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Focusing on the relationship between
physical and mental health





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Editorial

Welcome to the Autumn/Winter 2018 edition of **newparadigm**: *Improving physical health outcomes of people with mental illness.*



Angus Clelland, CEO,
Mental Health Victoria

One of the articles in this edition, by Amy Wallace, a Clinical Nurse Specialist for Physical Health Care at Graylands Hospital, a large metropolitan mental health inpatient service in Perth, tells the story of 'Bob'.

He is, she writes, a 58 year old inpatient of a secure acute psychiatric ward who presented as "highly disorganised and disoriented" and at times required full nursing care.

One day, he meandered into the service's new sports therapy group, joined in a game of cricket and is now "the reigning cricket champion of his ward", getting much meaning and pleasure from being involved in regular games.

It's a powerful and personal glimpse into the connection between mental and physical health - and ill health - which is at the heart of this edition of newparadigm.

Its theme arises from the work of the National Mental Health Commission towards bridging the life expectancy gap for people with mental illness through improved physical health.

As each of the articles attest through varying lenses, there is an urgent need to act. People with a mental illness have poorer physical health and live between 14-23 years less than the general population, yet they receive less and lower quality health care.

There are many reasons for the physical toll on people with mental health issues. They include, often, the mental illness itself and side effects of antipsychotic medication.

But just as critical are many systemic and practice barriers in mental health care, including stigma and discrimination, fragmentation of health services, and 'diagnostic overshadowing' - where people with mental illness experience harmful delays in diagnosis and treatment of physical illness because their symptoms are seen as mental health issues.

The edition opens with an overview from **Dr Peggy Brown**, CEO of the National Mental Health Commission, which has won strong support from a broad range of stakeholders for the *Equally Well* strategy which aims to improve the quality of life of people living with mental illness through equal access to quality health care. She writes that Equally Well is fundamentally about changing practice across the systems that support people living with mental illness.

Professor Maria Duggan and Ben Harris from the Australian Health Policy Collaboration at Victoria University also make the case for an integrated approach to mental and physical health care – ‘healing body and mind’, given that physical illness comorbidities are the rule rather than the exception for people with severe mental illnesses.

Mapping the intersecting issues, including poverty and disadvantage, they say there is an urgent need for clarity about where responsibility resides for addressing the physical health of mentally ill people at all levels of the system, and that “vague exhortations” that ‘this is everybody’s business’ are not enough.

Their concern about fragmented structures and practices is also shared by **Professor Tim Lambert** who says repeated calls to action to deal systematically and comprehensively with multi-comorbidity in people with serious mental illness have largely fallen on deaf ears in the past.

He outlines the work of the Collaborative Centre for Cardiometabolic Health in Psychosis (ccCHiP) as a replicable, scalable clinical model of care that can overcome traditional disciplinary silos. But, given ccCHiP can only target a limited cohort, he says there is still a ‘dearth of services and interventions’ available to help improve the global health outcomes for those with enduring psychotic illnesses.

However, there is much work now looking to fill these gaps. Our contributors highlight a number of services and interventions that are offering pathways to better practice and better health outcomes.

Among them:

- **Neami National** introduced a physical health screening questionnaire (the ‘Health Prompt’) to start and guide conversations between mental health staff and consumers, which has been found to deliver strong benefits, including improved attitudes, behaviours and outcomes related to physical health.
- That prompt also became part of the innovative Physical Health Action Team (PHAT) project in South Australia, with Neami and the **Central Adelaide Local Health Network** which also set up physical health ‘stations’ in mental health service sites and physical health action days in a mental health service environment.
- A peer mentoring program introduced by Eating Disorders Victoria and the Austin Hospital in Melbourne has been an “extraordinary initiative”, providing hope, inspiration and confidence for people with eating disorders and for their mentors.
- Including its sports therapy program, Perth’s Graylands Hospital designed and introduced a series of projects to address preventable physical health conditions experienced by its patients. They included the introduction of a new role – Clinical Nurse Specialist for Physical Health Care – plus a Wellness Clinic, all aimed at improving the overall physical health of inpatients, at both individual and group levels.
- **Associate Professor Kim Ryan**, CEO of the Australian College of Mental Health Nurses, outlines a number of initiatives that aim to give fuller rein to the skillset that mental health nurses can bring to physical health needs of patients. She explores the barriers now limiting integrated care and outlines opportunities for having mental health nurses and the broader nursing workforce able to work to their full scope of practice.
- The **Smile for Health** program for people living with severe mental illness, a partnership program between Neami National and the Melbourne Dental School, is believed to be the largest scale oral health promotion program conducted in a community mental health service in Australia, and internationally. It has been breaking through the anxiety, phobia, cost of care and communication issues that are barriers for people with mental health issues to accessing timely dental care.
- Cancer Council Victoria issues a call to action to mental health facilities and professions to consider smoking a social justice issue for people with mental health issues. It cites the mounting evidence for the need to offer help for people with mental health issues to quit smoking, rather than “killing them with kindness” by seeing it as a right or comfort, and offers tips and supports to assist people to quit.

Finally, **Dr Cathy Kezelman**, President of Blue Knot Foundation – National Centre of Excellence for Complex Trauma, writes comprehensively about the role of unresolved trauma, especially childhood (complex) trauma, on both long-term mental and physical health. Urging better ‘trauma literacy’ in primary care, she says lack of support not only undermines people’s psychological and physical health but also their capacity for healthy relationships, educational opportunities and ongoing work participation.

We hope you find much of interest in this edition.

As always, we thank the contributors for their generosity in sharing their research and work with our readers and the newparadigm Journal Editorial Group. I also thank the Mental Health Victoria team for their valuable work.

Bridging the life expectancy gap for people living with mental illness through improved physical health



The interaction of mental illness with other chronic diseases is one of Australia's biggest public health challenges.



Dr Peggy Brown, AO, former Chief Executive Officer and Commissioner, National Mental Health Commission

Almost four in every five people living with mental illness have a coexisting mortality-related physical illness (Australian Bureau of Statistics 2015). International evidence confirms that people living with severe mental health disorders have higher mortality rates than the general population with a notable life expectancy gap of between 10 and 20 years (Erlangsen et al. 2017, p. 937).

This inequality in life for people living with severe mental health disorders is attributable in part to individual, social, and system risk factors such as poor diet, heavy smoking, drug and alcohol use, poor physical activity, low investment in quality care, fragmentation of health services, side effects from antipsychotic medications, low health literacy, and experiences of stigma and discrimination (Liu et al. 2017, p. 31; Nursing, Midwifery and Allied Health Professions Policy Unit 2016).

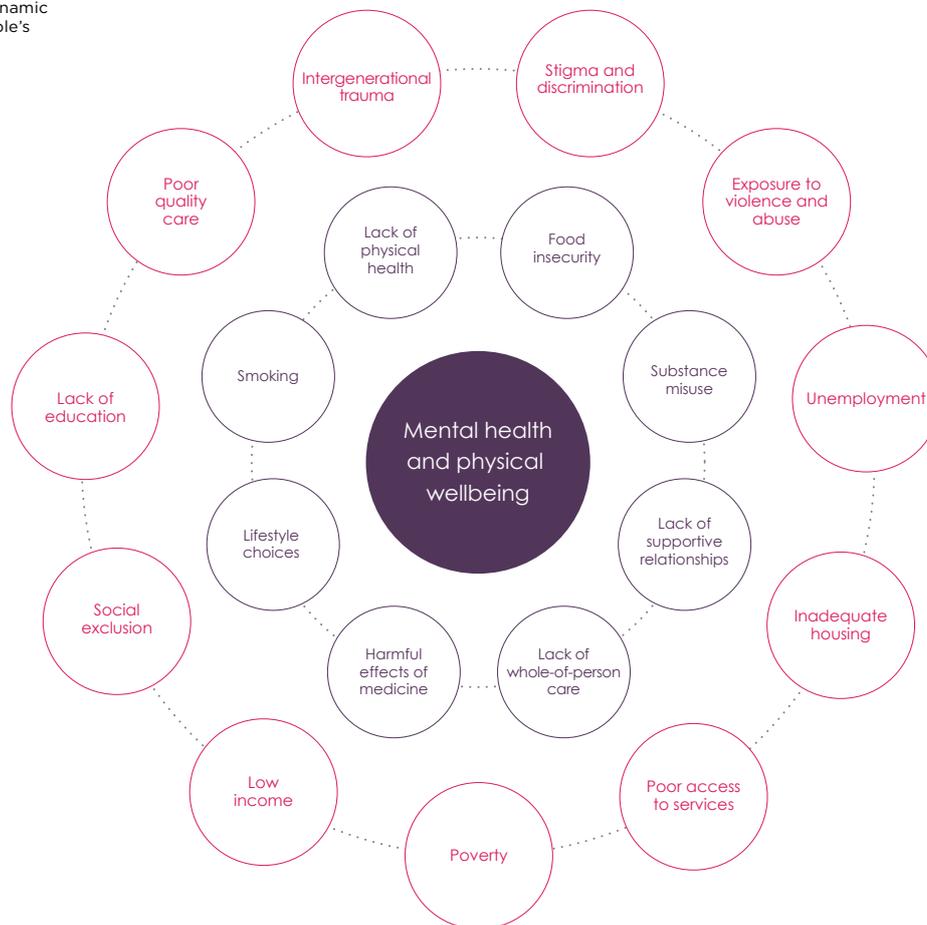
Recent reports highlight the stark reality that the physical health concerns of people living with mental illness continue to go unrecognised, undiagnosed, and untreated. Despite increased awareness and mental health reform over recent years, people living with severe mental health disorders have two times as many health care contacts as the general population, but they receive fewer physical health checks and screenings (Liu et al. 2017, p. 31).

