by gender. Therefore, responses need to consider gender in order to be most effective. In addition to a continuing commitment in tackling the number of suicides in men, there is also a strong case for seizing opportunities for effective intervention with women who have previously attempted suicide.

**Risk factors associated with suicide**

Although in some cases, suicide may occur without much warning, it is usually a manifestation of a long line of compounding factors. While the causes and precipitating factors for every suicide are likely to be different, there is a well-recognised interplay of risk factors that are linked to suicidality. Addressing these factors can in turn, protect against suicide.

**Mental illness**

The single biggest risk factor for suicide is mental illness. It has been found that women who have a history of mental illness, particularly depression, post-traumatic disorders, and anxiety disorders have a greater risk of suicide. This is concerning since mental illness makes up 15 per cent of Victorian women’s total disease burden. Apart from women’s own mental illness history, it has also been found that parental history of psychotic or affective disorders also presents a stronger risk factor for suicide among women compared to men.

Mental ill health is a result of a combination of biological and social factors. While the biological factors can be addressed through more traditional therapies, many of the social factors or determinants can be addressed by building a more positive social environment through addressing social connectedness, financial security and freedom from discrimination and violence. The following are social risk factors for mental ill health, suicide and self-harm and are cited in the literature as being particularly salient for women.

**Intimate partner violence**

Intimate partner violence can take on many forms including physical assault, threats and unwanted sexual experiences from serious or casual partners. This is a major concern, as 24 per cent of Australian women aged 18 to 24 years have experienced violence at the hands of their partner. Women who have experienced intimate partner violence are more likely to suffer mental health issues including post-traumatic stress disorder, depression, anxiety, self-harm and suicidal tendencies.

**Body image dissatisfaction**

While body image dissatisfaction is not a direct risk for suicide, it is associated with a range of mental illnesses that can lead to suicide. Apart from genetic predispositions, social values around gender also influence body image. Women are more prone to having body image dissatisfaction due to a societal demand which equates physical beauty with self-worth, success and happiness. An Australian study revealed that 67 per cent of women aged 18 to 23 years had a body mass index within a healthy weight range, but only 22 per cent of these women
The single biggest risk factor for suicide is mental illness. It has been found that women who have a history of mental illness, particularly depression, post-traumatic disorders, and anxiety disorders have a greater risk of suicide. This is concerning since mental illness makes up 15 per cent of Victorian women’s total disease burden.

Bullying

Bullying refers to wilful and repeated abuse, which occurs in many forms including inflicting physical injury, name calling, slander, social exclusion, and cyber-bullying. Cyber-bullying occurs frequently among adolescent girls, with 67 per cent of female teenagers report having been bullied online. Girls are generally big users of social networking sites where the majority of cyber-bullying occurs. Both bullying and cyber-bullying are linked to a range of emotional and psychological problems. These include low self-esteem, clinical depression and a lack of support structures, which can culminate in suicide. Bullying negatively impacts both victims and perpetrators and both are at an elevated risk of suicidal thoughts, attempts, and completed suicide.

Discrimination

Suicide has a strong correlation with discrimination. While many women experience discrimination to some extent, some groups of women are particularly exposed to compounded discrimination, that is, discrimination on multiple or intersecting grounds. This includes women with disabilities, Indigenous women, refugee women and same-sex attracted women. These groups of women are shown to have higher rates of suicide, suicide attempts and ideation than other women. For example, suicide rates among Indigenous women are between two to three times higher than that of non-Indigenous women.

Attitudes towards women who attempt suicide

There is a pervasive cultural stereotype concerning women who attempt suicide which impedes the level of support given to them. These women are often portrayed in classic literature and popular culture as engaging in a form of ‘manipulative femininity’. Their actions are interpreted as attention seeking, aimed at manipulating their loved ones into feeling guilty or responsible. This portrayal is entrenched and far too often influences the way in which suicide attempts are understood by families, the community and service providers.

One arena where the negative attitude is highly visible and problematic is in medical settings. There is still a popular misconception among medical staff that suicide attempts are attention seeking, which compromises the quality of care provided to women. It has been found that even though there are guidelines around the specialised assessment of patients who present with attempted suicide, these assessments may not necessarily be carried out. Some women who have been hospitalised for attempted suicide report feeling dissatisfied with emergency and psychiatric services due to the negative attitudes directed towards them.

Conclusion

While published suicide statistics indicate that men are most likely to die from suicide, statistically more women engage in non-fatal suicide behaviour. By acknowledging the gender differences in suicidality, addressing risk factors and challenging the negative attitudes, public understanding of suicide and its causes will be enhanced, thus reducing stigma and myths surrounding suicide. The promotion of evidence-based information on suicide that considers gender will contribute to prevention strategies that are targeted, relevant and therefore more effective.

(References can be supplied upon request.)
Life is just a breath away: breathing for anxiety

Louise Cooper, Psychologist and Coordinator - Group Recovery Programs, Anxiety Recovery Centre Victoria

Abdominal breathing – the ultimate breathing, with loads of gas smoothly entering and leaving the body at a slow, steady pace – seems to be the way to go, but for many it’s difficult to approach. Focusing attention on the body is a scary task for many people with a history of trauma. For others, the idea of counting breaths immediately increases anxiety because of the compulsive stranglehold that numbers seem to have over their lives. But there are many other ways of altering and using breathing and it seems that it is the therapist’s role to find a technique that meets individual needs.

The Anxiety Recovery Centre Victoria (ARCVic) provides support, recovery programs and educational services for people with anxiety disorders and their families. A fundamental aim is to offer something that is affordable and ongoing. The experience of regular and consistent support, opportunities for growth and a varied calendar of events helps people with anxiety disorders maintain hope and motivation in the process of recovery. One of our most popular programs developed over the past 12 months has been the breathing workshop. It seems that in our busy lives we need reminding of the impact that our breathing can have in regulating the anxiety response.

Since joining ARCVic a couple of years ago I have wanted to generate new programs and workshops to reinvigorate people as they struggle to maintain motivation in the battle against anxiety disorders. Many people attending ARCVic’s groups remark that they feel they are entering a community, that they experience a sense of acceptance and belonging and do not want to leave. So our job is to provide avenues for people to maintain that contact in a variety of ways. Motivation for change comes not only from the support experienced in our groups, but also from continued learning. Periodic one-day workshops are an ideal way of doing this, allowing people to ‘top up’ their knowledge and/or skills as well as maintain contact with the ARCVic community.

Themes on which to build workshops emerge from the evaluations of our therapeutic group programs. Consistently, participants in our groups highlight how useful they find learning breathing techniques. This led me, as a health
professional, to consider my own relationship with breathing. What, after all, did I really know about it? I don’t want to demean the fantastic training that I received during my studies to become a psychologist, but I don’t really remember much emphasis being given to learning breathing techniques. Abdominal breathing was something that was tacked on the end of a lecture, as if it was something that we all already knew about. And yet here were a group of consumers of mental health services saying that is was the most useful thing they learnt during a six-week cognitive behavioural based therapeutic program.

Like many people, I had done some breathing in yoga classes, but I’d never known if or how it might be making any difference to my own health. The results weren’t obvious; there were no ‘aha’ moments. Breathing had lodged itself in my mind as a peripheral technique, something not quite as significant as cognitive therapies and working on patterns of interpersonal relating. And then I was converted…

Towards the end of 2009 I attended a talk by psychologist Shawn Goldberg on working with trauma. Having a coffee on arrival and then another after the first speaker and then, sitting down to listen to Shawn, there was adrenalin aplenty in my veins. I had no idea how pumped I was until Shawn took us through the ‘Breathing Waltz’. After monitoring our breathing for a minute and counting the number of breaths we took, he then talked us through a minute’s breathing at the rate of about 12 seconds for each breath (in-two-three, hold-two-three, out-two-three). We then returned to our resting breathing pattern and counted our breaths once more. I was amazed that in one minute, my breathing rate had halved. This was a revelation to me. I was also acutely aware that I felt more relaxed than before the exercise. It was suddenly obvious to me that when previously doing breathing exercises I had not started off in an aroused state so any change was negligible. Shawn hadn’t even asked us to put our hands on our stomachs or focus on anything in particular; it had been so simple yet, oh so, effective.

Now that I had proof that a very short breathing exercise could have such a fantastic outcome I needed to know more. It wasn’t enough for me to know that it worked. I needed to know how it worked. Again, I’m sure that I had been taught this at some time in the past, but the message hadn’t stuck. This was when the workshop was born. It wasn’t just about teaching a breathing technique to a group of people, it was about giving people proof that breathing techniques were effective, backed up by a simple explanation of how they worked. I was sure I wasn’t alone in needing a good reason for incorporating something else into my daily routine.

As part of this workshop, I ask participants what they know about breathing and whether anyone in the room practices breathing regularly. I am astounded that in rooms full of people living with anxiety disorders, less than a handful see breathing as one of their best allies and use it regularly as a tool for the management of stress and anxiety. People seem to have some knowledge about breathing through the nose (just because they have been told to do so, but not knowing why) and also know that they are supposed to breathe slowly and deeply. Rarely do they know the reasons behind these instructions. This could be because the instructions are coming from someone like me.

So, by way of putting things straight, the following are the core messages that I believe help convince people that breathing is a worthwhile practice and motivates them to have a go:

- anxiety is an involuntary response generated by the autonomic nervous system
- breathing is the only function of the autonomic nervous system over which we as humans have both voluntary and involuntary control
- by taking voluntary control over our breathing we can influence the autonomic nervous system and our levels of anxiety
- breathing involves the exchange of gases (mainly oxygen and carbon dioxide) from the lungs into the blood
- we need oxygen for efficient functioning of our muscles and brain (with insufficient oxygen, neither work very well)
- we need carbon dioxide in our bodies as it facilitates the transportation of oxygen into the blood and it also acts as a natural tranquiliser by regulating our breathing
- when we are in a state of panic, hyperventilation is often involved. By taking fast and shallow breaths, the body is expelling too much carbon dioxide and we no longer have our natural tranquiliser (hence the paper bag method for panic attacks)
- in order for oxygen and carbon dioxide to fulfil their roles, we need sufficient air entering our bodies and it needs to stay there long enough to do its job
- breathing isn’t just about oxygen, carbon dioxide is also really important.
Breathing techniques are a skill that requires practice. Practicing in the quiet moments means being well equipped to deal with the difficult moments. Like a pianist learning a concerto to be performed in public, the practice needs to be done when the pressure is off.

And, on the subject of noses…

Our noses are designed for breathing, that’s what we use to breathe as babies (babies can feed and breathe at the same time). Mouths are designed for eating and talking, just a back-stop for breathing. Breathing through the nose means that the air is filtered for germs as it enters the body, it is warmed to body temperature before it enters the lungs and the breathing rate is naturally slower than when breathing through the mouth (our nostrils are so much smaller than our mouths). Add to this the fact that if you don’t breathe through your nose you won’t smell anything and will be missing out on an important means of sensory stimulation. These are great reasons to breathe through your nose.

