

## **Position Paper: Moving beyond integrated service delivery for mental and physical health care**

MHCC has reviewed a number of recently published Australian and international papers that seek to inform and influence the development of a model of integrated service delivery with particular reference to mental and physical health care.

The Australian Health Policy Collaboration (AHPC)<sup>1</sup> paper *Beyond the Fragments: Preventing the Costs and Consequences of Chronic Physical and Mental Diseases, Issues paper No. 2015-05*<sup>2</sup> is likely to influence policy reform in the context of the developing central role of Primary Health Networks (PHNs) in Australia through the Triple Aim<sup>3</sup> framework initiative. Likewise, the Mental Health Commission of NSW (MHC) in its recently published *Physical health and mental wellbeing: Evidence Guide*<sup>4</sup> highlights the “increasing role of primary care providers,” and the need for “engagement between mental and physical health services to ensure completely integrated and collaborative care” (p.25). This paper is a welcome addition to resources informing important discussion on the physical health inequities experienced by mental health consumers in NSW.

AHPC's paper states that “by world standards, Australia has robust systems to respond to physical and mental ill health”, but emphasises that neither ‘system’ is easy to navigate; that they often work poorly together; and frequently provide inconsistent quality of health care that is neither cost-effective nor delivers optimal health outcomes across the population. The paper also states that there is substantial evidence that the absence of integrated prevention and management strategies contributes to a greater burden of illness and disability, and greatly impacts the individual and the community in both social and economic terms. The large burden of illness and disability quantified in the statistics<sup>5</sup> is due to the increased numbers of people with complex co-existing conditions. Mental and physical health difficulties habitually co-exist, each representing a compounding risk factor especially when the treatment of one condition gives rise to damage in another sphere. Evidence clearly demonstrates that people taking a diversity of psychiatric medications often experience serious negative physical health

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<sup>1</sup> The AHPC is a research arm of the Victoria University, Melbourne which promotes and supports a national policy agenda for the prevention of chronic diseases that improves population health and wellbeing in Australia. Their stated mission is to contribute to the development of public policy and its practice, and to improve health outcomes through evidenced based research, particularly for socioeconomically disadvantaged Australians.

<sup>2</sup> Australian Health Policy Collaboration 2015, ‘Beyond the Fragments; Preventing the Costs and Consequences of Chronic Physical and Mental Diseases’, Issues paper No. 2015-05, Author, Duggan M, Available: <https://www.vu.edu.au/sites/default/files/AHPC/pdfs/beyond-the-fragments.pdf>

<sup>3</sup> The Triple Aim strategy is defined as: improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

The IHI is a not-for-profit organisation focused on motivating and building the will for change, partnering with patients and health care professionals to test new models of care, and ensuring the broadest adoption of best practices and effective innovations.

<sup>4</sup> Mental Health Commission of NSW 2016, ‘Physical health and mental wellbeing: Evidence Guide’, NSW Australia, Available: <http://nswmentalhealthcommission.com.au/sites/default/files/publication-documents/Physical%20health%20and%20wellbeing%20-%20final%208%20Apr%202016%20WEB.pdf> (Accessed April 2016).

<sup>5</sup> National Health Priority Action Council 2005, ‘National chronic disease strategy’, Australian Government Department of Health and Ageing, Canberra; Australian Institute of Health and Welfare (AIHW) 2006, ‘Chronic diseases and associated risk factors in Australia’, AIHW cat. no. PHE81, AIHW, Canberra; Australian Institute of Health and Welfare (AIHW) 2007, ‘Co-morbidity of mental disorders and physical conditions’, cat. no. PHE 155, AIHW, Canberra.

outcomes that may not be reversible and lead to poor quality of life and risk of premature death.

Despite the statistics, delivery of health services is characteristically designed around single conditions. The inability of the health system to respond to complex co-existing conditions is exacerbated by the separation of mental health services from the physical health system. Coordination and communication across services and systems and between multiple specialists and generalists involved in care is poor.