The high prevalence of coexisting physical and mental health conditions results in high economic costs to society, including costs incurred by direct mental health services and parallel services such as community services, housing, and criminal justice (RANZCP 2016, p. 7). The Royal Australian and New Zealand College of Psychiatrists (RANZCP) estimates the cost of premature death from coexisting physical and mental health conditions in people with serious mental illness to be \$15 billion per annum (RANZCP 2016).

The National Mental Health Commission's vision is to help people in our communities who experience mental health difficulties, and their families, to live a 'contributing life', in whatever way that means for them.

A contributing life is where those of us living with mental illness can expect the same rights, opportunities and health as the wider Australian community. It is a life enriched with close connections to family and friends, supported by good health, wellbeing and health care. It means having a safe stable and secure home and having something to do each day that provides meaning and purpose, whether this is a job, supporting others, or volunteering. This requires a shared vision, long-term strategies, and intersectoral collaboration.

Figure 1: Interrelated dynamic elements affecting people's physical health



Source: National Mental Health Commission 2016, *Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia*, NMHC, Sydney (based on UK Nursing, Midwifery and Allied Health Professions Policy Unit 2016)

A strategic approach

Improving the physical health of people living with mental illness is a priority in Australia and worldwide. Countries including New Zealand, Denmark, the United States, and the United Kingdom are dealing with similar challenges. The global importance of this public health issue is recognised by the World Health Organisation which has called for integrated and responsive care that meets both mental and physical healthcare needs (World Health Organisation 2013, p. 15).

In Australia, the significant physical health issues faced by people living with mental illness have been highlighted by initiatives such as the *Healthy Active Lives* (HeAL) program and the RANZCP 2014 report *Keeping Body and Mind Together*.

Recognising the need for a strategic approach, the Commission, in its 2014 national review of mental health programs and services, recommended that physical and mental health should be seen as interdependent and mutually integral in promoting the mental health and wellbeing of people (National Mental Health Commission, 2014).

Given that many organisations in both the health and mental health sectors were already committing to the need to improve the physical health of people living with mental illness, the Commission saw an opportunity to develop a National Consensus Statement for Australia known as *Equally Well* which draws on the original *Equally Well* model from New Zealand.

Stakeholders were consulted at every stage of the development process, reflecting a truly national consensus. *Equally Well* now has 73 supporters across Australia who have formally pledged to improve inequalities that lead to poor physical health outcomes for people with mental illness. Supporters include all jurisdictional health departments, state mental health commissions, medical colleges, carer and consumer organisations, Primary Health Networks (PHNs), peak bodies and community managed organisations.

Essential elements

Equally Well includes six essential elements that reflect what best practice should look like. These include:

- a holistic, person centred approach to physical and mental health and wellbeing
- effective promotion, prevention and early intervention
- equity of access to all services
- improving quality of health care
- care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life
- monitoring of progress towards improved physical health and wellbeing.

The essential elements, supported by actions, whilst not an exhaustive list, are incorporated into *Equally Well* to provide stakeholders with guidance on how to effect change in their spheres of influence and make recommendations for what coordinated care should look like.

Silos and other challenges

The concepts that inform integrated and responsive care for people living with mental illness centre on holistic promotion, prevention, and recovery, and are already practiced in various forms by both mental health and health professionals.

One of the challenges to reform, however, is that even the most positive actions do not create change if they occur in silos. What is required are inter-sectoral strategies to ensure that people are receiving the best possible care.

Coordinated care delivered seamlessly across both the mental health and health sectors needs to be prioritised. This should include assessment of coexisting health needs, promotion of the right to equal access to health care, and supports provided by a range of health professionals and service providers to treat physical health needs and to assist people living with mental illness to make lifestyle changes that will improve their physical health outcomes.

Beyond the Consensus statement

At a national meeting with a diverse range of stakeholders that was held in March 2017, priority areas for action were identified. They included:

- training resources such as training packages and tools for consumers and carers
- care collaboration including better coordination with general practitioners, pharmacists, and between mental health and general health services and PHNs
- consumer and carer participation with an emphasis on co-design, developing statements of rights and encompassing existing psychosocial supports.

To continue momentum and progress the principles of *Equally Well*, the Commission established the Equally Well Implementation Committee (EWIC) in July 2017, a national

A contributing life is where those of us living with mental illness can expect the same rights, opportunities and health as the wider Australian community.

leadership group to oversee, lead, and coordinate the implementation of *Equally Well* in Australia. EWIC members represent a broad range of stakeholders including general practitioners, nurses, psychiatrists, Aboriginal and Torres Strait Islander health organisations, private health service providers, consumers and carers, PHNs, governments, community managed organisations, and academics.

All governments have shown a commitment to reducing the mortality rate of people living with a mental illness, evident in the Fifth National Mental Health and Suicide Prevention Plan which was endorsed by the Council of Australian Governments (COAG) Health Council in August 2017.

It calls on governments to develop or update guidelines and other resources that can be used by health services and health professionals to improve the physical health of people living with mental illness in Australia. Additionally, it specifies the need for PHNs and Local Hospital Networks to build into their local treatment plans and clinical governance activity the treatment of physical illness in people living with mental illness (Department of Health 2017, p. 37).

Community action

Considering the high level of commitment received to date, *Equally Well* has the potential to inform better practice and achieve improved health outcomes for people living with mental illness. There are many examples of eminent work being implemented across Australia that demonstrate *Equally Well* in action. Presented here are several examples from the community sector that showcase the shared responsibility of care required to improve the physical health and wellbeing of people living with mental illness.

Reducing risk of weight gain related to antipsychotic medications

In New South Wales, the South Eastern Sydney Local Health District delivers the *Keeping Health in Mind* program where multidisciplinary teams consisting of a nurse, exercise physiologist, dietician and peer support worker, provide integrated care to people prescribed antipsychotic medications.

The program is an evidence-based model of care supporting people living with mental illness with the skills necessary to address risk factors including poor diet, lack of exercise, smoking and stress (NSW Government 2018). The efficacy of the *Keeping Health in Mind* program has been tested among young people with first-episode psychosis who are often at risk of experiencing significant weight gain, insulin resistance, hypertension, and metabolic syndrome when commencing antipsychotic medications (Curtis et al. 2016, p. 267-268).

The results of a controlled study in two early psychosis community services showed that participants who received lifestyle and life skills interventions such as health coaching, dietetic support, and supervised exercise treatment, gained a substantially lower level of weight (1.8 kilograms) compared to those participants who received standard care solely (7.8 kilograms) (Curtis et al. 2016, p. 267).

Smoking cessation support

Lifestyle changes are a particularly important contribution to the prevention of physical diseases, given that behavioural factors can contribute to 40 per cent of premature deaths among people living with severe mental illness (Linde-Feucht 2007). Smoking is a major behavioural risk factor for preventable diseases including heart disease, stroke, and cancer (Quit Victoria 2018). Considering that people living with mental illness are two times more likely than the general population to smoke (Lê Cook 2014, p. 173), educating and supporting them to make lifestyle changes is a critical step in reducing the risk of premature mortality and improving their physical health and wellbeing.

In Queensland, the Mental Health Clinical Collaborative leads an innovative program for smoking cessation which uses incentive payments to reward hospital and health services when they assess the smoking status of patients and refer them to services such as Quitline or their local GP for smoking cessation support (Queensland Health 2017, p. 16). The collaboration between dentists and oral health professionals, nurses, pharmacists, allied health professionals, and mental health staff has seen a significant increase in referrals to local services. Between August 2016 and January 2017, dental practitioners made 1,701 referrals to Quitline compared with 1,451 referrals made by all other health practitioners combined (Queensland Health 2017, p. 16).

Quit Victoria has also acknowledged people living with mental illness as a priority population and is working to support them towards a healthier lifestyle. This includes advocating options for addressing smoke infiltration in shared and personal living areas such as community mental health settings, and working with a range of clinical and community mental health services to pilot the NSW Cancer Council's *Tackling Tobacco* program for people living with mental illness (Quit Victoria 2016).

Conclusion

Equally Well has been very well received in Australia and is testament to the continued determination of the mental health sector to improve the physical health and wellbeing of people living with mental illness. *Equally Well* is fundamentally about changing practice across the systems that support people living with mental illness so they can lead a contributing life and live in thriving communities.

In order to achieve this, there needs to be coordinated and ongoing commitment to drive change and deliver action that bridges the life expectancy gap between people living with mental illness and the general population. This must be done in partnership with people with lived experience of mental illness, their families and other support people, and with local communities and organisations that can respond to local need through improved coordination of integrated services.

By working together, people living with coexisting mental health and physical health conditions will receive more comprehensive assessment, earlier intervention, person-centred treatment, and quality care. Effective mental health care will lead to improved health outcomes including better management of mental and physical health conditions, reduced risk factors, and improved life expectancy. Other recognised benefits include reducing costs over the longer term in health and other areas such as welfare, employment, justice, and housing and homelessness services.

To sign up and support *Equally Well* please visit the website: www.equallywell.org.au

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Healing body & mind: the case for an integrated approach to mental and physical health care

Physical illness comorbidities are the rule rather than the exception for people with severe mental illnesses. Comorbidities are associated with significantly higher rates of premature mortality and much higher costs to individuals, health systems and the economy. Many comorbidities are preventable. Services and practices must adapt to grasp this preventative potential.



Maria Duggan is Adjunct Professor of Health Policy at the Australian Health Policy Collaboration at Victoria University

Mental illnesses in interaction with other chronic diseases represent one of the biggest challenges to public health systems in Australia. About 12 per cent of the Australian population is estimated to have both a mental disorder and a chronic physical health condition.

Comorbidities, defined as the presence of two or more chronic medical conditions, are common for people with mental ill health and contribute to the significant gap in life expectancy between people with severe mental illnesses and the rest of the population (Lawrence et al. 2013). Men and women have different patterns of mental illness and associated comorbidities across the life course (Australian Bureau of Statistics 2008).

The relationship between mental and physical health is bi-directional. People with chronic ill health are much more likely to experience mental health problems than the general population (Australian Bureau of Statistics 2016a).