Passing on this information to people attending ARCVic’s breathing workshops is the stimulus for numerous ‘aha’ moments. Something that we take for granted because we all do it (we breathe so therefore we are) is suddenly seen in a different light. Simple is good, but it’s easy to miss the obvious. In the same way, people are often looking for a miracle psychological intervention whilst negating the effect of lifestyle factors such as nutrition and exercise. We are only talking about allowing a minute at a time to practice this stuff too. People who have attended the workshop have subsequently told me how they have gone home quite excited about it and keen to impart this knowledge to others.

Abdominal breathing — the ultimate breathing, with loads of gas smoothly entering and leaving the body at a slow, steady pace — seems to be the way to go, but for many it’s difficult to approach. Focusing attention on the body is a scary task for many people with a history of trauma. For others, the idea of counting breaths immediately increases anxiety because of the compulsive stranglehold that numbers seem to have over their lives. But there are many other ways of altering and using breathing and it seems that it is the therapist’s role to find a technique that meets individual needs. The topic of breathing as a tool for managing anxiety needs to be revisited in therapy and different methods should be explored until something suits.

Breathing techniques are a skill that requires practice. Practicing in the quiet moments means being well equipped to deal with the difficult moments. Like a pianist learning a concerto to be performed in public, the practice needs to be done when the pressure is off.

There is one final experience that I would like to share that has turned me into an advocate for the breath. ARCVic’s Helpline is run by trained volunteers and one of the components of that training involves several breathing techniques. These techniques are posted on the walls of the Helpline room for use when there is a call from someone in a state of high and distressing anxiety. We instruct the Helpline volunteers to just follow the instructions on the wall and hope that their training has instilled them with the confidence that if they do this, all will be well. It is not until volunteers have had this experience and a caller, having followed their instructions, is relieved of their panic and is thanking the volunteer profusely, that volunteers gain confidence in the effectiveness of breathing techniques.

Talking someone through a breathing exercise can work, even when you are feeling the contagion of anxiety yourself. So what are you waiting for? As a health professional, have a couple of cups of coffee and test it out for yourself. Like me, you may find that the simple things in life are sometimes the best.

FIND OUT MORE: Information about ARCVic is available via their website at: www.arcvic.org.au. Call 1300 269 438 for the ARCVic Helpline.
In it together: understanding the physical health needs of people with serious mental illness

Emma Ladd, Regional Manager for Quality and Service Development
Tara Smark, Health Promotion Project Manager, Mental Illness Fellowship Victoria

What would people need to hear, see and experience in order to have the sense that mental health services are ‘in it together’ with them and are genuine partners in wellbeing? The issue is one of engagement, not only for people with a serious mental illness, but also their support people and services within the health system.

‘Even if you know what to do, it doesn’t guarantee it will help.’ Quote from a person with a mental illness when asked about improving physical health (Schmutte, et al, 2008).

Improving physical health and wellbeing is an area of interest to most people and one that is fraught with challenges for many of us. There are few groups however, for whom the need to urgently address poor physical health is greater than for people with a mental illness. Research has consistently found that, due to a range of factors such as adverse pharmacological side effects, sedentary lifestyle, and economic and social disadvantage, the physical health outcomes of people with mental illness are getting worse. People with severe mental illness die up to 25 years earlier and have 2-3 times the morbidity and mortality from all major health conditions when compared with the general population (Coghlan et al, 2001). Illnesses exacerbated by atypical antipsychotic medications include obesity, diabetes, metabolic syndrome, osteoporosis, periodontal disease and sexual dysfunction. Psychosocial and environmental factors such as poverty, sedentary lifestyle, poor diet and heavy smoking exacerbate poor physical health and increase disability in people living with mental illness.

Faced with this appalling picture, the questions that come up often for the mental health sector are: How do we motivate people to improve their health? How do we get people off the couch and out of the house, attending medical appointments, eating healthily? Of course the answer is that we don’t ‘get people to do’ anything. Where we can have the greatest impact is in working alongside people to create an environment where they are more likely to feel motivated and engaged in improving their health and wellbeing. Being ‘in it together’ reflects our commitment to working alongside people in their journey toward recovery and wellbeing.

But what does this mean for people with a mental illness? What would people need to hear, see and experience in
order to have the sense that mental health services are ‘in it together’ with them and are genuine partners in wellbeing? The issue is one of engagement, not only for people with a serious mental illness, but also their support people and services within the health system. To effectively improve the physical health, and wellbeing of the people we serve, engagement strategies need to be directed in three areas:

1. Engagement of the person in improving their own health and wellbeing,
2. Engagement of the carers, workers and friends in supporting the person.
3. Engagement between the different services and systems supporting the person.

Engagement of the person in improving their own health and wellbeing

‘I don’t know why you’re asking us about this. If you really want to change this, you should talk to the mayor or governor’ (Schmutte, et al., 2008).

The challenges of being diagnosed and living with serious mental illness often lead to people feeling that their health and wellbeing is beyond their control. Feelings of helplessness are common and people may develop a fragile sense of wellbeing due to the cyclical or persistent nature of their psychiatric illness as well as the likelihood of developing serious physical conditions. Feeling powerless is a major issue for both the person living with mental illness and the people who care for them. The impact of this is often a reduction in an individual’s sense of self-efficacy, a critical factor in improving health and wellbeing (Lysaker, et al., 2001). Research has consistently identified low self-efficacy as a barrier that makes it difficult for people with a mental illness to engage in physical health programs (Lysaker, et al., 2001, Holmberg & Kane, 1999, Perese & Perese, 2003, Schmutte, et al., 2009, Ussher, et al., 2007, Gretchen-Doorly, et al, 2009).

Engagement of the carers, workers and friends in supporting the person

‘I would need a lot of help. It’s very hard to change old habits’ (Schmutte, et al., 2008).

Ussher, et al (2007) suggests that people living with serious mental illness are interested in improving their physical health, and will engage in increased physical activity if they receive effective social support to encourage and motivate them. For many people, lack of encouragement from their support network, including mental health workers, contributes to a lack of motivation to make these changes (Dean, et al, 2001, Medding & Perkins, 2002, Ussher, et al, 2007). Research suggests that in order to support people to make sustainable improvements to their physical wellbeing, effective interventions must also engage carers and service providers.

Engagement between the different services and systems supporting the person

‘By the time the appointment date with the doctor comes you’re either feeling better or dead’ (Schmutte, et al., 2008).

There are clear systemic barriers to quality medical care for people with serious mental illness, which may contribute to the unacceptable level of potentially avoidable deaths and disease. Wagner (1998) suggests that people living with chronic illness do not receive effective treatment under the current primary care focused healthcare system that centres on short appointments, laboratory investigations and patient-initiated follow-ups. Under this system, people and their carers often lack key information and support, which reinforces people’s feelings of powerlessness to improve their physical wellbeing. Wagner (1998) also suggests that a system change is required to increase healthcare workers’ ability to support people. This means that all healthcare workers would need to be educated on the relationship between mental and physical wellbeing, and health information systems need to be improved to track changes in healthcare and initiate reminders to help people stay engaged.

Effective engagement strategies and program design

Research suggests that health education, health promotion and structured health interventions lead to improved health outcomes and increased participation in community environments (Hutchinson, et al., 2006). Research into the physical wellbeing of people with serious mental illness also indicates that people are generally keen to engage in health promotion programs if these are embedded with support to assist in developing motivation (Hutchinson, et al., 2006, Russinova, et al., 2002). Overall, the essential element of an effective, sustainable physical health promotion program for people with a mental illness is increasing self-efficacy. Ussher, et al (2007) concludes that physical health promotion programs targeting mental health consumers need to ‘enhance self-efficacy [and] provide adequate social support’. To do this effectively, programs need to take a multifaceted approach to engagement that:

- asks people what health and wellbeing activities they are interested in trying out and supports the development of confidence and self-efficacy
- helps service providers and carers to listen and understand what support will be of greatest assistance in improving wellbeing
- ensures all health services working with a person are also talking to each other.
Richardson, et al (2005) reviewed evidence-based physical activity interventions targeted at people with serious mental illness and suggests several elements that should be considered in designing effective physical health programs:

1. Self-efficacy
   A lack of knowledge, experience, confidence, motivation and unrealistic expectations can have a negative effect on people’s engagement in physical health programs. Recognising individuals’ small achievements can assist them to rebuild self-efficacy and keep working towards long-term goals. It is equally important to people that activity leaders are as knowledgeable, enthusiastic and supportive as the program they are leading. Facilitators need to assist people to overcome self-esteem barriers and be sensitive to individual body image issues, as this will ensure people remain engaged with the program. The facilitator’s end goal should be to not only improve people’s physical wellbeing, but also to instil confidence in people so that they can recover their overall wellbeing and increase resilience to cope with future challenges.

2. Recommended levels of physical activity
   Richardson, et al (2005) found there are differing recommendations on the weekly level of physical activity. The Victorian government’s mental health and physical activity information pack (2006) follows the US Surgeon General’s recommendation of at least 30 minutes moderate daily activity and advises that this can be broken up into three ten-minute sessions throughout the day.

3. Structured versus lifestyle activity
   When developing physical activity programs there is the option to base activities in structured and supervised facilities such as gyms or, alternatively, people can be encouraged to incorporate physical activity into their daily activities. Structured facilities offer activities where people can be supported to ensure they are adhering safely to programs. The drawback of structured activities is that they can be expensive, as staffing, venue and equipment costs need to be met. Lifestyle activities offer people greater flexibility as they can easily be undertaken in their home or neighbourhood. Examples of lifestyle physical activities include using exercise DVDs or books at home, or walking. These activities are comparatively easy, cheap and safe for people who lack fitness and economic resources.

4. Individually tailored interventions
   Physical activity interventions are designed according to an individual’s age, gender, financial circumstances and fitness levels. These programs can be more effective than generalised programs, especially if the focus is on moderate intensity activities as opposed to higher intensity programs that have a high drop-out rate. It is also useful to include motivational messages, social support and encouragement for people to set small, realistic goals to change their behaviour. For long-term changes to become embedded in the person’s lifestyle, it is important to encourage people to undertake unsupervised activities at home in conjunction with individually tailored programs.

5. Self-monitoring
   The most effective sustainable behaviour changes come when people set goals and monitor achievements themselves, by keeping daily journals of healthy activities or use pedometers or heart rate monitors to review changes to their fitness levels. Feedback is a critical component of self-monitoring and regulation; this can be achieved by people keeping a diary of changes in their energy, mood and overall wellbeing, which encourages their continued engagement. The drawback of having people monitor their own activities is they may risk over exerting themselves and causing an injury, or finding that they are unable to meet unrealistic goals, which may lead to them discontinuing activities due to feelings of failure. This has a negative effect on self-efficacy and may deter people from engaging in activities in the future.

6. Group versus one-on-one sessions
   Group physical activities are less expensive than one-on-one training sessions however, due to social marginalisation people often value the individual attention of one-on-one activities. When making behaviour changes people always need to have their efforts acknowledged. This encouragement can be obtained in a group setting with certificates and social occasions that celebrate people’s achievements. Peer support programs can increase self-efficacy by providing participants with evidence that people living with a mental illness can overcome environmental and lifestyle barriers, such as medication side-effects, to improve their overall wellbeing. Peers and consumers are seen as readily accessible and trusted health advisors, whose support can assist people to overcome low self-efficacy and supply motivation to maintain activity when clients feel overwhelmed.