Duggan et al., (2016) refer to the effectiveness of integrated and collaborative models of care as now well established resulting in the widespread interest in models of integrated care internationally. Under review nationally and at a state and territory level, these discussions are informed by knowledge and awareness of best practice in population health planning with the aim of improving outcomes for people with co-existing conditions a high priority. The agenda, according to the AHPC, is driven in part by the development of the Triple Aim<sup>6</sup> framework defined by the Institute of Healthcare Improvement.<sup>7</sup>

Improved integration is central to systems reform both in Australia and internationally with a view to delivering better health and wellbeing outcomes. Nevertheless, it is important not to ignore the fact that a working definition has yet to be found for 'integration'. Indeed the WHO has highlighted its absence and the need for "greater conceptual clarity" (Williams 2009)<sup>8</sup> for a concept that is capable of incorporating multiple meanings. Williams (2009, p. 677) suggests that the "warm and woolly nature" of words such as collaboration and integration are such that to question them is "tantamount to opposing virtue". We raise this issue because the concept of integration "sets an expectation that this is a good thing, without necessarily being specific about why that may be so." In fact, the "official" policy and practice literature since 1988 in the UK have been dominated by acknowledgements of the shortcomings and "disappointing" progress associated with various initiatives to promote integration (Griffiths 2006, 2010; Audit Commission, 2009, 2011). In fact, it has been a consistent feature of the enthusiasm for integration in England, if not elsewhere, that policy makers have repeatedly found themselves in the paradoxical position of advancing its supposed merits while condemning its actual shortcomings whilst gearing up for another round of fresh initiatives (Wistow, 2011a, 2011b). The UK based academic research points to modest levels of achievement in integration, emphasising process rather than outcomes for consumers. In this context, whilst MHCC strongly support initiatives that improve mental and physical health, we urge that integration be well defined and that data collection reviews of outcomes are implemented as a key strategy for ensuring quality improvements and evaluating practice.

Whilst AHPC's paper provides a "compelling case for integrated care, supported by the evidence," from MHCC's perspective both this and MHC's paper should more strongly acknowledge the vital role that community managed organisations (CMOs) play in providing integrated and coordinated care for people with complex mental and physical health needs. Similarly, although MHC specifically recommends that GPs adopt a holistic approach, the action does not satisfactorily include the part CMOs can play in ensuring this approach.

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<sup>6</sup> Berwick, D Nolan TW & Whittington, J 2009, 'The Triple Aim: care, health and cost', Health Affairs, vol. 27, no. 3, pp. 759-769, USA.

<sup>7</sup> The IHI is a not-for-profit organisation focused on motivating and building the will for change, partnering with patients and health care professionals to test new models of care, and ensuring the broadest adoption of best practices and effective innovations.

<sup>8</sup> Williams, P & Sullivan H 2009, 'Faces of integration', International Journal of Integrated Care, Vol. 9, pp. 1-13.

Nevertheless, MHC's paper does talk about "creative partnerships", with, for example, PHAMS, highlighting the role of peer workers in the mix.

AHPC's paper references several models of integrated care that better meet population health needs. One such model is described in the King's Fund paper: *Bringing together physical and mental health: A new frontier for integrated care*.<sup>9</sup> In the UK, until recently, most efforts to promote integrated care have focused on bridging the gaps between health and social care or between primary and secondary care. The NHS five year forward view has highlighted a third dimension that brings together physical and mental health.

The King's Fund<sup>10</sup> paper determines that in the future local authorities see people with mental health conditions, particularly those with enduring mental health conditions – as a priority target group for public health interventions. Ideally this will include provision of tailored services provided by range of organisations, including community sector organisations who play an important role, and ensure that there are clear agreements over who holds clinical responsibility for the physical health side effects of psychotropic drugs. Closer working between health, local government and other sectors will help to address the social determinants of health for people with mental health conditions. Therefore all mental health professionals are to receive AOD training, and work much closer with addiction services. It is hoped that this fundamental cultural shift within the entire mental health workforce will lead to all professionals seeing that promoting physical health is an important part of their role. However, the AHPC (p2, 1.2) specifically identifies that this aspect of care is not within the scope of their paper, whilst acknowledging that principles of the Triple Aim Framework are applicable to this and other conditions. In MHCC's view this is an unfortunate omission since statistics demonstrate that people with a mental illness experience coexisting alcohol and other substance misuse problems at far higher rates than the general community. Studies suggest that around 50% of mental health consumers have coexisting difficulties. It is important, then, that both conditions are addressed simultaneously in order to optimise outcomes.<sup>11</sup> Likewise, MHC's paper focuses on 'serious' and/or 'severe' mental health (defined as 'psychosis') which might possibly disadvantage people experiencing varying degrees of depression, anxiety, trauma-related distress, alcohol and other substance issues.