There is particularly strong evidence for a close association between cardiovascular diseases (Fenton & Stover 2006; Goodwin et al. 2009), diabetes (Fenton & Stover 2006), chronic obstructive pulmonary disease (Livermore et al. 2010; NICE 2009) and musculoskeletal disorders (Sheehy et al. 2006).

There is also evidence of extensive mental health problems among people with a range of other conditions including asthma, cancer, arthritis and HIV/AIDS (Naylor et al. 2014). Co-morbid mental health problems are exacerbated if people have multiple, long-term physical illnesses (Gunn et al. 2010).

People with severe mental illnesses are also more likely to have poor physical health. According to the 2010 Australian 2nd National Survey of Psychotic Illness, over one-quarter (26.8 per cent) of survey participants had heart or circulatory conditions and one-fifth (20.5 per cent) had diabetes (Morgan et al. 2012). The prevalence of diabetes among this group is more than three times the rate in the general population.

The mortality rate from physical illness among people living with mental illness is significantly higher than in the general population (Lawrence et al. 2013). People living with schizophrenia die on average 10 years earlier than the general population; two thirds of this excess mortality is due to poor physical health (Lawrence et al. 2013).



Ben Harris is Manager National Policy and Strategy at the Australian Health Policy Collaboration at Victoria University

The burden of co-morbid chronic diseases in people with mental ill health affects the individual, their families and carers, Australian society and the economy.

Moreover, chronic illnesses develop at a younger age for people living with mental health issues and kill earlier, with five-year survival rates reduced by up to 16 per cent compared with the general population (Disability Rights Commission (UK) 2006).

The evidence suggests that almost 80 per cent of excess deaths among people with severe mental illnesses are the result of chronic physical health conditions (Sweeney & Hui 2016). These deaths are mostly caused by illnesses that can be prevented or treated successfully in the community, including heart disease, diabetes, respiratory disease and cancers. The gains made in the treatment of these and other chronic conditions in recent decades have not occurred for people with mental illnesses.

A costly burden

The burden of co-morbid chronic diseases in people with mental ill health affects the individual, their families and carers, Australian society and the economy.

Comorbid mental and physical health problems appear to have a greater effect on functioning and quality of life than the severity of any physical illness (Moussavi et al. 2007). People with multiple mental and physical health conditions are 60 per cent more likely not to participate in the labour force, than those without chronic disease and are more likely to be absent from work (Australian Institute of Health and Welfare 2009).

In 2014, the additional cost of the physical illness burden of people with severe mental illnesses was \$56.7 billion in Australia (3.5 per cent of GDP) (Sweeney & Hui 2016).

Linking mental and physical health

The mechanisms underlying the relationship between mental and physical health are not well understood. Evidence suggests that a combination of biological, psychosocial, environmental and behavioural factors is involved (Prince et al. 2007). In addition to genetic factors, at different life stages common risk factors and determinants have been identified. These include, but are not limited to:

- **Exposure to adverse life events** across the life course (Case et al. 2005; Wohlfarth et al. 2003; Figueroa-Fankhanel 2014).
- **Risky health-related behaviours**, including smoking (Szatkowski & McNeill et al., 2014), heavy alcohol use and physical inactivity (Morgan, et al. 2014).
- **Lack of adequate physical health status screening**, monitoring and support (Naylor et al. 2014).

- **Polypharmacy** – treatment with several different drugs (Fortin et al. 2007). This is known to create problems with adherence to drug regimens due to side effects that decrease quality of life and increase disorganisation and costs (Fortin et al. 2007; Townsend et al. 2003).
- **Anti-psychotic weight-gain** – people on long-term anti-psychotic medicine, for example, can experience a range of metabolic disorders including weight gain, dyslipidaemia (elevated cholesterol) and diabetes (Alvarez-Jiminez et al. 2010, Leucht et al. 2013, Teff et al. 2013).

Poverty and disadvantage

There is a well-documented social gradient in risk factors and on health status, although comparatively little of this research relates directly to the social determinants of co-morbid physical and mental ill health in Australia. The evidence points strongly to the higher prevalence of various risk factors in localities of low socioeconomic status and in communities characterised by disadvantage including low levels of educational attainment; high levels of unemployment; and substantial levels of discrimination (Dohrenwend et al. 1978; Fryers et al. 2005). This suggests a three-way interaction between social conditions, mental health and physical health.

Aboriginal & Torres Strait Islander people

On a number of measures on comparative health and wellbeing Indigenous Australians have much higher rates of chronic illnesses than other Australians, including significantly higher rates of mental health issues (Australian Bureau of Statistics 2016b). The life expectancy gap between Indigenous Australians and the rest of the population is 11.5 years for men and 9.7 years for women (Australian Bureau of Statistics 2010). It is estimated that 80 per cent of this excess mortality is due to preventable chronic diseases. Given the close association between chronic diseases and mental disorders it is probable that co-morbidities are a major component of this burden.

Fragmented structures and practices and widespread discriminatory attitudes will continue to inhibit an integrated, coordinated response to comorbidities.

Stigma and discrimination

In addition there is extensive evidence that people with severe mental illnesses receive sub-optimal health care despite being at high risk for serious physical disorders (Frayne et al. 2005; Rethink Mental Illness 2013). There may be discriminatory and stigmatising attitudes amongst health care staff in a range of settings which inhibit help-seeking by people with mental illnesses and associated physical health needs (De Hert 2011a).

Inequalities in access to and outcomes of health care are evident in relation to general medicine and cardiovascular care but may also be present in cancer and diabetes care (Mitchell et al. 2012). The Australasian College for Emergency Medicine (ACEM) has published the findings of recent research demonstrating that while mental health presentations account for only around 4 per cent of presentations in hospital emergency departments, this cohort disproportionately experiences delayed or blocked access to necessary treatment compared with patients presenting with other emergency conditions (ACEM 2018).

The mental health reform agenda: Fit for purpose?

Successive governments at state and Commonwealth levels have made commitments to improving the integration of care for people with comorbid mental and physical health conditions. However, these intentions have not consistently translated to better care or better outcomes.

Policies and funding mechanisms for state and territory-managed mental health services and hospitals; Commonwealth-funded general practice, Primary Health Networks and private health insurance; and the National Disability Insurance Scheme, have yet to implement a national mental health reform agenda that creates more integrated services and better outcomes. Rosenberg (2017) has, trenchantly, suggested that these reforms are ill-conceived, lacking in clarity about the level and scale of the required integration. Moreover, they are arguably at odds with each other, focusing on population health planning on the one hand and on person-centered care on the other.

Improving outcomes

National and international evidence suggests that supporting the psychological and mental health needs of people with co-morbid mental health problems can lead to improvements in both physical and mental health (Rosenbaum et al. 2016). Despite this, co-morbid mental and physical health problems are often undetected; where they are detected, care and support for both physical and mental health problems are uncoordinated and ineffective (Naylor et al. McGinty et al. 2015).

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has drawn attention to these pervasive and persistent inequalities in health and reduced life expectancy of people with severe mental illnesses, highlighting the need for high-level commitment to action from all levels of government, from the health systems and from health professionals (RANZCP 2016).

The RANZCP makes recommendations including incorporating health promotion programs such as:

- smoking cessation and weight management as a core element of mental health service delivery
- proactive screening and lifestyle interventions aimed at preventing and managing chronic conditions
- developing integrated pathways to care for people with multiple chronic health conditions.

...there is extensive evidence that people with severe mental illnesses receive sub-optimal health care despite being at high risk for serious physical disorders.

There is some evidence that the message is being heard in some places and that reforms are being attempted, though not yet at a scale that is sufficiently robust to transform experiences or outcomes for one of the most vulnerable and marginalised groups in Australia.

For example, an adaptation of an acclaimed screening and intervention toolkit to support the cardiovascular health of people using antipsychotic drugs has been developed by mental health experts in Sydney (NICE, 2014). This framework has been provided to GPs in the United Kingdom but is not yet in wide circulation in Australia.

There is a growing evidence base regarding the effectiveness of interventions to improve the health of people with comorbidities, with strong evidence of the clinical and cost-effectiveness of models of 'collaborative care' for people with these clusters of conditions (Katon et al. 2010; NICE 2009; McDaid 2011; Knapp et al. 2011; de Hert et al. 2011b).

There is consensus among experts that the way ahead involves:

- improved collaboration across primary, community, secondary and specialist health services
- ensuring that all access points for people experiencing severe mental illness assume responsibility for facilitating physical health assessments and monitoring physical health
- integrating evidence-based, chronic disease prevention approaches into mental illness recovery programs
- ensuring that population-health improvement programs appropriately target people living with severe mental illness and provide support to specialist mental health services to adapt practices to incorporate these approaches.

Implementing these strategic shifts requires a systemic policy approach, attention to workforce capabilities and the establishment of incentives that reward service outcomes not throughputs.

This level of transformation will not emerge overnight but, in the interim, there is much that can be achieved by acting on the extensive evidence that poor health and reduced life expectancy amongst people with severe mental illnesses can be ameliorated and prevented.

Mental health service providers and clinicians in all settings must become aware of the importance of physical health monitoring and interventions and monitor the side-effects of antipsychotic medications. Evidence-based, lifestyle intervention programs must become part of holistic strategies to address modifiable risk factors.

Conclusion

There are doubts that the current trajectory of mental health service reform in Australia is adequate to the task of repairing the systemic cracks through which many people fall. Fragmented structures and practices and widespread discriminatory attitudes will continue to inhibit an integrated, coordinated response to comorbidities.

There is an urgent need for clarity about where responsibility resides for addressing the physical health of mentally ill people at all levels of the system. Vague exhortations that this is 'everybody's business' are not enough. Until accountabilities are clarified and monitored, people with severe mental illnesses will continue to have high levels of unmet physical health needs and to be at risk of premature death from avoidable, chronic health conditions.