7. Safety
   In order to ensure people are physically able to undertake moderate intensity activity, it is important to identify the risk factors by asking them about their physical health history. Richardson, et al (2005) suggests the Canadian Society for Exercise Physiology’s physical activity readiness survey, PAR-Q + You, which is a seven-question survey that assesses people’s need to be referred to a GP before they engage in a physical activity program. Essential equipment such as proper footwear is an important consideration,
as people with illnesses such as diabetes risk developing foot ulcers if they wear inappropriate footwear. Gradual increases in activity will assist people who are suffering from fatigue as a side effect of their medication.

8. Adherence

Research on the adherence to physical activity programs targeting the general population have found that engagement reduces after six months. The program must allow people to drop in and out as they need, while actively encouraging the person through support that continues to engage them by walking along side and being able to adjust to the person’s changing needs.

Richardson, et al (2005) also identifies program facilitators as powerful support suppliers. However, this is dependent on the person’s confidence in their knowledge, enthusiasm for the program and support. This suggests that successful programs will need to engage staff in the planning stages to ensure they feel confident to support people to access and engage in physical activities. Staff input during the planning stages also fosters a sense of ownership of the program and increases their desire to see it successfully delivered. The program delivery stage should also supply informational support to staff and awareness that they may also need to increase their health literacy on the importance of physical activity and methods to address the barriers that make people resistant to engaging in activities.

It is important that any program responds to people’s physical health concerns, meets their current capabilities and encourages them to improve their overall wellbeing through identifying their own strengths. Friends, family and support staff will also benefit from encouragement and information on how to help engage them in supporting improved wellbeing. This flexibility, respect and acknowledgement of the role that people’s social support network plays in their wellbeing would assist people to increase their overall wellbeing by not only improving their physical health, but also increasing their self-efficacy, which plays an essential role in their overall recovery.

As a sector, we need to be fully engaged in the battle to overturn the unacceptable rates of mortality and ill health for people with mental illness. As services, we need to be engaged with each other in making the wellbeing of the people we serve our first priority. As workers, carers and friends, we need to be engaged with the people we are supporting. We need to ask the right questions and keep on asking them, in order to understand our own relationships with physical health and wellbeing, and to accompany the people we serve as they find a way to wellbeing.

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The link between serious mental illness and poor physical health has been widely documented nationally and internationally. Research has shown that people with serious mental illness are more vulnerable to chronic physical conditions such as diabetes and heart disease. Barriers to the provision of adequate health care for this client group exist, including service access challenges, mental health and medical health service system challenges. Our findings support the recommendations from Coghlan et al. (2001) to provide better support for the broader health needs of clients with serious mental illness.

The project

The evidence has led the Victorian Department of Health to explore this complex issue further by funding a demonstration project in 2009 – 2010: Improving Access to Primary Health Care Services for people with serious mental illness.
The demonstration project took a systems-change approach using the Chronic Care Model (CCM) as a guiding framework for improving care (see Figure 1).

The CCM has six interdependent components that identify key aspects of the health service system that must be in place to ensure effective client outcomes. The project identified and recommended 15 key areas for change that would address the needs of the six interdependent CCM components. It was evident that effecting such significant change across an organisation in all 15 areas in a 12-month demonstration project was unrealistic.

Three recommendations, although seen as a high priority for change, sat outside of the authorising environment of the project and were not included.

**Figure 1: The Chronic Care Model**

<table>
<thead>
<tr>
<th>COMMUNITY Resources and Policies</th>
<th>HEALTH SYSTEMS Organisation of Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Management Support</td>
<td>Delivery System Design</td>
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<td></td>
<td>Decision Support</td>
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<td></td>
<td>Clinical Information Systems</td>
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</tbody>
</table>

**IMPROVED OUTCOMES**

*Developed by The MacColl Institute® ACP-JAM Journals and Books*

The 12 priority target areas of focus are outlined in the table below.

<table>
<thead>
<tr>
<th>Chronic Care Model Component</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health system</strong></td>
<td>1 Staff Professional Development</td>
</tr>
<tr>
<td>Creating a culture that promotes safe, high quality care</td>
<td>2 Time allocated for physical health monitoring</td>
</tr>
<tr>
<td><strong>Decision support</strong></td>
<td>3 Routine measurement and conversation with clients about their physical health</td>
</tr>
<tr>
<td>Promoting consistent evidence-based and client-preference care</td>
<td>4 Broad client-centred screening</td>
</tr>
<tr>
<td><strong>Self-management support</strong></td>
<td>5 Routinely inform clients of the possible physical side-effects of their antipsychotic treatment</td>
</tr>
<tr>
<td>Supporting clients to manage their health and health care</td>
<td>6 Support clients to set specific goals in caring for physical chronic condition/s and to improve their general health</td>
</tr>
<tr>
<td><strong>Community resource mobilisation</strong></td>
<td>7 Client education</td>
</tr>
<tr>
<td>Organising community resources to meet the needs of clients</td>
<td>8 Document attempts to encourage and support clients to access physical health support or services</td>
</tr>
<tr>
<td><strong>Clinical information systems</strong></td>
<td>9 Provide information to clients and their carers on an ongoing basis regarding relevant physical health conditions and services</td>
</tr>
<tr>
<td>Organising client data and information to facilitate efficient and effective care</td>
<td>10 Formal arrangements for coordinating client care between AMHS GPs and CHS</td>
</tr>
<tr>
<td></td>
<td>11 Increase communication with GPs</td>
</tr>
<tr>
<td></td>
<td>12 Client care feedback systems between services</td>
</tr>
</tbody>
</table>
Primary Health Care

The focus of this demonstration project was to effect change in Primary Health Care with a focus on Community Health Services (CHS) and General Practice (GP). Through a staff survey, Community Health Care providers expressed varied confidence, skill, knowledge, capacity to respond to challenging behaviour, capacity for supporting change and improving physical health outcomes as issues when working with people with serious mental illness. In response, training was provided for staff at both project sites to build the knowledge and confidence of practitioners to work with and fully engage the client group. One site provided in-service Mental Health training, and the other provided the existing two-day Mental Health First Aid training to allied health workers. Feedback from participants at both sites was very positive and reinforced the need for a training focus to support system change.

To achieve a real system change perspective, embedding the change in practice requires more than training. Participants identified a need to build their learning through a range of mechanisms. Opportunities post training for reflective practice were identified. Existing platforms were utilised such as case review (including cross discipline), supervision, and team meetings. The challenge is in formalising the processes, whatever platform is used, to ensure allocated time is provided and that it remains an important standing agenda item.

Although the project attempted to engage GP, the authorising environment made it challenging and unrealistic to implement change to such a wide spread and often independently-run network of professionals. Engagement was generally on an individual basis with reliance on voluntary participation. For the project period, priority was given to changing practice in Community Health (CH) and AMHS rather than within GP. There remains a need for further exploration of the barriers preventing a systematic approach within GP to fully supporting the physical health needs of clients with a serious mental illness. Once the barriers are understood, further development within GP could occur to more fully support the physical health needs of clients with serious mental illness.

Area Mental Health Services (AMHS)

AMHS were a key partner, as people with serious mental illness will usually access AMHS at some point. Routine measurement and conversation with clients about their physical health through client centred screening and associated referral to allied health services within CH, was prioritised as a key area for trial within AMHS.

Methodology

Small trials of three screening tools were conducted over a three-month period with 19 SCTT (Health Conditions and Health Behaviour) screens and eight Client Physical Health Guides completed within the three months across the two sites. Despite the limited trial information, the data supported the extensive evidence regarding poor physical health risks and outcomes for people with serious mental illness, as well as the need for improved systems to support early identification of the broader health needs of clients.

During the course of the project only a small number of clients had health screens completed (n 21). Post project, a second phase of the trial was conducted within one AMHS with refinements made to the screening tool, process and trial period (lengthened). The trial numbers increased considerably, with an additional 61 health screens completed. The trial illustrated that undertaking health screening is an additional task for AMH clinicians that needs to be supported by good policy and process development, and that implementation requires time to reinforce the change in practice.

A significant limitation of the trial was the lack of high quality client outcomes data. Clear data indicating referrals made and appointments attended as a direct result of the physical health screen was not obtained. Drawing conclusions regarding the success of the project was limited to process and practice changes, without the additional client impact information to further support the recommendations.

In retrospect, it was ambitious planning to introduce additional challenges into the AMH environment without a clearer authorising environment and additional resources into the AMHS.

Key project findings

Effective change management is a key element to support sustainable change in the practice and service environment. The project identified a range of findings across all project activities.

AMHS

• Physical health screening of clients with serious mental illness is best undertaken by AMHS as most of this client group engage with the AMHS at some time.
• Practice change needs to be supported by the development of government and agency policy.
• Adequate resources and support for practitioners are vital to the success of this work and the change process.
• The limited timeframe of this project did not allow for the full realisation of maximum uptake of health screenings.
Although client outcome findings for the health screening trials were limited, a range of findings through client consultation were obtained.

Client perspectives

- The importance of client preferences, such as service options (choice, opportunity, range of services, accessibility, and cost).
- Importance of the relationships with service providers. It was identified that the relationship with case managers and other professionals is important and takes time to build and establish trust. Furthermore, engagement only really occurs when clients are heard. This factor is critical to client outcomes.

Primary Health Care

- The need to improve interactions between services and service providers to ensure effective coordination.
- Effective strategies for improved communication with GPs are still required. This would include further process refinement in the embedding of routine feedback processes to GPs.
- Service providers should communicate relevant information to each other (with client consent) to reduce multiple referrals and ‘telling the story’ many times.

Key project recommendations

Key recommendations were made across all project activity areas. Implementing sustainable change requires resources and a formal authorising environment. At the completion of stage one of these projects it became obvious that further consolidation of the projects within trial AMHS agencies was required. This would allow more time to ensure the processes supporting physical health screening are embedded and include:

- development of government and agency policy to support the process of physical health screening of clients accessing AMHS
- information provision to clients regarding the purpose of physical health screening within AMHS
- appropriate skilling of staff. All allied health staff in CH should be trained in Mental Health, such as Mental Health First Aid, and AMHS staff should be provided opportunities for behaviour-change training
- trialled further strategies to develop the relationship between AMHS, Psychiatric Disability Rehabilitation and Support Services (PDRSS), GPs and CH, to increase staff knowledge and confidence in working with clients with serious mental illness
- definition, agreement and communication of referral and information sharing pathways between GPs, CH and mental health services
- evaluation:
  - impact of strategies that aim to improve access to Primary Health Care Services for people with serious mental illness, through client outcomes evaluation
  - monitoring and reporting on implementation outcomes, for example percentage of clients screened, referred (where required) and accessing services.

Additional project recommendations were made that would require significant practice change and resources to investigate their effectiveness. They are:

- the role of peer mentors in providing a link between clients and health care professionals
- further investigation of both the service and client factors (including high cost, limited range and lack of choice) that may influence clients’ engagement or attendance at support services.