The AHPC lists foremost in its plan for action "an initial road map towards integrated health care for mental and physical chronic diseases" and that PHNs "...can act as catalysts of the future system. Quality and safety standards for PHNs should address greater integration of care for people with complex conditions. Performance expectations should be developed for PHNs consistent with the objectives of the Triple Aim approach." In our view this approach will include the need to address coexisting and complex psychosocial disability, which will require that CMOs are understood as key service providers in this space. This is not evident in the AHPC's (p. xi) plan for action. The MHC paper refers to local initiatives, but only provides two examples of programs - one in the public and one in the community sector (Schizophrenia Fellowship) with

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<sup>9</sup> The King's Fund 2016, 'Bringing together physical and mental health: A new frontier for integrated care', UK, Authors: Naylor, Das, Ross, Honeyman, Thompson & Gilbert, Available: <http://www.kingsfund.org.uk/publications/physical-and-mental-health> (Accessed April 2016).

<sup>10</sup> Ibid.

<sup>11</sup> Drug and Alcohol Services South Australia (DASSA) Clinical Services and Research, 2008, 'Comorbidity of mental disorders and substance use: A brief guide for the primary care clinician, Drug and Alcohol Services South Australia, Author: Author: Dr Andrea Gordon, Adelaide, South Australia; AIHW analysis of National Survey of Mental Health and Wellbeing 2007, Commonwealth of Australia, Available: [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/FE16C454A782A8A8AFC2575BE002044D0/\\$File/mono71.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/FE16C454A782A8A8AFC2575BE002044D0/$File/mono71.pdf) (Accessed April 2016).

little evidence about data gathering and outcome studies undertaken by a range of community organisations concerning their programs.

Numerous CMOs have established programs that have embedded robust data measurement and evaluative processes. Some have initiated research studies to inform further development of programs and services (see Appendix)<sup>i</sup>.

The King's Fund paper<sup>12</sup> describes examples of where integrated multidisciplinary teams in the community are a key mechanism for co-ordinating the care provided to people with multiple or complex chronic conditions. A successful example of integration at this level is the 3 Dimensions of care for Diabetes (3DfD) service in South London, which provides integrated care for the physical, mental and social aspects of diabetes (p.50 & Appendix A). The service is "specifically targeted at people with poor glycaemic control, and serves a highly mixed population, some of whom have multiple complex co-morbid conditions and high levels of social deprivation." While inclusion of a mental health professionals in multidisciplinary team meetings is increasingly common in diabetes care in the UK, the 3DfD model goes further than most by having a wider range of mental health professionals, including social support workers, fully integrated in the team. As an enabler of change at the organisational level, 'acute trusts' are encouraged to appoint a board-level champion for mental health, and mental health trusts should consider appointing a board-level champion for physical health. Commissioners are expected to recognise and support the important role that community sector and voluntary organisations can play in helping people to deal with the psychological challenges of living with a long-term condition. Evaluation and sharing of knowledge is encouraged from specialties where, for example, support for the psychological aspects of physical illness is increasingly seen as a routine part of care.

In a service commissioned by Lambeth and Southwark Clinical Commissioning Groups, 3DfD integrates medical, psychological and social care delivered by a multidisciplinary team comprising a consultant diabetologist, a consultant liaison psychiatrist, a clinical psychologist and two community support workers. The team works across three trusts in the London metro area giving equal attention to a person's' biopsychosocial<sup>13</sup> needs. Members of the integrated team can address them simultaneously, which means there is no need for multiple referrals to separate services.

### **Integrated care across population health systems**

Integrated care has become a key focus of health service reform in England in recent years, as a response to fragmentation within the NHS and social care system. Yet efforts to integrate care services have rarely extended into a concern for the broader health of local populations and the impact of the wider determinants of health. The experience in the UK is quite similar to what is being discussed in Australia, and in reviewing numerous international and Australian papers the issue arises of needing to think beyond integrated care to population health systems.