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There is no *mental* health. There is no *physical* health. There is... health.

The Collaborative Centre for Cardiometabolic Health in Psychosis was established to be an integrated service for screening, detection, management and follow up of metabolic disorders among patients with serious mental illness. Its approach to physical and mental health and wellbeing provides a model for a replicable, scalable clinical service but also underscores the 'dearth of services and interventions' still generally available to help improve the global health outcomes for those with enduring psychotic illnesses.



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For more than half a century the parlous state of neglect of the physical health co-morbidity of people with enduring and complex psychiatric disorders has been evident (Brown et al. 2000). The most common causes of this increased mortality ratio (as well as increased morbidity) are cardiovascular illness, diabetic-related illnesses, respiratory illnesses, and substance-related disorders (including tobacco).

For the general population, life expectancy continues to grow and yet for those with serious mental illness, death from common, largely treatable/preventable diseases continues to be notably premature resulting in an ever-widening longevity gap (Saha et al. 2007). For people experiencing schizophrenia, bipolar disorder, and major depressive disorder, medical causes of death are often two to three times that of the general population.

Despite reductions in the population rates of cardiovascular illness over the last 30 years, those with serious mental illness continue to have a three-fold difference in mortality rates (Gatov et al. 2017). Repeated calls to action to deal systematically and comprehensively with multi-comorbidity in those with serious mental illness have largely fallen on deaf ears, if the low rate of establishing effective new services in Australia is any measure.

The world-wide 'diabetes epidemic' has impacted heavily on our population and it became clear some time ago that the way forward was to develop truly interdisciplinary models of care that encompassed biological, social and

psychological determinants of illness as both causes and targets of intervention. The result was the development of The Collaborative Centre for Cardiometabolic Health in Psychosis (ccCHiP).

ccCHiP: An integrated one-stop-shop service model

ccCHiP was established in 2008 to develop empirically-driven models of integrated health care for the most vulnerable of psychiatric populations – those with chronic, often refractory psychotic and affective disorders carrying multiple cardiometabolic risks.

It has grown from a single clinic to become a major component of the Sydney Health Partners National Health and Medical Research Centre Translational Research Centre as well as acting as a wellspring for the development of the Living Well, Living Longer program in central Sydney that won the 2017 NSW Innovations Symposium's People's Choice award.

The structure of the ccCHiP clinic (Kritharides et al. 2017) puts into practice a way of working that facilitates integrated care precepts (Figure 1). The ethos and subsequent clinic structure was developed in such a manner so as to overcome the most likely barriers to introducing new models of care; i.e. that reflect integrated care principles rather than traditional psychiatric ones. (For an overview of barriers, see Lambert and Newcomer 2009).

Figure 1. Structure of ccCHiP and its external relationships



Getting to the clinic

Recognising the difficulty clients experience in attending multiple, serial and geographically dislocated assessments, our model provides assessment by up to eight disciplines in a single session. These comprise dietetics, exercise physiology, oral health (dental), nursing, cardiology, endocrinology, sleep medicine, general medical psychiatry, and pharmacology.

For many who experience serious mental illness, one of the central barriers to clinic attendance is the physical act of getting to the appointment. Motivational deficits as part of the core illness, combined with organisational difficulties, positive symptom severity, and a need for adequate, affordable, and well-connected public transport, among other factors, all conspire to reduce attendance (Daniels et al. 2014).

To facilitate turnout, we work with referring teams and GPs to help ensure that the client is accompanied by a care coordinator or family member. Carpooling, usually organised by a care coordinator, provides an efficient method of group transport for those without family supports. In the last year, these approaches have resulted in an attendance rate of 80 per cent of those booked into a clinic, a robust figure given the cohort is drawn from among the most disabling of chronic and severe mental health conditions.

The clinic flow

Clients arrive at the clinic together and are provided with an overview of the purpose of the clinic, a printed list of who they will be seeing, and what will be covered. We have found that accenting the physical health components at the start is helpful in initiating engagement. Enhancing engagement throughout is a key principle in the running of the clinic as it is a long process for each attendee (up to two hours) and they are presented with a lot of information.

Following their arrival, they then move from room to room to visit with various clinicians in a flexible flow matrix. A Peer Support worker, who attends the whole session, helps guide them from clinician to clinician and supports those who may be overwhelmed by the number of clinicians involved.

As a client progresses through each stage of the clinic, an increasingly integrative approach to feedback and discussion is presented so that mental health elements are woven into the medical (and social). For each stage of the visit they can record personal notes or the clinician will summarise 'homework' on their visit attendance list. At each station, the clinician has the option of also providing graphical feedback to the client that reflects their current state (as compared to expected norms), as well as between-visit changes in agreed management targets such as lipid levels, weekly exercise levels, soft drink consumption, etc.

Figure 2A. Framingham Heart Age (FHA) vs. actual age

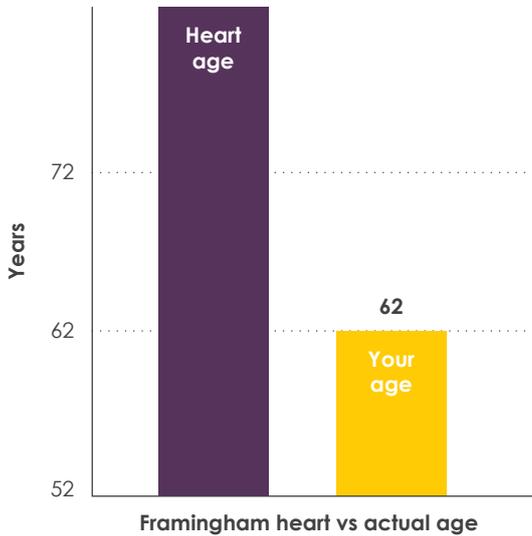
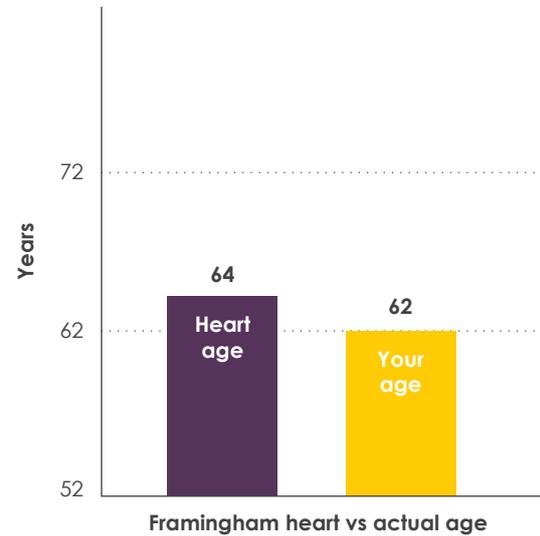


Figure 2B. Simulation of effect on FHA of ceasing smoking and controlling lipids



Taking a visual psychoeducational/feedback approach results in greater immediate apprehension of risks and targets by the client (see below), especially when used within a motivational interviewing style of interaction. In a similar vein, the use of ultra-realistic food models by the dietitian also serves to engage the client more directly, for example, with respect to appreciating the value of portion control.

Clinical synthesis

At the end of the session, the whole team discusses each client in order to provide an interdisciplinary synthesis of the issues presented during the assessment (and incorporating relevant clinical materials assessed prior to the clinic).

This approach obviates the difficulties for the client when specialists and allied health are consulted serially over long periods of time – often there will be differing opinions on treatment and implicit hierarchical impressions may lead to a confused appreciation of which elements of management should be attended to. In the team-based synthesis approach, each clinician's insights and opinions are given equal consideration and the formulation of suggested management is derived on the basis of being the best option for the individual client that is acceptable to the team, the client, and the family.

Embracing IT innovation

To help clinicians work with a lot of information, the service is also innovating in the IT space. The workflow incorporates a bespoke web application that features the functions of a relational database, an adherence promotional tool to assist clients (using a variety of graphics-rich tools), an e-learning tool for multidisciplinary students, and a reporting tool which automates the development of reports for all relevant clinicians involved in the client's care, as well as aggregate reporting for services planning.

Clinicians (with appropriate credentials) can log in to the tool anywhere in the LHD network using any device that can access the internet. During a clinical session, each clinician can immediately review the findings of the other ccCHiP clinicians, consult the background material provided prior to the clinic, examine graphical trends for key parameters over time, and use the app to give feedback to the patient.

Although an in-depth discussion is beyond the scope of this brief commentary, recent developments have incorporated simulation feedback to very good effect. This entails running scenarios such as change in Framingham Heart Age in response to ceasing smoking, and/or reducing lipids or blood pressure (Figure 2). For the client, seeing an animated graphical representation of their cardiovascular risk change in front of their eyes engenders an immediate reaction and more often than not results in their spontaneous acknowledgment of self-risk and the need to change.

However, after nearly a decade or more of effective work, we find there is still a dearth of services and interventions in place to help improve the global health outcomes for those with enduring psychotic illnesses.

The same app also serves to generate comprehensive reports for referring parties. Current research is close to finalising an automatic link between the area LHD electronic Medical Record (eMR) service, GP practice databases, private and public pathology, and the ccCHiP app. This will allow for rapid referrals where required information is automatically abstracted from the relevant sources and will allow for automatic electronic delivery of reports to referrers and the eMR. This connectivity will enhance the all-important communication aspects of integrated health care.

Translational research

The main focus of ccCHiP's academic side is under the broad rubric of 'services research' i.e. what works, is efficient, and embeds the clients in its design etc. However, beyond that are a plethora of subprograms such as:

- investigating obstructive sleep apnea, sleep architecture, and circadian disruption (clinical, molecular, and instrumental) in those at cardiometabolic risk
- developing better early-detection cardiovascular risk algorithms suitable to those with mental illness
- developing integrated IT-based referral and reporting systems (see above)
- investigating methods to improve client and staff health literacy, and
- determining the potential role for brief high intensity interval training amongst cardiometabolically-challenged clients with deficit states.