Conclusion

In summary, the project focus was in two domains: CH and AMHS. In CH, this entailed building the confidence and skill of allied health staff (including administration and intake staff) to engage with the client group. In AMHS, the focus was on engaging the staff, developing and trialling a physical health screening tool that could be realistically implemented given the diverse range of professional training of case managers.

The timelines for the project were ambitious, as indicated by the small number of screens implemented in the original time frame. The reality is practice change takes commitment, training, authorisation, resources and time to embed. It rarely happens in a sprint, especially when not compelled or resourced.

▶▶▶ FIND OUT MORE: The full report of the demonstration project Improving Access to Primary Health Care Services for people with serious mental illness can be downloaded from:

For further information on the project, you can contact Alan Murmane at Inner South Community Health Service on 03 9520 3108.

References

RESEARCH
The attitudes and practices of Victorian PDRS staff in addressing the physical health needs of consumers

Kirra Yates, Service Manager, Neami and Master of Social Health (Health Policy) student at the School of Population Health, The University of Melbourne

It was found that PDRS staff have a high level of awareness of the poor physical health experienced by people who live with mental illness, and believe it is part of their role to support consumers with physical health-related issues.

Introduction

In 2008 VICSERV published a set of proposition papers called Pathways to Social Inclusion. These papers argue that social inclusion is intrinsically linked to recovery from mental illness and, despite the fact that Victoria is 25 years past de-institutionalisation, overall outcomes for people who experience mental illness are generally much poorer than those of the general population. The papers discuss three areas in which people who experience mental illness face social exclusion: health inequality, economic participation and housing. They highlight the significantly poorer physical health outcomes that are experienced by people who live with mental illness. These outcomes include:

- an overall health status that is far lower than that of the general population
- a death rate two and a half times higher than the general population (equivalent to a life expectancy of 50-59)
- a 30% higher likelihood of dying after a cancer diagnosis
- a death rate from heart disease that has not decreased in line with that of the general population, and has increased amongst women.

The papers call for the establishment of a research agenda on this issue and a ‘self-review’ of how Psychiatric Disability Rehabilitation and Support (PDRS) services are currently able to support consumers with their physical health needs. The aim of this research project is to contribute to that sector 'self-review'.

Background

There are multiple factors that contribute to the poor physical health outcomes experienced by people who live with mental illness. For example, many of the antipsychotic medications that are currently prescribed have been found to cause and/or contribute to metabolic disorders such as diabetes and obesity (Barnes, et al, 2007; Sachs & Guille, 1999; Semyak, 2007). Health behaviours related to diet and low activity levels also contribute to the prevalence of a range of diseases, as do higher levels of tobacco, alcohol and other drug use (Seymour, 2003). Social determinants of health are a significant factor (Fiscella & Franks, 1997 & Hayen et al, 2002), with 85 per cent of people who have been diagnosed with psychotic illnesses being in receipt of government benefits, and nearly half living in a tenuous form of housing (Jablensky et al, 1999).
Lawrence et al (2001), in their landmark paper Duty to Care: Preventable physical illness in people with mental illness, argue that a key contributing factor to the poor physical health outcomes of people who experience mental illness is the health service system. More specifically that there is a separation between mental health services and physical health services, and ambiguity about who is responsible for the physical health care of users of the mental health system. A recent study by Mai et al (2010) found that people in Australia who use mental health services visit GPs more often than the general population. Mai et al discuss whether poor physical health outcomes endure, despite increased contact with GPs as a result of an ongoing focus upon mental health to the neglect of physical health issues. Lambert & Newcomer (2009) suggest that this neglect can be attributed to a combination of: physical complaints being attributed to psychosomatic symptoms, lack of workforce training, and mental health staff attitudes about whether physical health is their responsibility.

There is a limited research base examining the practices and attitudes of clinical mental health staff in addressing physical health needs of consumers. Hyland et al (2003) looked at the attitudes and practices of case managers from a public clinical mental health service in Melbourne in addressing the physical health needs of their clients. This study found that whilst case managers generally acknowledged that there is a role for them in addressing physical health needs, they experience both cultural and practical barriers to doing so. Cultural barriers included lack of strong relationships with physical health services such as GPs; practical barriers included a lack of resources and time. The study found that whilst case managers did report reviewing some aspects of their clients’ health, preventative health screening, e.g. pap smears, was not often addressed.

St Vincent’s Mental Health carried out a similar survey of clinical mental health service staff as part of their physical health monitoring program (Organ et al, 2010). The St Vincent’s survey found that amongst mental health staff, although most believed that monitoring physical health was their responsibility, there remained a lack of clarity around whose role it is to address physical health needs. There were also identified barriers connected to workload, training and equipment. A physical health demonstration project funded by the Victorian Department of Health included the same survey of staff at other clinical mental health services in Melbourne. In this case, mixed perceptions of both the role and capacity of mental health staff to address physical health needs were identified, along with barriers related to confidence and capacity to address these needs (Davidson & O’Boyle, 2010).

Method

The research questions that this project has sought to address are:

1. What attitudes and practices exist amongst Victorian PDRS service staff in relation to supporting consumers with their physical health?
2. What factors influence the attitudes and practices of Victorian PDRS service staff in relation to supporting consumers with their physical health?

Question one is concerned with the overall attitudes and practices that exist amongst staff employed by Victorian PDRS services in relation to their role in supporting consumers with their physical health. Question two is concerned with the influence of demographic factors, such as geographical location, service setting and years of experience on those practices and attitudes.

An anonymous, online survey was chosen for predominantly quantitative data collection and measurement processes. The survey was developed following a review of similar research (Barnes et al, 2007; Davidson & O’Boyle, 2010; Hyland et al, 2003; Organ et al, 2010) and with permission from the authors was based on that developed by Hyland et al (2003). The survey comprised 24 questions and was administered through the web based platform Survey Monkey. The survey questions related to attitudes, practices, barriers and enablers in addressing physical health with consumers. Opportunities for free text explanations and comments were provided in order to gather further contextual information about the responses.

A sample frame of direct support workers and supervisors/managers employed at VICSERV member organisations was chosen. The total number of potential respondents was estimated, upon advice from VICSERV, to be approximately 1500. Respondents were recruited via an email containing a link to the online survey. The email was sent by VICSERV to their mailing list of CEOs and Coordinators, who were requested to forward the email to all staff at their organisation.

A simple descriptive analysis was used to identify overall trends in staff responses to the questions. Trends in responses relating to demographic factors were identified using non-parametric statistical techniques including cross-tabulations and Chi-square tests. Qualitative data from free-text responses was analysed via interpretive content analysis to identify main response themes.
The attitudes of more experienced staff regarding the way physical health support is and should be provided to people who experience mental illness were more likely than others to be consistent with the literature. They tended to agree that physical health needs are not adequately met, that consumers experience difficulties in accessing services and that mental health is often prioritised over physical health.

Results

Respondent demographics

The total number of staff employed at PDRS services who responded to the invitation to participate in the online survey was 373 out of an estimated total of 1500. This number represents a response rate of 25%. The majority of respondents were direct support staff (64%), the rest reported that their role involves both direct support and supervision of other staff (19%), or that they are a supervisor/manager (12%). The professional backgrounds of respondents were varied, although the most common backgrounds were Social Work (20%), Psychology (13%) and Welfare Work (13%). There was some range in the number of years that respondents had been employed in the PDRS sector, although more than half had been employed for five years or less. The majority of respondents were employed at services in metropolitan Melbourne (63%), with a smaller proportion employed at services in regional centres (23%) and the minority at services in rural areas (14%). Half of the respondents were employed at services that are part of PDRS-only organisations, with the majority of the other half being employed at services that are part of a larger health service (37%), and the rest at services that are part of a larger welfare service (13%).

Main findings

The main findings related to the first research question (What attitudes and practices exist amongst Victorian PDRS service staff in relation to supporting consumers with their physical health?) are summarised below:

• most PDRS respondents are aware of the poorer physical health of people who experience mental illness
• nearly all PDRS respondents agreed that it is part of their role to address the physical health needs of consumers
• there is a perception amongst PDRS respondents that consumers experience their mental health issues to be overwhelming to the exclusion of physical health issues
• PDRS respondents generally agreed that there are shortcomings in the way physical health services are provided to consumers

• the least reported areas of physical health support were those related to preventative health screening such as mammograms and pap smears
• the most commonly reported areas of training need were diabetes, preventative health screening and substance use issues
• PDRS respondents indicated that the holistic and recovery orientated approach taken by the PDRS sector is a positive attribute in providing physical health support to consumers
• PDRS respondents indicated that the most important improvement needed in the sector is to enhance relationships with physical health services

The main findings related to the second research question (What factors influence the attitudes and practices of PDRS service staff?) are summarised below:

• managers/supervisors and staff who have been employed in the PDRS sector for longer were more likely to agree that there are issues with the way physical health services are provided to consumers
• staff employed in the PDRS sector for a shorter period of time reported providing support in fewer areas of physical health, and reported more need for training
• staff employed at services that are part of a larger health service reported providing support in more areas of physical health, and reported less need for training
• more staff employed at services that are part of a larger health service reported that partnerships with physical health services and physical health screening are taking place in their organisation.

Discussion

What attitudes and practices exist amongst Victorian PDRS service staff in relation to supporting consumers with their physical health?

In answer to the first research question it was found that PDRS staff have a high level of awareness of the poor physical health experienced by people who live with mental illness, and believe it is part of their role to support consumers with
physical health-related issues. Findings suggest that cultural and role-perception barriers found amongst clinical mental health staff (Davidson & O’Boyle, 2010; Hyland et al., 2003; Organ et al., 2010) are avoided to some extent in the PDRS sector due to the more holistic and ‘individual recovery’ focused approach taken by the PDRS sector.

There was a perception amongst PDRS respondents that consumers experience their mental health issues to be overwhelming to the exclusion of other issues. Further research related to this finding could provide important feedback to services in developing appropriate responses to the physical health needs of consumers.

Attitudes relating to the way that support with physical health is, and should be, provided to people who experience mental illness were generally consistent with relevant literature (Lambert & Newcomer, 2009; Lawrence et al., 2001; Mai et al., 2010). Findings showed that PDRS staff believe that physical health needs are not adequately met, that consumers experience difficulties in accessing services and that mental health is often prioritised over physical health. Findings showed that PDRS staff are aware of the range of barriers that people with mental illness face in attaining optimal physical health, including access to health services (Lambert & Newcomer, 2009 & Lawrence et al., 2001), health behaviour (Seymour, 2003) and social determinants of health (Fiscella & Franks, 1997; Hayen et al., 2002; Jablensky et al., 1999). The results of the online survey showed that support with physical health is a significant part of the work carried out by PDRS staff, in particular support is commonly provided to consumers in accessing physical health services. Consistent with results from similar research carried out in clinical mental health services (Hyland et al., 2003), preventative health screenings, such as pap smears and mammograms, are addressed less often. This finding gives cause for concern, given that the increased likelihood of people who experience mental illness to die after a cancer diagnosis can, in part, be attributed to late detection (VICSERV, 2008). Many PDRS staff identified this area, along with diabetes and alcohol and other drug use, as one in which they would like to receive training. The survey showed that, consistent with the overall attitudes and practices of PDRS staff, organisational practice and policy within the PDRS sector recognises the need to the address the physical health needs of consumers.