AHPC's paper suggests that PHNs may fail to achieve their potential without deliberate strategies to move beyond narrow interpretations of integration where the fundamental unit of

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<sup>12</sup> The King's Fund 2016, 'Bringing together physical and mental health: A new frontier for integrated care', UK, Authors: Naylor, Das, Ross, Honeyman, Thompson & Gilburt, Available:

<http://www.kingsfund.org.uk/publications/physical-and-mental-health>, Available:

<http://www.kingsfund.org.uk/publications/physical-and-mental-health>

<sup>13</sup> The biopsychosocial model ("BPS") is a broad view that attributes disease causation or disease outcome to the intricate, variable interaction of biological factors (genetic, biochemical, etc), psychological factors (mood, personality, behavior, etc), and social factors (cultural, familial, socioeconomic, medical, etc). Available:

[https://en.wikipedia.org/wiki/Biopsychosocial\\_model](https://en.wikipedia.org/wiki/Biopsychosocial_model)

intervention is individual patients, to a broader focus on population health. International case studies, including that of Kaiser Permanente,<sup>14</sup> summarised in a recent report by the King's Fund (Alderwick et al., 2015)<sup>15</sup> suggest that this requires a profound shift at three broad levels: macro, meso and micro.

- **At the macro level**, integrator organisations use a population-level lens to plan programmes and interventions across a range of different services and sectors. Key features include: population-level data (to understand need across populations and track health outcomes); population-based budgets (either real or virtual) to align financial incentives with improving population health; and involvement of a range of partners and services to deliver improvements.
- **At the meso level**, integrator organisations have developed different strategies for different population segments, according to needs and level of health risk. Key features include: population segmentation and risk stratification; strategies targeted at different population segments; and developing 'systems within systems' with relevant organisations, services and stakeholders.
- **At the micro level**, integrator organisations deliver various interventions (including housing support, education programmes, employment advice and smoking cessation services) to improve the health of individuals. Key features include: integrated health records to co-ordinate services; scaled-up primary care systems; close working across organisations and systems to offer a wide range of interventions; and close working with individuals to support and empower them to manage their own health.<sup>16</sup>

The King's Fund paper<sup>17</sup> challenges us to conceptualise integrated care as part of a broader shift away from fragmentation towards an approach focused on improving population health, drawing upon examples from organisations and systems in other countries that are making this shift. It is clear that improving population health is not just the responsibility of health and social care services or of public health professionals – it requires co-ordinated efforts across population health systems.

The APHC and the King's Fund (Naylor et al. 2016)<sup>18</sup> papers also refer to the Kaiser Permanente (KP) model<sup>19</sup> in the US: the nation's largest not for profit integrated health care system. KP's financial incentive is to provide high quality, affordable care and manage population health. KP-California is often seen as a prime example worldwide of integrated care. The aligned structure and underlying contractual relationship between entities has led to the design of an efficient acute care delivery system that addresses consumers' needs across the continuum of

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<sup>14</sup> The Brookings Institute 2015, 'Kaiser Permanente – California: A Model for Integrated Care for the Ill and Injured', Available: <http://www.brookings.edu/~media/Research/Files/Papers/2015/05/04-emergency-medicine/050415EmerMedCaseStudyKaiser.pdf?la=en>

<sup>15</sup> The King's Fund 2015, 'Population health systems: Going beyond integrated care', Authors: Adlwich H Ham C & Buck D, Available: [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/population-health-systems-kingsfund-feb15.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf)

<sup>16</sup> The King's Fund 2015, 'Population health systems: Going beyond integrated care, Authors: Adlwich H Ham C & Buck D, Available: [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/population-health-systems-kingsfund-feb15.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf) (Accessed April 2016).

<sup>17</sup> Ibid.

<sup>18</sup> The King's Fund 2016, 'Bringing together physical and mental health: A new frontier for integrated care', UK, Authors: Naylor, Das, Ross, Honeyman, Thompson & Gilbert, Available: <http://www.kingsfund.org.uk/publications/physical-and-mental-health> (Accessed April 2016).

<sup>19</sup> The Brookings Institute 2015, 'Kaiser Permanente – California: A Model for Integrated Care for the Ill and Injured', Available: <http://www.brookings.edu/~media/Research/Files/Papers/2015/05/04-emergency-medicine/050415EmerMedCaseStudyKaiser.pdf?la=en> (Accessed April 2016).

care and maximises population health. To facilitate care, physicians have access to a plan-wide electronic health record (EHR) system that contains every member's complete ambulatory and hospital medical history.