Ensuring equitable access to integrated health

ccCHiP has demonstrated through year on year referral, attendance and participation growth (in partnership with the LHD and GPs) that the barriers to providing integrated health care engendered by traditional disciplinary silos can be overcome. However, after nearly a decade or more of effective work (Lambert and Chapman 2004; Lambert et al. 2017) we find there is still a dearth of services and interventions in place to help improve the global health outcomes for those with enduring psychotic illnesses. Given that our limited target cohort comprises 'only' schizophrenia, bipolar disorder, and severe mood disturbance, this still represents about 3.5 per cent of the population – that is a sizeable proportion of the general population to tacitly neglect.

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Body and mind recovery: physical health screening among people living with mental illness

The introduction and evaluation of a Health Prompt that prompts guided conversations between mental health staff and consumers has shown that an integrated, holistic approach to health is a key strategy for reducing the physical health disparities experienced by people living with severe mental illness, and for achieving optimal health and wellbeing outcomes.

Mental illness and physical health

People with a lived experience of mental illness experience poorer physical health outcomes and lower life expectancy compared to the broader population. Evidence indicates that all mental health conditions are associated with a significant gap in life expectancy, the largest of which are associated with psychotic illnesses (22.7 years for males and 22.6 years for females) (Lawrence et al. 2013).

Approximately 80 per cent of premature mortality is attributable to preventable chronic physical illness (RANZCP 2015). Research reveals that people living with severe mental illness experience higher rates of type-2 diabetes (3 times), cardiovascular disease (6 times), obesity (2 times), poor oral health, and chronic pain (Chacon et al. 2011).

People living with serious mental illness are at a higher risk than the general population of many social, environmental, and behavioural determinants of poor health, including low educational attainment, low health literacy, unemployment, poverty, poor housing, decreased social networks, lack of strong family supports, smoking, unhealthy levels of alcohol and other drug use, unhealthy dietary patterns, and lack of exercise (de Hert et al. 2011).

Systemic factors affecting their health include low access to, and understanding of, health services, lower rates of diagnosis and treatment, stigma from health professionals, and diagnostic overshadowing (over-attributing a patient's symptoms to a particular condition, resulting in key co-morbid conditions being undiagnosed and untreated) (RANZCP 2015).

When treating people with a mental illness, both general and mental health clinicians tend to focus predominantly or exclusively on mental health issues to the detriment of physical health needs (de Hert et al. 2011). Consequently, people with mental illness frequently receive little to no preventive screening or baseline and follow-up physical examinations, increasing the risk of late diagnosis of, or complete failure to diagnose, physical diseases (de Hert et al. 2011).

It is well accepted that the integration of collaborative care between mental health and physical health services is an effective approach to improving the physical health among people living with severe mental illness (de Hert et al. 2011; RANZCP 2015).



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Health Prompt: a physical health questionnaire

Neami National, Australia’s largest community mental health service, has long recognised the poor physical health outcomes experienced by those living with severe mental illness. In 2012, the top reported goal among consumers of Neami services was to improve physical health (33 per cent). In response to the existing research and the key needs identified by consumers, Neami designed the Health Prompt, a physical health questionnaire.

The Health Prompt aims to improve the physical health of consumers by prompting guided conversations between staff and consumers. It draws upon existing national and international resources and aligns with a strength-based, recovery-oriented approach. The Health Prompt is comprised of 28 questions, each of which generates a ‘yes’ or ‘no’ answer. Questions cover a range of areas relating to holistic health care, each aligning with recognised standards and evidence-based literature.

An excerpt from the current version of the Health Prompt (Version 4, 2017) is shown in Figure 1. The prompt is offered to all consumers at six-month intervals.

In 2014, following 18 months of implementation, a formal review was undertaken to explore consumer and support staff experiences of the Health Prompt.

The qualitative review employed focus groups as a method of capturing the attitudes, experiences, and opinions of consumers who had completed the Health Prompt, and of Neami staff who had supported consumers to do so.

Eight focus groups were conducted across Victoria, New South Wales, Queensland, Western Australia, and South Australia. A total of 43 consumers were interviewed. Participants were asked a variety of open-ended questions and invited to participate in a range of engagement activities to facilitate conversations. This paper explores the key findings from the data collected from consumers.

Approval for this research was obtained through the Neami National Research and Evaluation Committee.

The experiences of consumers indicate that attributing physical health symptoms to mental illness is not only detrimental to overall health outcomes, but it is also disempowering for people living with severe mental illness.

Figure 1: Excerpt from the current version of the Health Prompt (Version 4)

HEALTH PROMPT



INTRODUCTION *(Please read to consumers)*

Thank you for agreeing to take part in this brief prompt about your health. I am going to ask you some questions to help establish whether your health needs are being met and identify areas you may like support with. Whilst we are interested in knowing about your health, please be assured that this information will be treated as strictly confidential.

Consumer Name:		Service Site:	
Gender/Sex:		Age:	
Date Completed:		Review Date:	

Questions	Yes	No	N/A
1. Do you have a regular GP?			
2. Are you satisfied with the relationship you have with your GP?			
3. Have you had your blood pressure checked in the last 6 months?			
4. Have you had your cholesterol checked in the last year?			
5. Have you had your blood sugar levels checked in the last 3 years?			

Findings

Improvement of health knowledge

Participants described improved knowledge of health issues since using the Health Prompt. They shared experiences of how it had raised their awareness of their physical health issues and had supported them to identify areas they wanted or needed to work on.



“There’s things on [the Health Prompt] that I would never have thought of. It gets me thinking about it. I’m just sick of my physical state and I’m trying to turn that around.”

“The Health Prompt raised my awareness and totally was a motivating factor in choosing to change my lifestyle.”

One participant explained how the knowledge gained had prompted a number of lifestyle changes.



“I wasn’t really aware that people with mental [illness] can have physical health factors that cause them to have a shorter life expectancy by up to 15-20 years... that scared the crap out of me... And that caused me to take stock and change my diet and change my lifestyle.”

Participants shared experiences of conducting their own research into topics that had been raised by the Health Prompt, such as what constituted a healthy diet. This approach to improving health literacy was evident in the conversation during one focus group.



“Once I looked into it, diet is pretty much more important than exercise [to maintain a healthy weight]. A lot of people have different ideas as to what the best nutrition is.”

In some cases, the Health Prompt had brought their attention to aspects of their physical health that they had not considered until then. Participants described how their physical health awareness had increased, in particular the importance of addressing areas that had been neglected.



“It was confronting because I’d neglected that side of my health for so long. Fortunately for me I was well enough mentally to follow through and get the checks done. It’s got me back on track.”

“I worry about my mental health all the time, and [I] forget about the rest. But I’ve noticed [since doing the Health Prompt], it’s all coming together.”

Prompting action and physical health improvements

The findings revealed that the Health Prompt had played a significant role in supporting consumers to work towards specific health goals. Consumers described significant achievements of small and larger goals triggered by completing the Health Prompt. It helped build a sense of empowerment from taking action towards improving their health or identifying what they felt was a priority for them.



“I talked about whatever was on [the Health Prompt] and I saw the dietician, I saw the dentist, I got my eyes checked [and] stopped smoking.”

“Up until last year I was still smoking 70 cones [of cannabis] a day. Now I might have two days a week where I’ll have a smoke. So it’s a massive difference. The next step is to get away from it all together.”

Participants explained how they had made positive changes around healthy eating, cooking and losing weight since completing the Health Prompt.



“Before I actually got one of these [Health Prompts], I never used to eat vegetables, but now I eat more fruit and vegetables, I am cooking a lot more for myself too.”

“That scared me, knowing my obesity was a big factor in this, [so] I changed my lifestyle.”

One participant explained feeling empowered to identify, achieve and maintain a health goal.



“After doing the Health Prompt I worked out that weight loss was one of my goals... and was something I could do by myself, changing my diet and making it a more sustainable living goal.”

Participants identified how the Health Prompt had not only influenced physical health changes but also acted as a reminder for medical appointments.



“For years I was unable to remember appointments... and the Health Prompts are a handy reminder because I forget things so quickly and it’s a reminder of things I need to do to go and see a doctor about. Without the Health Prompt, I’d be lucky if I’d remember one.”

Relationships with GPs and reviewing medication

Empowering consumers to take steps to manage their physical health was also evident in the ways in which, after doing the Health Prompt, they were advocating for their health needs within the health system. Consumers were asked about their relationship with their general practitioner (GP) and whether they felt they had enough information about the medication they were taking. These were particularly successful in prompting awareness, discussion, and action from consumers.



“When I first filled this out I didn’t have a GP. I have a GP now. I found my local medical centre, saw a couple of different GPs so I can be a bit more flexible.”

“Now I’ve got a GP, a regular GP that has been the best GP I’ve had in all my life.”

Several consumers described the benefit of reflecting on their relationship with their GP, with some making to decision to find a new GP who would better meet their needs.



“This helped prompt me to go and make an appointment with this new GP, (who said) “let’s try you on this [new medication]” which is more specific to what I’m dealing with at present. And that’s worked for me and I’m feeling better.”

“It did prompt me to think about the GP, [how] they wanted to keep me on the same sort of medication that I was on for 10 years. They weren’t hearing me, and they were discounting it.”

One participant explained how bringing the Health Prompt to the GP appointment supported clinical conversations.



“The suggestion to take the Health Prompt form with me to the doctor was really helpful because then I didn’t have to relay or try and have the conversation about all these different things.”

“Participants also talked about wanting more information about psychiatric medications and, in particular, the side effects that affect their quality of life.”

“I don’t understand how [the medication] works. It’s like I’m taking Tic Tacs... I have been on it for over 22 years now. So that question helps you identify maybe it’s time to talk to my doctor or my GP about the medications to try and get more information.”