**What factors influence the attitudes and practices of Victorian PDRS service staff in relation to supporting consumers with their physical health?**

In answer to the second research question it was found that the attitudes of PDRS staff were generally consistent across all staff backgrounds and service settings and so were not greatly influenced by these factors. However, a significant relationship was found between attitudes and level of experience. The attitudes of more experienced staff regarding the way physical health support is and should be provided to people who experience mental illness were more likely than others to be consistent with the literature. They tended to agree that physical health needs are not adequately met, that consumers experience difficulties in accessing services and that mental health is often prioritised over physical health (Lambert & Newcomer, 2009; Lawrence et al., 2001; Mai et al., 2010). It was also found that staff employed in metropolitan areas perceive greater issues in accessing physical health services. This is contrary to the well-documented lack of health services in rural areas compared to those available in Metropolitan areas (Smith et al., 2008). The finding implies that people who experience mental illness may face greater access barriers in Metropolitan areas due to, for example, a more complex system.

Factors of staff background and service setting had more influence over the practices reported by PDRS staff. Findings show that staff who have been employed in the sector for less time provide less support in relation to physical health, most significantly with preventative health screening, but also with safe sex and diabetes. This group reported more need for training related to these and most other areas related to physical health. Service settings also appear to have influence over the practices of PDRS staff, as staff from settings within larger community health services reported greater provision of physical health support and less need for training. Notably, staff from this setting also reported greater frequency of organisational partnership with physical health services and general physical health screening programs.

**Scope and limitations of the study**

The response rate for the online survey was 25% of the estimated total of potential respondents. This response rate is not sufficient to draw generalisable conclusions from the survey data. However, demographic characteristics of the respondents indicate that the sample was somewhat representative of the population, as they were similar to characteristics of respondents to VICSERV’s (2010) training needs analysis. Both this study and the VICSERV training needs analysis found that the most common professional backgrounds among PDRS staff are Social Work, Psychology and Welfare work; with Social Work being the most prevalent. Data from both studies also indicate that most staff have been employed in the sector for less that five years.

There were some issues related to questionnaire design, with the response options provided for some questions limiting the efficacy of the survey. The quantitative design of this project enabled a sample large enough to create a ‘snapshot’ of the sector, and to enable comparisons between different service settings. However the size of the study has limited how
generalisable the findings are. The quantitative design of the study limited the depth of data gathered, compared to that potentially gathered through a qualitative study. Given the size of the project and the preliminary nature of research into this aspect of the Victorian PDRS sector, the scope of the project was appropriate in creating a base for further research.

Conclusion

This research project has responded to the call made by VICSERV (2008) to establish a research agenda addressing the physical health inequalities faced by people who experience mental illness. In particular, it responds to the call for a ‘self-review’ of how PDRS services are currently able to support consumers with their physical health needs.

The existing literature shows that people who experience mental illness have significantly poorer physical health outcomes than the general population, and that this can be attributed to various factors including health behaviour, social determinants and service system inadequacies.

Responses to the online survey indicate that PDRS staff are very aware of the issues faced by people who experience mental illness in relation to their physical health, and believe it is part of their role to address these issues. They also indicate that PDRS staff provide support to consumers in many areas of physical health, and that the holistic, recovery orientated focus of the sector enables this to occur. However, improvement could be made through training focused upon PDRS staff who are newest to the sector. This training should be in areas related to preventative physical health screening, diabetes and alcohol and other drugs. The training should also include some awareness-raising related to the challenges faced by the current health service system in providing appropriate physical health support to people who experience mental illness.

Both existing research and the results of this project indicate that the PDRS sector should continue to strengthen partnerships with physical health services, in order to improve coordination of care across mental health and primary health services. PDRS services that do not have natural organisational relationships with physical health services through being part of a larger community health service should be aware of the greater organisational challenge that this presents to them.

Further research related to addressing the attitudes and practices of staff from the sector should aim to build upon this preliminary study. Larger studies would produce generalisable results, and qualitative research design would gather more in-depth data about staff attitudes. Future research should look more closely at the ways that people who experience mental illness understand their health and healthcare needs, as well as how these insights could guide the support provided to them.

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Let’s make it work: collaborative physical health screening for consumers of mental health services

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Initial results of the screening show a distinct disparity between the physical health of mental health consumers and the general Victorian population. Figures indicate that 68% of participants self-reported their health as poor or fair; more than double that of the general Victorian population at 32%.

Background

Worldwide, mental illness is acknowledged as one of the largest causes of disability burden. The World Health Organisation (2007) estimates that around 10% of all adults worldwide (about 450 million people) have mental health problems. Australian statistics released in 2007 indicate that of the 16 million Australians between the ages of 16 and 85, 7.3 million will suffer from a mental health issue(s) in their lifetime (ABS, 2007).

Furthermore, research indicates that mental illness significantly augments the risk of physical illness. This co-morbidity of physical and mental illness can impact upon diagnosis and prognosis for those who experience poor mental health (Prince et al, 2007). Statistics reveal that those with severe mental illness are more than twice as likely to be obese, five times more likely to have type 2 diabetes and two-and-a-half times more likely to die from cardiovascular disease (Coglan et al, 2001). Such alarming statistics are attributable to a variety of lifestyle factors including poor diet, smoking, social isolation and sedentary lifestyle. Attributable systemic concerns include side effects of medication, poor access to (and understanding of) health services and prioritisation of mental health needs (diagnosis and treatment) above physical health needs. Due to these issues, people with severe mental illness have a life expectancy of 15-20 years below the general population (Coglan et al, 2001).

In response to the poor health outcomes associated with severe mental illness, the Australian Government commissioned a number of reports (Duty to Care - physical illness in people with mental illness, 2001 and Activate: Mind and Body – Queensland 2009). These reports provided a more comprehensive understanding of the physical health requirements of mental health consumers, indentifying the following findings. Firstly, physical health screening should be undertaken by mental health services. Secondly, strong government policy support is required to support mental
health services around improving consumer physical health outcomes. Thirdly, consumers require improved accessibility to primary health care services. Finally, ongoing funding is required to support organisational changes within mental health services.

To date, publically funded mental health services are not mandated to actively manage the physical health of consumers. However, recent policies (including the NSW Physical Health Care of Mental Health Consumers Guidelines and Policy Directive, 2009. Because mental health matters: Victorian mental health reform strategy, 2009, and the National Standards for Mental Health Services, 2010) have identified ‘physical health management in a mental health service environment’ as a priority area. Additionally, Victoria’s community health priority tools, 2009, now recognises people with a serious mental illness as a priority group. This tool provides consumers with access to a diverse range of community health services. These changes are indicative of the shift towards a more holistic approach to mental health.

**Project**

In March 2010, a project between Austin Health (Clinical), Neami Ltd (a Psychiatric Disability Rehabilitation and Support (PDRS) service) and Banyule Community Health Service was established. There were three aims of this project:

1. Identify the physical health needs of consumers from these mental health services.
2. Further develop service partnerships and collaboration between the aforementioned agencies.
3. Support mental health consumers in gaining timely and affordable access to primary health care services.

The partnering agencies agreed that the best way to identify the physical health needs of mental health consumers was via a collaborative screening project. Two screening tools were selected (and then adapted) from the Service Coordination Tool Templates (SCTT) – a Victorian initiative developed to facilitate and support improved service coordination practices between agencies (Primary Health Branch, Victorian Government Department of Human Services, 2009). SCTT was selected due to the ease of implementation, sector acceptance and minimal staff training requirements.

The two adapted SCTT tool templates (Profile: Health Behaviours and Profile: Health Conditions) were used to gain a broader understanding of the physical health of these mental health services. Consumers were asked to report on areas such as self identified health status, smoking status and current level of physical activity. Additional questions were also integrated into the profiles that covered sexual health, mental health (interest in counselling services) and drug use.

To ensure an adequate understanding of the project objectives and tasks, staff from Austin Health and Neami Ltd were provided with an assortment of training. Training included briefing sessions on the rationale for the health screening project as well as project information sheets. Staff were informed how to use the adapted SCTT tools with consumers and where applicable practiced them in team meetings. Education was provided on the data collection process as well as the referral pathways to primary health care services. Guest speakers from Banyule’s primary health care services (dental, problem gambling, counselling and general practice) also presented at staff team meetings.

Austin Health Case Managers and Neami Ltd Community Rehabilitation Support Workers administered the two SCTT profiles to consumers, using a question-and-answer interview process. To avoid duplication, Neami Ltd staff only administered to those consumers who were not also case managed. Very few consumers declined to be involved in this process and the majority of staff were actively involved in data collection with their consumers. Where physical health ‘gaps’ were identified as a result of the screening, staff from both Austin Health and Neami Ltd actively supported consumers in gaining access to appropriate primary health care services at Banyule.

**Results**

Data was collected from 177 adult consumers, aged between 18 and 68. The sample comprised 96 (54%) males and 81 (46%) females with the mean age of participants being 42 years. Eighty-nine respondents were both clinical and PDRS consumers and 88 were PDRS consumers. The respondents were predominantly from the Continuing Care Team, however data was also collected from the Youth Early Psychosis Service and the Mobile Support and Treatment Team. Data from the PDRS service was collected from two locations in the same mental health region.

A descriptive analysis of data was undertaken and results were then contrasted with the Victorian Population Health Survey, 2008. Where possible, data was analysed against additional population health data including dental health (Trends in Access to dental care among Australians, 2010), physical activity guidelines (National Physical Activity Guidelines, DoHA, 2010) and falls (Preventing Falls in Victoria, 2007–12 Discussion Paper).

Initial results of the screening show a distinct disparity between the physical health of mental health consumers and the general Victorian population. Figures indicate that 68% of participants self-reported their health as poor or fair; more than double that of the general Victorian population at 32% (Victorian Population Health Survey, 2008). Preliminary results also indicate a significant variation between those with a serious mental illness and the general population on a range of
Of particular interest were the results around emotional support. It was found that 52% of participants identified their interest in receiving further support from counselling services. When asked which counselling support they required, 44% of respondents indicated they wanted help with anxiety, 43% with depression, 35% with relationship/family issues, 23% with trauma and 21% with grief/loss.

Discussion

The results of the physical health screening are broadly consistent with recent findings in this area (Davidson & O’Boyle, 2010; Everett et al, 2008; Coghlan, et al, 2001). These results lend strong support to the aforementioned state and federal policy initiatives that intend to address this crisis in health care. Of particular concern is the self-reported health status of mental health consumers, which is significantly lower than the Victorian population (Victorian Population Health Survey, 2008). This measure has been shown to be a reliable predictor of ill-health, future health care and premature mortality (Idler & Benyami, 1997; Milunpalo, et al, 1997; Burstrom & Fredlund, 2001).