KP is a pre-paid integrated system consisting of three distinctly separate, but related entities: a health plan that bears insurance risk, medical groups of physicians, and a hospital system. The financial incentive is to provide high quality, affordable care and manage population health rather than generating a high volume of compensable services. Both the health plan and the medical group are aligned and accountable for a global budget, and only contract directly with one another for the provision of medical services. All three entities share in the goal, reflected in the KP's capped payment system, of keeping patients healthy while optimising utilisation. This alignment is crucial in KP's effort to maintain affordability for their purchasers and members.

As well as focusing on improving members' health, Kaiser Permanente has been involved for a number of years in efforts to improve the 'total health' of the broader communities it serves. For example, to help improve the availability of healthy food, Kaiser Permanente supports food stores in deprived areas to stock fresh fruit and vegetables, sets up farmers' markets at Kaiser Permanente facilities and in the community. It also provides financial support for a wide range of assistance programmes including community health initiatives to support the development of place-based interventions to improve population health. It has sponsored or co-founded more than 40 Healthy Eating Active Living (HEAL) collaborations since 2006.

### **What would a more integrated approach look like?**

Taking a population health perspective on integrated care puts the integration of mental and physical health centre stage. The APHC and Alderwick et al. (2015)<sup>20</sup> make the case for building closer connections between integrated care and public health. However, MHCC point out that throughout the APHC paper what is stressed is the integration of 'clinical' care for people with "chronic complex health conditions" across service systems and barely mentions the biosocial approach which is central to both King's Fund papers.

If, as Naylor et al. (2016)<sup>21</sup> propose, those leading integrated care initiatives move their emphasis from "the care of patients to the health of populations" this will require that they also assume a health inequalities perspective, and broaden the focus to consider the role of social determinants of health.<sup>22</sup> In this context, integration of mental and physical health must be central, for two reasons. First, the premature mortality of people with mental illnesses is one of the starkest health inequities in the UK today. Second, the relationship between mental and physical ill health is closely associated with social deprivation (Barnett et al. 2012)<sup>23</sup>, and represents a way in which inequities are perpetuated and become entrenched.

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<sup>20</sup> Alderwick H, Ham C, Buck D 2015, 'Population health systems. Going beyond integrated care', London: The King's Fund, Available: [www.kingsfund.org.uk/publications/population-health-systems](http://www.kingsfund.org.uk/publications/population-health-systems) (Accessed April 2016).

<sup>21</sup> The King's Fund 2015, 'Population health systems: Going beyond integrated care, Authors: Adlwich H Ham C & Buck D, Available: [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/population-health-systems-kingsfund-feb15.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf) (Accessed April 2016).

<sup>22</sup> *ibid* p.68

<sup>23</sup> Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B 2012, 'Epidemiology of multi-morbidity and implications for health care, research, and medical education: a cross-sectional study', *The Lancet*, vol 380, no 9836, pp 37–43.

The King's Fund (2016) propose that "a more integrated approach to population health would tackle the determinants of poor physical and mental health in a co-ordinated way, using 'place-based' approaches to combine resources from different sectors."<sup>24</sup> In this approach, mental health and wellbeing would be central to joint strategic needs assessments (JSNAs) with health and wellbeing strategies giving particular priority to improve mental and physical health in care planning. These might include: promotion of physical activity (Institute of Health Equity 2014;<sup>25</sup>Rosenbaum et al., 2014);<sup>26</sup> prevention of harmful substance use; and engagement with programs that enhance social interaction, facilitate social cohesion and reduce isolation (Economic and Social Research Council 2013;<sup>27</sup>Jenkinson et al 2013).<sup>28</sup>

A concerning feature of most of the papers reviewed was the absence of a well-articulated philosophy and practice approach to integration. MHCC are pleased to note that integration in the context of mental and physical health was underpinned in MHC's paper by reference to trauma-informed recovery oriented principles and practice. Nevertheless, MHCC would have liked to see this more robustly embedded in the discussion particularly in relation to the workforce skills and competencies necessary to work in this context.

Finally, MHCC highlight another important aspect of these deliberations, which is to ensure that alongside the literature informing these papers, that broad-based consultation processes are established in governance structures and that the voice of consumers and carers is central to ensuring that services meet their expectations.