‘This helped prompt me to go and make an appointment with this new GP, (who said) “let’s try you on this [new medication]” which is more specific to what I’m dealing with at present. And that’s worked for me and I’m feeling better.’ (Participant)

Discussion

Improvement of health knowledge

Participants indicated that using the Health Prompt had improved their health knowledge and use of that knowledge to effect behaviour change. The findings indicated a number of participants had previously felt disempowered around their physical health but using the Health Prompt helped them to develop knowledge and self-empowerment.

It was evident that some participants developed a level of confidence around their physical health, initially by acknowledging and understanding their physical health needs. Furthermore, participants linked that increased knowledge to greater decision-making skills and awareness of choices. It was evident that conversations generated by the Health Prompt had been a trigger for participants to investigate ways of improving their health.

Participants reflected that while it had been confronting to learn that their current behaviours were detrimental to their physical health, it had also been an important realisation. There was a clear association between the increase in knowledge and the increase in motivation towards addressing physical health concerns. These are key components of health literacy that lead to improved health outcomes, demonstrating the value of initiating physical health-related discussions within mental health settings. This theme confirms that the Health Prompt creates a space for learning about and exploring physical health needs in line with the individual recovery journey.

Relationships with GPs and reviewing medication

Participants indicated that they had experienced ‘diagnostic overshadowing’, particularly in regard to physical health symptoms such as weight gain and dry mouth syndrome. They had also felt disempowered when it came to having conversations with their doctor about their physical health due to the emphasis on prioritising their mental health.

A number of participants noted that since completing the Health Prompt they had felt empowered to initiate physical health conversations with their doctor or seek advice from a different doctor if they felt their needs were unmet.

These changes suggest that reflecting on experiences around accessing health care can increase an individual's capacity to self-advocate and exercise ownership over their own health and health care options.

The prevalence of diagnostic overshadowing experienced by people living with severe mental illness is symptomatic of a currently narrow approach to addressing physical health and achieving optimal wellbeing. The experiences of consumers indicate that attributing physical health symptoms to mental illness is not only detrimental to overall health outcomes, but it is also disempowering for people living with severe mental illness. These findings contribute to evidence of the need for clinical settings to adopt an integrated approach to health, broadening their treatment paradigm to address the whole person.

It was evident that conversations generated by the Health Prompt had been a trigger for participants to investigate ways of improving their health.

Prompting action and physical health improvements

A key result reported by participants was the generation of health goals, such as quitting smoking, losing weight, reviewing medication, or changing doctors. These findings highlight the critical role of the Health Prompt in supporting participants to identify, plan, and achieve goals. Some participants said they had not thought about their particular physical health issues until they used the Health Prompt. In these cases, consumers were provided with support by their Neami worker to identify and consider addressing any unmet physical health needs.

Some participants indicated that using the Health Prompt was a catalyst for moving from contemplation to preparation in addressing health goals, whilst others were motivated by the Health Prompt to take immediate action and start pursuing their goals. The findings indicate the Health Prompt had supported participants to make changes in their health behaviour, which in many cases has led to physical health improvements.

“Carly’s helped me a lot with losing weight. I’ve lost probably about 20 kilos up until this date.”

“I’ve got a couple of consumers that stopped smoking for a year and a half. It’s great to do the Health Prompt again and now they’re saying ‘yes, I’m a non-smoker.’”

The experiences of participants indicated that providing a supportive space for people living with severe mental illness to discuss their physical health needs can lead to:

- increased health literacy, including improvements in health knowledge

- health care-seeking behaviours
- confidence engaging with healthcare providers, and
- self-management of physical health needs.

Such improvements in health literacy are likely to result in fewer demands being made on the health system, representing a more sustainable approach to public health.

Conclusion

The findings of this study demonstrate that participants benefited strongly from their experience with the Health Prompt in developing their health literacy (knowledge gained, use of knowledge, and access to health services). The results identify a clear link between completion of the Health Prompt in a mental health setting and the improvement of attitudes, behaviours and outcomes related to physical health.

This study contributes to the current evidence base around improving the physical health of people living with severe mental illness, and offers a contribution to the broader mental health system, peak physical health organisations, and community health sector. The findings support the promotion of an integrated, holistic approach to health as a key strategy for reducing the physical health disparities experienced by people living with severe mental illness, and achieving optimal health and wellbeing outcomes.

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Increasing awareness of physical health care in a mental health setting

Responding to the challenges of mental and physical co-morbidity for consumers living with severe mental illness is a key area of mental health service development. An innovative South Australian project has brought together partners on a program promoting consumer information and education, physical health assessments, lifestyle interventions and interagency supports.

It is well documented that mental health consumers, particularly Aboriginal and Torres Strait Islander people, and those from culturally and linguistically diverse backgrounds, regularly experience extremely poor physical health outcomes. Some groups have life expectancies of 10-25 years less than people who do not experience mental illness (Leucht et al. 2007).

The reasons can be varied and attributed to a range of issues which include: poor lifestyle choices, inactivity, medication side effects, poor or uncoordinated health care or lack of practitioner training in physical healthcare (Nash 2013).

The stigma of mental illness also looms large as a barrier to physical health care. Linked to this is the concept of diagnostic overshadowing (Nash 2013) where consumers present with physical health problems that may be dismissed as being part of their mental illness (Leucht et al. 2007).

As one of the eight directives of the 5th National Mental Health and Suicide Prevention Plan (Department of Health, 2017), working to improve both the physical and mental health status of consumers requires a significant movement in thinking, clinical practice and program development.

For consumers, it is a challenge of increasing self-awareness of physical health, alongside their mental health, for quality of life and personal wellbeing. It also requires effective collaboration between consumers, agencies and sectors.

Aims of the PHAT project

The Physical Health Action Team (PHAT) project was developed over 2016, building on a promising 2013-14 trial undertaken by the Central Adelaide Local Health Network (CALHN).

The trial had demonstrated positive health outcomes for people with mental health issues from physical health assessments and interventions, including strengthening their relations with general practice and other community supports.

The 2016 project aimed to increase awareness for staff and consumers about the importance of addressing and discussing physical health within the treatment of mental health. Its particular objectives were to:

- increase the number of physical health assessments offered to community mental health consumers



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- promote self-management of consumers' physical health through various lifestyle and monitoring strategies (diet, exercise, lifestyle change, increased activity)
- promote a collaborative approach of physical and mental health between consumers and supporting primary care, NGO (non-government organisations) and specialist providers.

To achieve these aims an innovative approach was required. The project sought activities which would promote cultural change in staff behaviours, service practices and consumer capacities. It was important for this initiative to have a sustainable approach, where new practices would become embedded, prompting consumers and clinicians to focus and attend to physical health care.

From a health promotion approach, it was essential to recognise consumer autonomy and agency as central processes for improving physical health awareness.

Innovation and collaboration

The project received \$45,000 in funding from Partners in Recovery (PIR) Innovation and Collaboration Grants. An early decision involved directing some funds to Neami National as a project partner. This enabled the project to employ a non-government Project Officer to lead implementation for a six month period.

This approach resulted in a strong partnership between CALHN Mental Health Directorate (MHD) and Neami National, opening up physical health pathways and resources for consumers and workers in each organisation. It also enabled access to a larger consumer group for the project in its co-design.

Neami National had been doing its own development work in the physical health area, focusing on supporting health conversations. Neami consumers were encouraged to complete a form called the 'Health Prompt', which initiated conversations about health checks, visiting GPs, smoking cessation, nutrition, physical activity, oral health, foot care, hearing and vision. This background and capacity assisted the PHAT project significantly.

An early proposal was to look at ways to promote physical health differently, encouraging consumers and carers to think about their health before they engage with mental health staff. To achieve this, physical health action days were held and physical health 'stations' set up in the CALHN MHD community sites which included scales, BMI measures and health promotion resources.

The physical health action days were run approximately every three months at the Eastern and Western Community Mental Health centres, with one held during Mental Health Week. The aim of the action days was to encourage consumers to interact with nursing staff and gain information whilst waiting

for appointments. Here consumers could choose to have their weight, height, waist measurement, and blood pressure and glucose levels checked.

These assessments were recorded on a card by the Neami Health Promotion Officer, which was given to consumers. Nursing staff supporting assessments were encouraged to enter data on the Community Based Information System (CBIS) for any follow-up required.

The consumers using the stations could also discuss any physical health concerns with the nursing staff and Health Promotion Officer. They could access pamphlets and other information, which were provided in show bags. This included information on metabolic syndrome, oral health, smoking cessation, healthy eating, diabetes and exercise.

In addition, representatives from SA Dental Services, Quitline and a dietician attended some physical health days, giving one-on-one information and advice to consumers on any issues or concerns they raised. Peer workers were also available to talk one-on-one with consumers and carers from their lived experience perspective of addressing physical health.

Recognising consumer autonomy and agency

Given the waiting room context, the hope was that consumers would use these experiences and resources to become more engaged and knowledgeable about physical health issues.

From a health promotion approach, it was essential to recognise consumer autonomy and agency as central processes for improving physical health awareness. Encouraging personal agency, such as consumers asking questions about their physical health during appointments, also needed to occur in supportive and responsive social environments. The challenge was to create a service environment which would contain information, prompts, opportunities and capacity for identifying and responding to physical as well as mental health issues.

Funding for the project also enabled the production of information resources. These included factsheets and a video featuring consumer and staff stories about mental health and physical health. The creation of all resources and the physical health stations involved consumers in the design and content of the material. Using a co-design and partnership framework was seen as a key marker of success for engaging both consumers and clinicians in physical health actions.

Other aspects of change involved exploring the way physical health assessments are recorded by CALHN MHD services. We arranged for our CBIS client information system to have a physical health assessment completion check box (yes /no)

Using a co-design and partnership framework was seen as a key marker of success for engaging both consumers and clinicians in physical health actions.

on the consumer's profile. This information about assessment comes from GP practices which are either contacted by phone or email. The actual physical assessment from the GP practice was often provided.