In response to such concerns, the implementation of routine screening and referral processes should be considered an essential part of holistic care. The findings of this project, which have identified poor physical health outcomes for mental health consumers, reinforce the necessity of routine screening and referral processes. Staff in the mental health care sector have also recognised the benefits of screening tools. One staff member from Neami Ltd stated that ‘having a health screening tool] opened up a conversation about physical health…questions about specific physical health [issues] such as vision were really good, as these areas are often overlooked.’ The project also demonstrated that in order to facilitate this level of holistic care, the development and maintenance of collaborative relationships between primary care and the mental health sector is vital.
In response to such concerns, the implementation of routine screening and referral processes should be considered an essential part of holistic care. The findings of this project, which have identified poor physical health outcomes for mental health consumers, reinforce the necessity of routine screening and referral processes. Staff in the mental health care sector have also recognised the benefits of screening tools.

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YOUR SAY...
Member profile

Western Region Health Centre

The First Response model and access to primary care for complex needs groups: emerging outcomes

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Clients have ... anecdotally reported that they find accessing services at First Response user-friendly, compared to their previous experiences. A key element appears to be the scale of the space, and the welcoming environment. The clinics are responsive and clients are seen in a timely manner.

Introduction

Western Region Health Centre’s (WRHC) ‘First Response’ is an integrated primary care model aiming to improve health outcomes for people with mental health issues and those at risk of homelessness. The model has been developing over the past two years. It commenced operation in January 2010, with the aim of becoming a best-practice service for the client group. First Response was established through strategic management of existing funding streams, and no additional funding has contributed to operationalising the service. Currently, a formal evaluation of the model is underway. This article qualitatively describes the background to First Response, implementation of the model and emerging outcomes to date.

Background

In 2008, the World Health Organisation (WHO) highlighted the rationale for integrating mental health services at the primary care level, citing this as optimal for social inclusion, access, human rights and decreasing the stigma associated with mental health services that exist in isolation (WHO, 2008). The report Integrating mental health in primary care – a global perspective, explained that there is no overarching one-size-fits-all model to achieve this. Instead, they call for ‘sensible local application of broad principles’ of integrating mental health and primary care. The concept of sensible local application of principles that enhance access to primary care for people with mental health issues, is highly relevant to the Victorian and Australian context today. The proposition paper Pathways to Social Inclusion – Health Inequalities (VICSERV, 2008) reviewed research into health inequities for people with mental illness and concluded that policy and practice failure in Victoria has led to significant health inequity for this group, including decreased life-expectancy and a death rate 2.5 times greater than for the general population. The report explains that the mental health sector operating in isolation from the broader health sector, is a contributing factor. It has limited awareness of, and capacity to address, the physical health and chronic care needs for people with mental illness (VICSERV, 2008).

It is clear from the evidence above that new and innovative approaches need to be piloted locally to attempt to bridge the gap in health outcomes for these groups, and in particular approaches that integrate mental health services at the primary care level.
The vision

WRHC is an organisation based in the Western region of Melbourne, comprising a community health service and significant mental health and assertive outreach programs that are funded from a range of sources including both federal and state funding streams. Following the release of the proposition paper *Pathways to Social Inclusion – Health Inequalities* (VICSERV, 2008) strategic priority was given to the development of a model of integrated primary care for people with mental health issues and complex needs. WRHC set out to re-design its service model at the Footscray location. The aim of the re-design was to create a model that is:

- **responsive**: based on an understanding of the commonly occurring needs, lifestyles and behaviors of people in the target group
- **holistic**: the service model considers the social, emotional, mental and physical health needs of people in the target group
- **integrative**: an extensive range of WRHC programs and service providers working together in a coordinated approach.

(WRHC Internal report, 2009)

Specifically, the objectives of the First Response model were to:

- provide an immediately useful, holistic, First Response to all clients
- actively engage people who may not trust ‘mainstream’ services
- reduce the risk of escalation of health issues faced by clients
- provide clear pathways to longer-term support service options to clients where needed.

See Figure 1 for a visual representation of the model. The inverted triangle represents the First Response concept, with clients entering from the top and having the majority of their needs met; a smaller number of clients are then channeled towards longer-term support programs based on the initial, and ongoing, comprehensive assessment of needs. Accessible pathways to primary care are a feature of the clients journey at all stages.

This report describes First Response and emerging outcomes to date, under the following four facets of the model:

1. An integrated service site
2. The ‘Open Door’ and First Response
3. Accessible primary care: onsite clinics
4. Streamlined access to longer-term supports

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**Figure 1: Integrated Health Response Model**

- **Integrated First Response**
- **First Response**: Assessment
- **Sustainable Response**: 2nd phase care planning
- **Onsite Clinics**: – no appointment necessary
- **Allocation to longer-term or Sustainable Supports – as required**
- **Some Clients**
- **External providers**:  
  - Legal clinic
  - Centrelink
- **Few Clients**
- **Longer-term Supports**
- **First Response**:
  - Assessment
  - Internal/external referral
  - Coordination of immediate care responses
- **Sustainable Response**:
  - 2nd phase care planning
  - Specialist assessments
  - Self-health management
  - Care coordination
- **Onsite Clinics**:
  - WRHC Programs
  - Screening; dental, diabetes, optometry
  - Sessional GPs
  - Living Well
  - Allied health; podiatry, physiotherapy...
  - Health promotion
- **Longer-term Supports**
  - Few Clients
I An integrated service site

Outcome 1.1: re-alignment of services
Prior to establishing the First Response model, a new integrated service site was established. This site was developed in a historic building located beside Health Works, WRHC’s primary health care centre for people who inject drugs. The redeveloped site provided a multiple purpose clinic space and shared office space for staff in related programs.

The Assertive Outreach and Community Mental Health Outreach Programs moved to the new site. The Assertive Outreach Programs are funded through the low cost accommodation programs and provide a suite of outreach and recreation programs to people who are homeless, at risk of homelessness or living in low cost accommodation. The Community Mental Health Programs provide a suite of outreach and recreation programs to people with mental health issues.

The relocation to the integrated site was a significant achievement for both programs and the expectation on those involved to change their practices was great. Staff were previously located in individual sites and operating independently on a day-to-day basis with their own work practices, procedures and systems. The site brought over sixty staff together, including Health Works staff. A number of strategies were implemented prior to the move to assist the process of integration. Working groups were established with representation from each of the program areas to provide input into the design of the building and the service delivery programs planned for the space. There was also a focus on developing social activities to bring the teams together. In addition, process evaluation was undertaken to understand staff perceptions. This involved in-depth interviews and focus groups. Information from the evaluation was reported to the relevant working groups and thus provided an avenue for staff feedback.

Outcome 1.2: new systems and processes
As new systems and processes were developed they were implemented across the integrated site. Where possible, these were implemented prior to the move so that staff became accustomed to working with the systems. Some examples included integration of the electronic client file system, consolidation of the paper client file system, the implementation of an electronic car booking system and an electronic booking system for shared resources.

2 The ‘Open Door’ and First Response

A key feature of the First Response model is the walk-in, ‘open door’ that aims to make the non-appointment based service highly accessible and flexible. Two shifts are provided daily, morning 10:00am – 1:00pm and afternoon 1:00pm – 4:00pm. Accessibility is further enhanced by the physical location of the service in Footscray CBD, close to public transport and to other services such as housing, employment, resettlement, clinical mental health and drug and alcohol services. This means the target population is familiar with and drawn to the vicinity. A skilled First Response worker is available to meet clients and undertake an assessment of need in conjunction with the client and will then assist the client to plan a response to the need. Where appropriate, the assessment then progresses towards assessing the client’s broader health needs and linkages to onsite clinics, or external referrals are made. For some clients, the level of urgency or distress around their presenting needs means that progressing to broader assessment at that point is not feasible. In this instance the skill of the First Response worker is assessing the client’s capacity to engage, and the meaning and relevance of the interaction to the client. With the consent of the client the First Response worker will make referrals to longer-term supports where appropriate. The team recognises that frequent crisis presentations to First Response is an indicator of high support needs where referrals can be made accordingly.

Emerging outcome 2.1: an accessible service

In February 2011, a ‘snapshot’ evaluation (set in the context of a larger evaluation) of the accessibility of the service was undertaken over a two-week period. During the period, there were 66 client contacts at First Response. The majority of these clients had their needs met via First Response. Three months later, eight of these clients were linked to longer-term support programs, and a further seven continued to receive a service from First Response.

During the ‘snapshot’ period of two weeks, a small group of 12 self-selected clients engaged in a survey to provide feedback on the service. Their responses are summarised below. First Response workers gave feedback that a survey method was not appropriate for a large proportion of cases due to their presentation. (Staff responses explaining these situations are also included below). This highlights not only the complexity of clients accessing the service, but also the multiple and complex needs they present with. It also raises the challenge of how to include the perspective of this complex group in future formal evaluation. Accessibility will be further evaluated later in 2011, however feedback trends are positive.
Snapshot survey results

**Clients’ impressions of the assessment and interview process**

- ‘Helpful’
- ‘The staff were very helpful and gave clear and concise information that was very helpful for my mother’s housing application’
- ‘The person who interviewed me was very good. I was happy with them’
- ‘I was impressed with it. They took all the appropriate information so they can better help me’
- ‘Excellent – feel a lot better’
- ‘Excellent’
- ‘Feel relaxed and good’
- ‘The GP was fantastic’
- ‘Slow but good’

**If you were asked by people not associated with WRHC to comment on the First Response process, what would you tell them?**

- ‘Very good’
- ‘That the staff were very helpful and gave many options in regards to finding housing’
- ‘The staff [are] very helpful and supportive’
- ‘They are very friendly and they will do whatever they can to help you’
- ‘Excellent’, ‘good’
- ‘Pretty quick. Lots of questions asked, most of them good’
- ‘Recommend it’
- ‘That it is good and helpful. Promptly organising aid and referring you on to many helpful segments’
- ‘Go to 215 [First Response]. They’re pretty good people there. They can help you’.

**Clients’ understanding of the next step in their care following initial contact with First Response program**

- ‘Joining D2DL group’
- ‘An appointment with Metro West housing and then back to First Response for further support’
- ‘My next step is to wait for the workers to have a meeting to work out how to best help me’
- ‘I don’t really know. I come in here when I need some help and the worker helps me’
- ‘Counselling and appointment next week with worker’
- ‘Been linked in with an outreach support worker. Outreach support worker has been very helpful’
- ‘Linked with a counsellor’
- ‘I received the medical, dental and optical care I needed’.

**Staff-documented barriers to clients completing the evaluation survey. (Themes)**

- Time-constraints
- Level of distress was too high
- Literacy issues
- Clients presenting as substance affected
- The snapshot survey did not include views of CALD clients.
Underpinning the development of this integrated service was a strong focus on collaborating with internal and external stakeholders, and a workforce with the capacity and willingness to embrace change. Change included organisational systems, work practices, and working within multi-disciplinary and multi-functional teams.

**Emerging outcome 2.2: an established First Response team**
The First Response team is a ‘virtual’ team, whereby ten staff from mental health and assertive outreach programs have been trained to be First Response workers, each completing one to two First Response shifts weekly. Participation in the First Response team has allowed these staff to diversify their roles, and build skills, particularly in holistic assessment, assessing physical health needs and triage. The essential skills, as identified by the team, are summarised in the list below. Alongside staffing the team, considerable emphasis has been placed on developing team practice guidelines, communication processes and the creation of a safe environment within the First Response space. An important feature in creating and sustaining this safe ‘space’ is the back-up manager system, whereby a nominated manager is always present onsite and has capacity to respond if needed. This supports the First Response team in the event of a challenging situation.