## Conclusion

MHCC's position is that we seek to support current imperatives for the integration of mental and physical health services to provide improved outcomes for consumers. This we propose whilst highlighting the paradox of a strengthening in the perceived policy imperative for more integration, alongside an absence of robust evidence that integration initiatives have delivered better health and wellbeing outcomes.<sup>29</sup> We also draw attention to the multiplicity of meanings associated with integration and its attachments and the scope for ambiguity, contention and confusion to which this characteristic may give rise.<sup>30</sup> Cameron et al., (2012) and other reviewers point out that evidence is starting to accumulate on the impact of integration on outcomes, including those based on what is important to service users.<sup>31</sup>

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<sup>24</sup> The King's Fund 2015, 'Population health systems: Going beyond integrated care, p.23, Authors: Adlwich H Ham C & Buck D, Available: [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/population-health-systems-kingsfund-feb15.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf) (Accessed April 2016).

<sup>25</sup> Institute of Health Equity 2014, 'Local action on health inequalities: improving access to green spaces', London: Public Health England, Available: <https://www.gov.uk/government/publications/local-action-on-health-inequalities-evidence-papers> (Accessed on April 2016).

<sup>26</sup> Rosenbaum S, Tiedemann A, Sherrington C, Curtis J, Ward PB 2014, 'Physical activity interventions for people with mental illness: a systematic review and meta-analysis', *The Journal of Clinical Psychiatry*, vol 75, no 9, pp 964–74.

<sup>27</sup> Economic and Social Research Council 2013, 'Mental health and social relationships. Swindon: Economic and Social Research Council', Available: <http://www.esrc.ac.uk/news-events-and-publications/evidence-briefings/mental-health-and-social-relationships/> (Accessed on April 2016).

<sup>28</sup> Jenkinson CE, Dickens AP, Jones K, Thompson-Coon J, Taylor RS, Rogers M, Bamba CL, Lang I, Richards SH (2013). 'Is volunteering a public health intervention? A systematic review and metaanalysis of the health and survival of volunteers'. *BMC Public Health*, vol 13, no 1, p 773, Available: <http://bmcpubhealth.biomedcentral.com/articles/10.1186/1471-2458-13-773> (Accessed April 2016).

<sup>29</sup> Dickinson H 2012, *Policy and practice in the reform of health care*, Palgrave Macmillan

<sup>30</sup> Cameron A Lart R Bostock L & Coomber C 2012, 'Factors that promote and hinder joint and integrated working between health and social care services', Research Briefing 41, Social Care Institute of Excellence, London.

<sup>31</sup> Ibid.

Authors of the literature, particularly in the UK ask that we pause to consider how far the criteria for integration is shaped by findings when there is little or no evidence for the impact of integration on outcomes. MHCC therefore propose that whilst strongly supporting initiatives that aim to improve mental and physical health, that integration be well defined and that data collection reviews of outcomes are implemented as a key strategy for ensuring quality improvements and evaluating practice. At the very least we seek to highlight the tensions that exist, to prompt further thought and questioning in the design of future integrated models of care in Australia.

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## **i Appendix**

Note: the following organisations have given permission to be listed in the appendix to this paper.

**Title:** New Moves Program

**Organisation:** The Schizophrenia Fellowship of NSW

**Type of Approach:** Group-based health promotion and exercise program

**Description:**

The New Moves program was developed to address the physical health and recovery needs of mental health consumers in a fun and socially interactive environment. The free program is delivered in a group setting over sixteen weeks, and is facilitated by a peer educator, an exercise physiologist and a staff member. Each session includes cardiovascular and strength training exercises, food preparation and a health discussion topic. Consumers are offered the opportunity to be trained as a peer educator and to co-facilitate future programs once they complete the program.

**Title:** The Health Prompt

**Organisation:** Neami National

**Type of Approach:** One-to-one consumer health check tool

**Description:**

The Health Prompt is a tool developed by Neami to guide workers in conversations around physical health with consumers. The purpose of the tool is to improve the physical health outcomes of consumers by increasing awareness of health needs, improving the confidence of staff in providing physical health information and referrals, and increasing the regularity and quality of physical health checks. Consumers are offered the opportunity to complete the tool on a six monthly basis; their responses are recorded and consumers are supported to engage with appropriate health services and to develop follow-up plans.