The project was managed by a team including the Neami National Health Promotions Officer, an Advanced Nurse Consultant, the Lived Experience Workforce Coordinator and a Principal Occupational Therapist. We also sought to involve clinicians in practice improvement, peer workers, nurse consultants and a health promotions staff member. The project reported to the CALHN Mental Health Directorate Quality and Governance Committee.

Outcomes, evaluation, challenges & future directions

Data from initial action days recorded that 70 physical health show bags were provided to consumers and 40 consumers utilised the metabolic health stations in waiting areas.

Survey results indicated that 73 per cent of consumers said they would discuss results gained from the health stations with their treating team. The three-monthly health (action) promotion days have continued for two years post project completion, with an average of 20 consumers attending each site on the allocated physical health day.

The resources developed by the project continue to be utilised, and there is continued interest from consumers, carers and staff in both the promotion days and the health monitoring stations. In a recent health service accreditation, this project was highlighted across the whole directorate as an innovative approach to improve the physical health awareness and activity of consumers.

Recent CALHN MHD data (sourced from CBIS) for January 2017 to January 2018 shows that 21 per cent of all consumers have had a physical health assessment in the last 180 days. This compares with CALHN MHD's Clozapine Clinics which have a 100 per cent completion rate. In Australia consumers who are prescribed clozapine must have a blood test and physical assessment each month prior to the next month's supply being dispensed. Data for consumers attending depot clinics show a 63 per cent assessment completion rate for our Eastern (Adelaide) community clinic and 17 per cent rate in the Western clinic. Depot clinics, where consumers attend for long acting injections, also have data from GPs where the rates are 33 per cent for East and 29 per cent for West.

Low rates of recording physical health data for mental health consumers are not unique to CALHN MHD. A retrospective case note audit by Happell and others (2016) found only 36 per cent of consumers had their electronic metabolic monitoring forms completed. The authors went on to describe that there was no consensus on what should be included in a metabolic screening form.

The PHAT project implementation has continued after project funding has ceased due to the motivation of staff involved. It is acknowledged that the three-monthly promotional activities and physical health action days require significant worker resources, particularly for the Health Promotion Officer provided via Neami National.

Another challenge has been the context of data and reporting, where work is still required across the service to ensure that improvements in the number of health assessments is linked to project activities.

Evidence of the need to address physical health as part of mental health care is well documented. Mental health plans and a growing commitment at a state, national and international level continue to highlight the need for focus in this area.

This project is one example of how a Local Health Network-NGO partnership has been able to use the approaches of health promotion and consumer engagement to promote action and supportive service environments. We believe that the project highlights how small projects can have significant impact on starting conversations and promoting positive health care. Our vision is that we continue to work toward mental health services which see physical health action as a core priority when supporting consumers in the recovery journey.

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Peer mentoring for people with eating disorders

A peer mentoring program was introduced by Eating Disorders Victoria and Austin Hospital in Melbourne for people with eating disorders who were exiting hospital services, aiming to better their recovery outcomes in the long term. The first time such a program has been offered in Victoria, its early work has provided hope, inspiration and confidence for all involved.



Jennifer Beveridge is CEO, Eating Disorders Victoria

Background

Eating disorders (anorexia nervosa, bulimia nervosa, binge eating disorder, other specified feeding and eating disorders) are bio-psychosocial illnesses with significant psychological and physical impacts that affect over one million Australians (Deloitte Access Economics 2012). They are characterised by disturbed eating patterns and a preoccupation with food, eating, body shape and weight.

These behaviours create a complex and dynamic illness that can deteriorate quickly and require an integrated approach to treatment. All eating disorders are associated with significant physical and nutritional health issues often resulting in high medical risk (Hay et al. 2014). They have one of the highest impacts on health-related quality of life of all psychiatric disorders (Australian Institute of Health and Welfare 2007) and carry the highest mortality rate of all psychiatric illnesses (Arcelus et al. 2011).

Effective treatment for eating disorders requires evidence based, holistic and client centred approaches to address the complexity of the illness and the subsequent impacts on physical health. Despite there being many evidenced based treatments available for people with eating disorders in Australia, the efficacy of treatment is limited and results in less than ideal recovery

outcomes and high relapse rates (Couturier J 2006). This complexity demands specialised treatment that attends concurrently to medical stability along with nutritional and psychological aspects to reduce incidents of relapse and increase recovery rates.

Some people with eating disorders are admitted to hospital when their physical health requires medical intervention and often, due to dislocation from community supports, their mental health deteriorates as a result. Currently there are very few options available to people being discharged from hospital treatment to support their recovery, resulting in high rates of readmission and/or long term illness with little hope of full recovery.

Some people with eating disorders are admitted to hospital when their physical health requires medical intervention and often, due to dislocation from community supports, their mental health deteriorates as a result.

Ongoing support to address the psychological and physical symptoms is often provided by a GP and psychologist, with nutritional support being provided by a dietitian. However, research has shown that maintaining social connections and applying life skills can support recovery in eating disorders (Sledge WH et al. 2011, Perez M et al. 2014). In 2015 staff at Eating Disorders Victoria (EDV) and Austin Hospital in Melbourne set about to develop a peer mentoring program for people exiting specialist eating disorder services.

Many people with an eating disorder have never met anyone who has recovered, and so have little idea of what a future of recovery may be like for them.

Establishing a peer mentoring program

EDV has been supporting people with eating disorders and their families since 1983 in Victoria. We provide information, support, education and advocacy for people with eating disorders, their families, and the wider community.

There have been numerous requests over time for a peer mentoring program that facilitates a relationship between someone who is unwell and someone who has recovered. Many people with an eating disorder have never met anyone who has recovered, and so have little idea of what a future of recovery may be like for them. EDV provides a Stories of Recovery program where ambassadors share their experience of recovery in face to face, media and online forums. However, these sessions are one-off and do not provide opportunity for an ongoing relationship such as between a mentor and mentee.

In 2016 EDV began offering a peer mentoring program for people exiting hospital services at the Body Image and Eating Disorders Treatment & Recovery Service (BETRS) – a partnership between Austin Health and St Vincent’s Hospital – which is based on a combination of peer support principles, documented evidence and practice experience. It aims to ensure patients with an eating disorder leaving hospital can better sustain their recovery outcomes in the long term. This is the first time such a program has been offered in Victoria.

The program participants work with a paid and recovered peer mentor to build their own capacity to manage their physical and mental health so that they are not readmitted to hospital. The program operates on a rolling intake basis and offers a series of 13 mentoring sessions following the participant’s discharge from the BETRS inpatient unit or transition to/from the BETRS intensive eating disorders day program. Participants and mentors are matched on the basis of preferences and information provided by both parties.

Mentors are recruited through usual organisational processes and attend training and induction specific to the peer mentoring program. The mentors are employed as casual staff of EDV and an allowance is available for expenses to facilitate a range of activities.

Activities are guided by each participant’s Wellness Plan that is developed during the first session, and includes peer support activities such as providing information, emotional support and sharing of their recovery experiences. The plan has a focus on goals in the following domains: living circumstances and skills, health, self-care, social relationships and connectedness, creative interests and hobbies, work/career and education, identity and sense of self, and community roles and responsibilities.

Participants are supported to work toward their identified goals through community-based activities such as supermarket shopping, self-care activities, reconnecting with community or navigating social interactions involving food. Mentors share aspects of their own recovery stories to promote hope and provide an empathic response to the challenges associated with recovery.

(Mentors also complete their own Wellness Plan which documents self-care strategies and identifies potential risks to ensure that the program coordinator can support and ensure the mentor role is not detrimental to their continued health and wellbeing.)

Evaluation of the program

Research is being undertaken to evaluate the effectiveness of the program on eating disorder patient (participant) outcomes. A secondary, exploratory aim of the program is to evaluate the effects of the program on peer mentors in terms of their eating disorder symptomatology and quality of life. Quantitative and qualitative measures are being taken from both groups and our first dataset has produced the following results.

Quantitative results

Readmission to hospital has been the main quantitative measure, and the program to date has delivered a success rate of 72 per cent participants not being readmitted against a target of 60 per cent. The sample size has been small (n = 18), and we hope that each additional cohort of participants will provide further data supporting this outcome.

Qualitative results

Perhaps the most interesting results have been the themes obtained from the qualitative measures for both participants and mentors. These have included:

For participants:

Hope and inspiration

The most universal theme reported by the participants was that involvement in the program gave them a sense of hope that they too could recover. They felt that talking with someone who had recovered helped challenge their beliefs that they would never get better and assuaged their fear of the future.

▼
“(It has) shown me that it’s very possible – that I don’t have to be as scared as I am about my 20s – even having this disorder I can still get better and study.”

A relaxed forum

Participants reported that the peer mentoring program sessions were more relaxed and less stressful than other traditional treatment types. They found value in doing activities while also working on their recovery, and contrasted this to the intensity and structure of the one-on-one talk therapy setting.

▼
“It can get a bit overwhelming, having so many different treating team members and having to see so many different people and talk. It’s good to just be able to do something a bit more fun, and still be able to talk if that is what you need to do but in a less structured way.”

Evidence from lived experience

The participants reported that they trusted their mentor’s knowledge of eating disorders, because it came from direct experience, not from study or science. This made it easier for them to “take it on”, because it was “real for them”. The participants felt that the mentors had a more genuine reason for sharing their insights (than therapists), because they are motivated by helping others who have been through what they have been through.

▼
“Some professionals will say that everyone with an eating disorder will say that they are not sick enough.... (therefore they don’t need) to get better, and they (feel they) don’t deserve help, and I find it really hard to take on. But it was different when she said she felt that way too.”

Acceptance and validation

The participants often commented they felt accepted by their mentors regardless of their stage of recovery or ability to stick with treatment protocols. Mentors can understand “irrational thoughts” and “rules”, and what power they have for people who are unwell, while others without the lived experience of an eating disorder struggle to understand the impact of such thoughts.