**Essential First Response worker skills as identified by the team**
- Assessment skills (including health screening, drug and alcohol, mental health)
- Care coordination
- Listening and engagement skills
- Flexibility
- Lateral and creative thinking
- Communication skills
- Assertiveness
- Advocacy
- Self-care skills
- Cultural competency
- Cross-sector knowledge and understanding
- Time management / ability to prioritise
- Strong team skills
- Risk assessment and de-escalation
- IT skills

**Emerging outcome 2.3: increased awareness of community needs**
Establishing the First Response service had the additional important benefit of enabling the organisation to become more aware of current community needs in a very real way. This provided valuable data on which to base strategic planning and partnership development. For example, a significant proportion of clients present with housing instability or homelessness as an immediate need, which reflects the housing crisis in the West. An emerging trend at First Response is the high prevalence of older people (60 - 70 years) presenting in housing crisis due to the reduced availability of affordable private rental properties in the area. This group presents with specific health and social needs in addition to homelessness or housing instability, and these can be assessed and addressed at First Response. However, the trend highlights the need to build on existing partnerships in order to address the specific needs of this group, for whom health and housing are often inextricably linked, and influence overall quality of life.

**3 Accessible Primary Care: onsite clinics**
First Response included the development of clinic-based services, with the collaboration of the WRHC Community Health team. This included the design of an allied health and GP service based within First Response. Allied health and GP staff collaborate closely with the First Response team. Clinics include: GP, physiotherapy, podiatry, and dental screening. In addition, external service providers host clinics within the First Response service. For example, the Australian College of Optometry provides a clinic, as do Centrelink, and Senior Rights Victoria operate a clinic addressing issues of elder abuse. Also, health promotion groups targeting the client group are promoted and co-coordinated form the site.
If there is a six-week waiting period for home-based outreach, traditionally the client would receive phone-call support from the team, but limited one-to-one contact during the wait-period. With the introduction of First Response, the client can begin to have broader health needs addressed during this time. Also, clients who are waiting for high-demand, longer-term supports are offered a service at First Response as an interim support if necessary.

The clinical space at First Response is designed to be multi-functional and to have the capacity for a range of services to be delivered from the same space. The importance of ensuring that clinics are highly accessible is recognised. Where possible, the services are drop-in based and free.

**Emerging outcome 3.1: increased multi-disciplinary service coordination**

A key outcome has been the development of more advanced multi-disciplinary service coordination for clients accessing First Response. Clinic staff collaborate with longer-term support teams who may be working with the same clients. For example, when the GP is consulting with a client in the clinic they routinely contact other workers, involved in the client’s care. The immediacy of contact between workers enhances communication and timeliness of care and has increased workers’ capacity to develop a greater understanding of holistic health care.

**Emerging outcome 3.2: creating positive health-service experiences**

The First Response clinics have also improved the relationship between clients and other WRHC services. Clients coming into First Response are able to have an experience of a responsive and accessible service at their first point of contact. This means having the experience of being heard and having at least some of their needs met immediately. This creates a trusting relationship with the service, which in turn makes follow-up attendance at other WRHC appointments more likely. For example, clients can access dental screening if required. Here, they receive a thorough assessment of their dental care needs. Should they require follow up treatment, a ‘fast-track’ appointment for treatment within a week will be made. The treatment is booked at the general dental clinic at another site, however since implementing the screening system, attendance rates for dental appointments have improved. This indicates significant improvement in access to dental services for this client group.

Clients have also anecdotally reported that they find accessing services at First Response user-friendly, compared to their previous experiences. A key element appears to be the scale of the space, and the welcoming environment. The clinics are responsive and clients are seen in a timely manner.

**4 Streamlined access to longer-term psychosocial supports**

A further aim of the integrated site was to provide streamlined access to longer-term support programs for clients, including those who access via First Response.

**Emerging outcome 4.1: matching intensity of service to client need**

All clients who are identified as needing streamlined access to additional / longer-term supports are presented at a weekly allocation meeting where the following services are represented: Psychiatric Disability Rehabilitation and Support Services (PDRSS), Intensive Home-Based Outreach Support (IHBOSS), Housing Support for the Aged, Assistance Care Housing for the Aged, Care-Coordination, Living Well, Community Connections and Prevention and Recovery Care (PARC) services. The weekly nature of the meeting ensures the allocation process occurs in a timely manner, to the team that is best placed to meet the clients’ individual needs.
In some cases, this involves more than one team. The feedback from all teams is that channeling clients through First Response and the allocation process reduces the time individual teams spend in assessment, triage and care-coordination. Additionally, the process has built relationships between teams, increased capacity of staff, and fosters multi-disciplinary working.

**Emerging outcome 4.2: ‘live’ waitlists**

Clients entering the service via the broad base of the ‘triangle’ (Figure 1) have access to a range of primary care services in advance of being allocated to a longer-term support program. For example, if there is a six-week waiting period for home-based outreach, traditionally the client would receive phone-call support from the team, but limited one-to-one contact during the wait-period. With the introduction of First Response, the client can begin to have broader health needs addressed during this time. Also, clients who are waiting for high-demand, longer-term supports are offered a service at First Response as an interim support if necessary. For example, there are currently 12 clients on the home-based outreach waitlist; all 12 have been reviewed via the allocation meeting process. Eight have had at least one referral made via First Response to address their physical health and/or chronic healthcare needs. Of the others, three were referred from PARC and one from Hospitals Admission Risk Program (HARP). These programs also have strategies to address clients’ physical health needs. One-hundred per cent of this ‘waiting’ group have already been linked to primary care services and taken steps towards addressing their physical health needs.

**Conclusion**

In summary, integrating services and the establishment of the First Response model appears to have improved client access to primary care services and streamlined access to longer-term supports. This will be further explored via formal evaluation, the results of which will be available in late 2011. Underpinning the development of this integrated service was a strong focus on collaborating with internal and external stakeholders, and a workforce with the capacity and willingness to embrace change. Change included organisational systems, work practices, and working within multi-disciplinary and multi-functional teams. Future plans include comprehensive evaluation with a view to assessing the feasibility of replicating the model more broadly. In addition, further enhancement of onsite clinics is envisioned, to address client need. Funding opportunities will need to be explored to further expand and develop the model.

**References**


WRHC (2009) Western Region Health Centre: Integrated Health Response Nicholson St Model of Service (Internal report), Western Region Health Centre Footscray
Letter to the Editor
Strengths-based practice explored

Marg Brooks, Andrew Shirres, Marlene Lamprell, Michelle Quirk, Chris McInnes and Sharlene Green,
St Luke’s Anglicare

Strengths-based practice is a values-based philosophy that sits very well with a social justice understanding. As a values-based philosophy, it integrates principles of social justice: inclusion, collaboration, self-determination, transparency, respect and the sharing of resources. At St Luke’s we’ve found this to be a very effective and empowering model for working with people with significant disadvantage.

St Luke’s has been practising in a strengths-based framework for over 25 years now and we’ve found it to be very effective and ‘liberating’ in our work with people who present to St Luke’s with a range of concerns such as mental illness or homelessness. I’ve deliberately described it as ‘liberating’ because this is how the people we work with have described it to us. By focussing on strengths (what people ‘can do’) we’ve found that it supports people to regain hope and enables many possibilities to emerge over time. However, there is much more to strengths-based practice than just identifying strengths.

Sadly, by the time people often get to services, they’ve lost much of their confidence, may feel defined by their mental illness and by that stage, people often have a very negative view of themselves with minimal positive belief in their future or in what they can do. Sometimes when people feel overwhelmed they can lose sight of hope, their own strengths and also of the skills that helped them manage in their lives. Along the way they may have also lost faith in change being possible. In our experience, helping people to recognise and think about their strengths enables confidence and growth and people are able to start thinking about, shaping or changing their aspirations for the future. As practitioners, our role is to support people to regain control in their lives and develop their own picture of the future. At St Luke’s, we think of hope as an acronym for ‘helping other possibilities emerge’.

In saying this, we recognise that strengths-based practice does not sit outside other approaches such as Cognitive Behaviour Therapy, Narrative Therapy, Crisis Intervention or a skills-based approach. Strengths-based practice sits alongside these approaches and indeed, it underpins and informs them. Narrative Therapy for example, has much in common with strengths-based practice. For example, we encourage consumers to re-author their story from their perspective, see people as not defined only by their illness but looking at the exceptions through the definition of strengths and differing past experiences. No matter what core approaches are used, our role as practitioners is to support people to see other possibilities rather than have a focus on what they cannot do.

Using strengths practice does not inhibit the identification of skills or undervalue the need for practical support, such as having access to computers, assistance with using public transport, as described by Maggie McGuire in her Opinion
A further example raised by Ms McGuire was in relation to a report by the Tasmanian Commissioner for Children in 2010, ‘She will do anything to make sure she keeps the girls’ following the tragic incident of a mother prostituting her 12-year-old daughter. The title of the report was taken from a list of strengths the mother recorded as part of the lapsing of a Guardianship Order in 2009. This was a terrible circumstance with disastrous consequences.

However, it does lead to a reflection of our responsibilities as workers. This example of using a list of strengths as a safety plan, or as a justification for family reunification, is indeed questionable practice. Whatever practice approach is used, proper consideration and priority for the safety of children is paramount.

Strengths-based practice should be, and indeed is, a responsible practice. Assisting people to think about and recognise their strengths is part of a whole framework of strengths-based practice, which does not preclude considerations and discussions of safety. Straight talk, or directly naming problems and concerns, is also an integral part of strengths-based practice. In these extreme circumstances it may often be the skills of, and supports for, the practitioner that need rigorous exploration and examination rather than the practice model as such.

Strengths-based practice is a values-based philosophy that sits very well with a social justice understanding. As a values-based philosophy, it integrates principles of social justice: inclusion, collaboration, self-determination, transparency, respect and the sharing of resources. At St Luke’s we’ve found this to be a very effective and empowering model for working with people with significant disadvantage.
About the Cunningham Dax Collection
The Cunningham Dax Collection, amassed over a 70-year period, consists of over 15,000 artworks including works on paper, photography, paintings, sculptural work, journals, digital media and video created by people with an experience of mental illness and/or psychological trauma. The Cunningham Dax Collection is part of the Dax Centre.

The Dax Centre promotes mental health and wellbeing by fostering a greater understanding of the mind, mental illness and trauma through art and creativity.

For more information on the Cunningham Dax Collection and the Dax Centre, visit: www.daxcentre.org
Expression Session

Julie Goodwin

Doing these portraits made me realise that by chipping away a little bit each day you end up with something big and meaningful at the end of it. I realised later that you can apply this to your life.

Artist profile
Julie Goodwin is a Melbourne-based practicing artist who works with large-scale oil paintings on canvas. However, after the birth of her third child, she was diagnosed with postnatal depression and has commented, ‘at the time I was struggling with caring for my children and the most basic household chores became exhaustingly difficult.’