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The Health Prompt is accompanied by a comprehensive guide that provides staff with information about particular health areas and provides links to further information. Information to support culturally appropriate administration of the tool is also provided. Staff receive training in the use of the tool as part of their induction to Neami and an ongoing program of training to improve their own health literacy. The tool has also been translated into Auslan and is available in an audio-visual format.

NEAMI are currently conducting a research project in partnership with the University of Wollongong which examines health literacy across the areas of smoking, oral health, physical health prompts, healthy behaviours and chronic disease. Results will be published shortly.

**Title:** Back On Track Health (BOTH) Program

**Organisation:** RichmondPRA

**Type of Approach:** Physical health self-management resources

**Description:**

The Back On Track Health (BOTH) Program was developed by RichmondPRA to support people with a lived experience of a mental health issue to identify and manage their own physical health and wellbeing needs. People are invited to use the Camberwell Assessment of Needs Short Appraisal Summary (CANSAS) to identify any unmet physical health needs they have. People can access the My Health Needs Checklist – a self-management tool designed to assist a person to review all aspects of their physical health and highlights any needs that they would like to address and/or talk to a health professional about.

As part of the BOTH program, people are also able to access a variety of information resources and tools to support them to keep their health on track including planning, facilitating, and participation in locally-run physical health and wellbeing promotions.

**Title:** Breathe Easy Program

**Organisation:** Uniting Mental Health

**Type of Approach:** One-to-one support program

**Description:**

The Breathe Easy Program assists consumers who wish to reduce or cease their smoking behaviours. The program promotes the benefits of smoking reduction, provides financial assistance for the purchase of nicotine-replacement therapies, and supports staff to encourage consumers to change their smoking behaviours within a recovery framework. The program is integrated into various Uniting Mental Health programs for consumers.

**Organisation:** MoodActive

**Type of Approach:** Group exercise program

**Description:**

MoodActive is a volunteer-run community program in eastern and central Sydney consisting of group exercise classes for people experiencing mood disorders. The groups use a range of assessment tools, developed with input from the Black Dog Institute, to evaluate consumers' health progress. Consumers can be referred to MoodActive's physical health groups via self-referrals or a referral from a mental health clinician.

**Title:** YMCA Brightside Mental Health & Wellbeing Program

**Organisation:** YMCA Brightside

**Description:**

YMCA Brightside Mental Health & Wellbeing program offers opportunities for mental health consumers to improve their physical, social and mental health and wellbeing. The free program runs for 60 days, providing unlimited access to the YMCA's facilities, as well as a customised exercise program and one-on-one support. It aims to orient individuals into a customised

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exercise program, eliminate or minimise factors which give rise to distress and loss of wellbeing, and maximise factors that create a pathway to ongoing regular exercise.

YMCA Brightside Mental Health & Wellbeing program was established based on current research which highlights the positive effects of physical exercise on mental health. Designed in collaboration with Suicide Prevention Australia and the Black Dog Institute, the Y's Brightside program has assisted over 500 people since it began in 2009.

**Organisation:** Mental Health Sports Network under the auspices of The Schizophrenia Fellowship NSW, Inc

**Type of Approach:** Community events program

**Description:**

The Mental Health Sports Network consists of approximately 10 events per calendar year designed around promoting community involvement in group-based physical activity. Examples of events include sporting camps, gala days and tournaments. The aim of the MHSN to give people experiencing mental distress opportunities to improve their social, physical, and mental well-being through engagement in sporting activities.

**Title:** Exercise Your Mood Month

**Organisation:** BlackDog Institute

**Approach:** Community Awareness Campaign

**Description:**

Exercise Your Mood Month is the Black Dog Institute's annual national fundraising campaign every September to increase community awareness about the importance of regular exercise for maintaining good mental health. People of all ages can participate in either an individual or group exercise throughout the month, by organising their own activity or participating in one of the many *Exercise Your Mood* community events.

**Title:** Healthy Living Guide

**Organisation:** SANE Australia

**Approach:** Health promotion, health literacy, and information resources

**Description:**

SANE Australia have developed several information resources for mental health consumers to address their physical health needs. The *Healthy Living Guide* consists of factsheets on physical and mental health, accessible online for free. Additionally, consumers and mental health workers can purchase SANE's *Healthy Living DVD* and *Smokefree Kit*, which provide guided sessions, activities, and further resources.