Finding it difficult to return to her art practice, a friend suggested she start a visual diary and create a self-portrait and diary entry each day to get back into the act of creating. Her visual diaries, created over a period of several years form a remarkable record of her emotional and physical journey during this time.

Julie Goodwin’s works are featured in the current exhibition, Melancholia. The exhibition at the Dax Centre is open until the 21st October 2011.

Artist’s statement
‘Although some days it was extremely difficult to do anything, [the diary entries] did make me feel better once I got started. And on good days I enjoyed making my next entry. Sometimes I forgot to write anything down because I enjoyed the process of drawing so much.

I don’t do these any more as the need to create in this format is finished. Now I have gone back to my painting. However, I am glad I did them at the time. They are small things that led me back to the big things.

I always used a mirror, but the choice of material and colour was instinctive and I just let myself tune into my feelings. So whatever came out, came out. I didn’t plan it. And that’s probably why I look so different in all the pictures. Part of my obsessive thing was to always do things differently, even driving home from school a different way each day. I don’t do this anymore.

Doing these portraits made me realise that by chipping away a little bit each day you end up with something big and meaningful at the end of it. I realised later that you can apply this to your life’, Julie Goodwin, 2011.
13/7/00 8pm
20 min 150 milligrams
Extremely difficult day
with much stress & low
mood
20 mg Valium
- a little less stressed
- 2 red wine
- caffeine
not much change

6pm 1 beer
3 white wine

Julie Goodwin
No title, 2000
graphite pencil on paper
21 x 14.8 cm each
The Cunningham Dax Collection
2007.0234a-b
30/1/00 1:30 pm

Yesterday I thought I was taking 225 mg EFEXOR ER. Today I find out, after talking to my therapist, I discover I'm actually on 300 mg. The pharmacist messed up the script. The side effects were overwhelming. Fatigue and difficulty in holding conversation and nausea.
4/1/01  10 pm

Drinking far less + feeling much better. Things in the home are in better order now maybe that has helped too.

My tolerance of the kids has improved + my energy levels have increased. Positive, positive, positive.
Yoland Wadsworth is an Australian social research and evaluation practitioner, methodology theorist and educator – and author of the bestsellers *Do-it-Yourself Social Research and Everyday Evaluation on the Run* – who has put innovative and empowering tools of social inquiry into the hands of many thousands of people in their communities, to help give them a stronger ‘say’ in dealing with community, health and human service organisations.

Wadsworth’s new book, *Building in Research and Evaluation: Human inquiry for living systems* is said to be the final instalment of her social research and evaluation trilogy (Allen & Unwin). This far-reaching and comprehensive book of more than 300 pages took a decade to write and is described as the Magnum Opus of a busy and distinguished career. Yoland Wadsworth is Adjunct Professor, Centre for Applied Social Research, RMIT University, and holds several other posts.

This outstanding work offers a generous feast of practical knowledge and wisdom, drawn from the author’s 38 years as a leading ‘resource person for others’ later efforts’ in practice-based social research, across many sectors and organisations.

Wadsworth writes about her pleasant surprise, in early preparations to this book, in learning about an apparent high level of adoption by researchers and evaluators in many fields of methodologies similar to those she has tested and recommended. However, there were other reports of all-too-many ‘people centred’ conflicts and other problems such as an apparent lack of adherence to an evidence base, in human service organisations. Meanwhile, many innovative projects were being initiated here and there, but often funded as rather ad hoc short-term projects. There was also little evidence of widespread preparations to develop and build in cyclic structures for ongoing social research and evaluation in the running of very many human service organisations, let alone with much in the way of humanising ideals.

These and other conundrums set many challenges for the author to study the structures and processes of human service organisations, by envisioning them as ‘living systems’ and working out the benefits that might flow.

Wadsworth’s book has a great deal to offer on many levels. Beyond its functions as a reference work – which reviews and draws upon extensive lessons learned from past projects – there is much which is new, creative, strategic, inspiring, questioning, challenging and determinedly striving to develop ways for the voices of people disempowered by ‘systems’ to be heard by policy makers and power holders.

While many combinations of ‘sequences of research cycle questions’ are offered, it is worth noting that the foundations are somewhat similar to action research frameworks, which tend to start out straightforward – then are elaborated upon. While there can be many permutations, the basic four steps for can be summarised:

Observe → Action → Reflect → Plan → Act → Observe → Action →

The book deals extensively with ‘building in a culture of inquiry’ – both in organisations and in the community – and in several parts, it closely examines many structural underpinnings of social research and evaluation, particularly when applied to mental health consumer participation, evaluation, and community-based Participatory Action Research.
There is a powerful exposition of methodological structures in social inquiry, which can inform the reader’s thinking about:

- detailed principles for research and evaluation within complex human service organisations, when viewed as ‘living systems’
- sequences and examples of ‘research cycle questions’, which can be creatively harnessed in working towards ‘intelligent systems’ which could also become self-adjusting
- promotion of the development of more human services, partly through service providers being encouraged to open up and listen carefully, without flinching to the expressed hurts, unmet needs, and creative thinking of consumers.

There is also a major section which crystallises ten ‘exemplars’ of substantial projects in which Wadsworth has been involved over a long period in human services settings. But the larger list spanned: health, education, welfare, non-government organisations, local, state and federal government, community groups working with youth, homelessness, disability, community and mental health, health promotion, hospitals, schools, universities, child and family services, the disadvantaged, the excluded, agriculture, environment, Indigenous people with a commercial small business.

Yoland Wadsworth is well known as the social research and evaluation theorist who worked in collaboration with consumer researcher Merinda Epstein in establishing and leading the Understanding and Involvement Project at Royal Park Psychiatric Hospital in 1990-96, which won awards as a consumer participatory/staff collaborative project. U & I (as it became affectionately known) became a training ground for many consumer consultants, and ultimately became a major part of the model for the statewide introduction of consumer consultants in 1996. (See the compendium, The Essential U & I (Wadsworth, in ongoing collaboration with Epstein; VicHealth 2001.)

In Building in Research and Evaluation, Wadsworth explains that the U & I project was an attempt to establish and refine processes by which staff and consumers in psychiatric wards could routinely collaborate research, evaluate the experiences of consumers and make the consequent relevant and appropriate changes to the hospital practices. In some ways this was attempting to build back into the system a capacity for reflection and time enough for understanding. These changes could also allow a shift in debate in the mental health field towards the notions of health, healing and recovery rather than defaulting, too quickly, to matters of fear, control and coercion.

Wadsworth writes: ‘It wasn’t in the end seeking a ‘new vision’ or a ‘breakthrough formula’ which would leave distancing, ‘othering’, fears, anxieties and iatrogenesis as things of the past. In the end we saw how “the system” mirrors and writes large the nature of each human being, and what we were seeking to put in place was something “equally systemic” to discharge the forcefield of oppositional distancing by creating spaces and places for both professionals and end-beneficiaries to come “side by side” – for staff to feel it was safe to come out of the nursing station and for consumers to feel safe to tell staff what they were experiencing.’

Such shifts of emphasis can be found within the book’s summary of the U & I model’s 12-component framework summary, explained as placing a premium on such factors as: quality assurance, a two-way consumer-staff dialogue, appropriate and built-in forums, utilising dynamic means of culture shift, and multiple and creative means of consumer input. Wadsworth also continues to espouse the need for ‘a missing fourth site’ – a place for system staff trying to work for change – mirroring consumer-only places where people share understanding and peer support, and tired and battered people can work on their health growth and development ideas.

Wadsworth’s book carries many little touches of somewhat wry humour, arising naturally as observations from the text and her enjoyment of the powers of language. This is complemented by many cartoons satirising agency-life, quote panels, some key learning tables, sidebars, and stories from the field.

In presenting an overview of ‘human inquiry for living systems’, Wadsworth uses an example of an ordinary learning activity from life by conjuring up the thoughts, words, and actions of a person who has just learnt to ride a bicycle. This includes lines like: ‘Wobble, wobble. Fall off. Go a bit further. Wobble. Getting the hang of it. Staying on. Go faster, easier, better…’

Wadsworth’s book also provides a valuable participant’s eye overview of the history of research, evaluation and organisational development from the 70s onward, throughout human services and many of the political and bureaucratic processes in operation throughout. There are also a number of interesting accounts of the history, development, and changing adaptations of many methodologies of social research and evaluation.

Reviewed by

Allan Pinches
Consumer Consultant in Mental Health
VICSERV is a membership-based organisation and the peak body representing community managed mental health services in Victoria. These services include housing support, home-based outreach, psychosocial and pre-vocational day programs, residential rehabilitation, mutual support and self-help, respite care and Prevention and Recovery Care (PARC) services.

Many VICSERV members also provide Commonwealth funded mental health programs.

**VICSERV envisages a society where mental health and social wellbeing are a national priority and:**

- Everyone has access to timely mental health treatment and support
- Mental health services are recovery oriented
- People participate in decision making about their own lives and their community
- People affected by mental illness have access to, and a fair share of, community resources and services
- All people are involved as equals, without discrimination.
As the peak body for the community managed mental health sector in Victoria, we pursue the development and reform of mental health services.

Our Mission

We support members by:

- Promoting recovery oriented practice
- Building and disseminating knowledge
- Providing leadership
- Building partnerships and networks
- Undertaking workforce development, training and capacity building
- Promoting quality in service delivery
- Undertaking advocacy and community education

Our Values

Collaboration (Teamwork)

- Working together to achieve shared objectives
- Respecting the knowledge and skills of others
- Putting the needs of the organisation above individual interests

Inclusiveness

- Listening to a range of views
- Representing and embracing the diversity of the sector
- Honouring the consumer and carer experience

Flexibility

- Proactively embracing change and new opportunities
- Stepping up and out from our roles and perspectives when required

Courage

- Taking leadership by speaking up on important issues
- Encouraging and supporting innovation
- Persistence in the face of obstacles and delays

Integrity

- Doing what we say we will do on time and to the best of our ability
- Listening and responding to members
- Having a respected voice and visibility in the sector, broader system and in government
- Being an honest broker of information and resources.
Membership Application Form

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Type of Membership applied for

☐ Ordinary (full)  ☐ Associate  ☐ Individual

Is your organisation psychiatric specific support  ☐ Yes  ☐ No

If yes, what type(s)?

☐ Day Program  ☐ Home-based Outreach  ☐ Respite Care

☐ Mutual Support and/or Self help  ☐ Residential Rehabilitation  ☐ Statewide (describe)

Please describe any other services your organisation provides

The funding level of your organisation (for billing and statistical purposes)

The above named organisation (or individual) hereby applies for membership of Psychiatric Disability Services of Victoria (VICSERV) Inc. and nominates the above-named person as the contact person for all correspondence. Upon acceptance of this application, Psychiatric Disability Services of Victoria (VICSERV) Inc. is authorised to insert the name of this organisation (or individual) in the register of members of the incorporated association. We hereby agree to abide by the Rules of Psychiatric Disability Services of Victoria (VICSERV) Inc.

Signed Official Representative

Name

Position

Upon approval of the application by the VICSERV Committee of Management, you will be invoiced for the membership fees due.

If an organisation, please supply a copy of your last Annual Report, and a Statement of Purposes, or other information about your service.

Please mail completed form to:

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