▼
“You believe these... rules (created by the eating disorder), and... she could understand that in less of a just “you’re being silly” way. She could really properly understand it all.”

Realistic view of recovery

Participants found value in hearing that the mentors’ trajectories of recovery were not linear, and that this helped them realise that struggling didn’t equate to failing.

▼
“(My mentor told me) recovery is up and down. I’m constantly trying to remind myself that it’s not going to be an “upwards from here” kind of thing – and no one recovers (in a linear way).”

Value in the relationship

Several participants commented they were surprised at how well they got along with their mentor, despite differences in personality or diagnosis. Some discussed how the relationship helped them to build confidence in making new friends and talking to people in other contexts.

▼
“I started a new job while I was with my mentor... and I feel like I did better in getting to know everyone because I have confidence (from the program).”

For mentors:

Connection and shared experience

Connection and a common experience were cited by all mentors as one of the key strengths of the program. Some mentors described the common language being spoken amongst mentors and participants that allowed for a shorthand to develop and increased feelings of being understood.

▼
“The fact that you know you’re sitting down across the room from someone who’s had an eating disorder, and that they’ve recovered, there is more of a willingness to open up.”

Turning a negative into a positive

Mentors discussed their experience of having an eating disorder and recovering as changing from a negative into a unique story and skillset that they could use to help others.

▼
“Getting to use my lived experience, you know, past experiences that were quite negative and traumatic, and then being able to use it in a positive way.”

Honesty and imperfection

Many mentors described the peer mentoring relationship as more relaxed and honest compared to traditional treatment relationships. Sharing imperfections was seen as a positive way of demonstrating that recovery is not always linear, and that setbacks are likely, and also surmountable.

▼
“I’m honest with [my participant] about [my difficulties in recovery] and so... it made it more three dimensional – and sometimes that’s all she wanted, she wanted to be like “oh, okay, so this is ‘a’ recovery story and I can build my own now, and it’s okay if it’s not perfect or linear.”

Strengthening own recovery and developing new skills

Many mentors talked about the way the program benefitted them in their own recovery, allowing them to understand aspects of their recovery which they had forgotten about or tried to ignore, with a support team that was available to work through any issues which came up over the course of the program. Mentors also reported that they had gained perspective on how far they had come in their own recovery.

▼
“It’s just opened up so many doors for me – it’s helped me to grow as a person, it’s made me more confident.”

‘(It has) shown me that it’s very possible – that I don’t have to be as scared as I am about my 20s – even having this disorder I can still get better and study.’

Conclusion

The EDV peer mentoring program has been an extraordinary initiative that provides hope, inspiration and confidence for everyone involved. EDV is seeking funding for the program to expand to other hospitals and research results will be published in due course.

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Making a difference: introducing a clinical nurse specialist for physical health care in a mental health service

Graylands Hospital, a large metropolitan mental health inpatient service in Perth, was concerned that the majority of co-morbidities experienced by its patients were due to preventable physical health conditions. Beginning with the introduction of a Clinical Nurse Specialist for physical health care, it designed and introduced a series of projects to address them.



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People with serious mental illness have reduced life expectancy of more than 20 years and a two to threefold increased mortality risk compared to the general population. (Happell et al. 2012, p. 202). There is extensive research and evidence to support this fact, but little application of practical and innovative interventions at a ward or community based level.

The role of Clinical Nurse Specialist, Physical Health Care (CNS PHC) was introduced three years ago to Graylands Hospital, Western Australia's largest mental health inpatient facility and the only public stand-alone psychiatric teaching hospital. It comprises 70 acute psychiatric beds and 64 psychiatric rehabilitation beds.

This role centres on improving the physical health status of mental health patients within not only the primary inpatient hospital, but other areas within the service, and cemented the importance of the physical health of the mental health patient.

The creation of the role also led to a series of projects specifically designed to help reduce the burden of preventable co-morbidities and subsequently the overall health disparities experienced by mental health patients within the service.

A number of those projects are detailed ahead.

Project One: The Wellness Clinic

This project involved the introduction of the Clinical Nurse Specialist, Physical Health Care (CNS PHC) as one stage, followed by the employment of a part-time General Practitioner in the second stage, to design a formal service aptly named The Wellness Clinic.

The Wellness Clinic was launched in 2016 comprising clinics run by both the CNS PHC and the GP, covering all physical health issues experienced by the patient population. The Wellness Clinic would focus on procedures unable to be completed within a GP consultation such as spirometry, wound care and bladder scanning, as well as being centred on providing education to inpatients.

The Wellness Clinic was launched as a wider quality improvement project focusing on improving the overall physical health status of inpatients at the service. When referrals remained low, the decision was made to launch a Wellness Clinic pamphlet, which would double as a health promotion tool for patients and assist to increase referrals to both the hospital GP and the CNS PHC. This pamphlet also included information on all the other physical health services offered by the hospital including occupational therapy, dietetics, physiotherapy and podiatry, as the major focus was providing holistic care.

This pamphlet was placed in all patient areas and inside all patient and carer information packs. Alongside the pamphlet, additional strategies were undertaken to embed the Wellness Clinic in the hospital. These included having Wellness Clinic workers attend the orientation of all new doctors, where they provided information on the physical health services offered within the hospital and more specifically the referral process. After orientation, personal emails were sent offering one-on-one time to reengage with these doctors and provide more detail.

The combination of strategies saw referrals from GPs increase from 25 in the previous 12 months to 101 in the 12 months of the project, with an additional 79 referrals to the CNS PHCs, totalling 180 inpatients seen for their physical health care needs.

The Wellness Clinic was launched as a wider quality improvement project focusing on improving the overall physical health status of inpatients at the service.

Project Two: Sports Therapy Program

In May 2016 a sports therapy program was launched as a collaborative quality improvement project between the CNS PHCs and a senior occupational therapist. Low rates of exercise by mental health consumers contribute to the poor health they often experience (Thornicroft 2011). This is compounded by evidence that mental health consumers also lead a significantly more sedentary lifestyle, leading to higher rates of cardiovascular risk factors (Sancassiani et al. 2018).

The idea was to introduce sport as a form of therapy to help improve the physical health of participants. However the project also aimed to measure the effect of physical activities on specific psychiatric symptomatology and management options: reduction in seclusion, reduction in self-harm and reduction in PRN (as required) medication use for six hours post-participation in the group. These parameters were chosen to see the real time effects of physical activities on decreasing agitation and anxiety – major symptoms that can lead to aggression, self-harm and the need for extra medication. The timeframe of six hours was chosen after research and consultation with project members. The project would also subjectively measure relief from boredom and pleasure.

Social exclusion or isolation is a well-known social determinant of health that sport can help to prevent (Sancassiani et al. 2018). Taking this into consideration and generally working within an inclusion model of care it was decided the sports therapy group would be 100 per cent inclusive: that is, anyone who wanted to participate could, including those patients on 'nursing specials' (when one or more nurses are required to appropriately care for a high need and complex patient) or even full nursing care.

The group was run collaboratively across two wards: a 14 bed male secure acute inpatient ward and a mixed 15 bed secure acute inpatient ward. The sports played were chosen by patients and catered to the specific needs and functioning abilities of the participants.

The sports therapy group ran for 24 weeks as a trial and is now part of the regular occupational therapy timetable. Prior to its introduction, there was no sports group offered at the service, therefore baseline participation was zero. Throughout the 24 weeks there was a total of 118 participants. In that time there were zero incidents of self-harm, four incidents of seclusion and ten incidents of PRN six hours post participation in the group.

The program contributed broadly to improved physical health, reduced sedentary behaviour and contributed to the elimination of restrictive practices by the minimal use of PRN and seclusion six hours post-participation in the group. Subjectively the group experienced enjoyment and less boredom. The program also offered links to community sports programs on discharge.

The sports therapy program will now be implemented at all mental health inpatient sites across the service led by the executive team. Its benefits have been recognised and can be easily adapted to any mental health service or facility.

Sports Therapy Group case study

Bob (not his real name) is a 58 year old man who had been an inpatient on the male secure acute psychiatric ward for 10 months. Initially the treating team thought he may have Korsakoff Syndrome or dementia, but his formal diagnosis was schizoaffective disorder. Bob had been on a long-term 'nursing special', had difficulty communicating, and experienced high levels of paranoia. He presented as highly disorganised and disorientated, had difficulty following direction and at stages required full nursing care.

Bob meandered into the sports therapy group. Cricket was the sport of the day and almost instinctively he grabbed the ball and had a bowl. He participated throughout the hour-long session, batting, bowling and fielding. Bob is now the reigning cricket champion of his ward, his title still unbeaten today. Despite his current mental health he can still recall his cricket skills and gets meaning and pleasure from this activity.

Social exclusion or isolation is a well-known social determinant of health that sport can help to prevent.

Project Three: Improving Metabolic Syndrome Monitoring

Metabolic Syndrome (MetS) is a collection of conditions that often occur together and increase risk of diabetes, stroke and heart disease. It is becoming more prevalent in Australia, especially within mental health consumer populations.

Within the service, MetS was found to be particularly prevalent among patients in the psychiatric rehabilitation stream who had a diagnosis of schizophrenia and had been prescribed one or more atypical anti-psychotic medications. The link between schizophrenia and cardiometabolic disorders is complex but has been well researched: in part it can be attributed to lifestyle factors and anti-psychotic medications (Henderson et al. 2015).

In Western Australia, the shorter life expectancy gap for those with mental illness increased between 1989-2005, mostly due to common, preventable conditions such as heart disease (Lawrence et al. 2013). MetS is a contributor to this, placing patients at twice the risk of developing cardiovascular disease and five times the risk of developing type 2 diabetes (Alberti et al. 2009). This project aims to improve the way the wider service assesses, monitors and provides interventions for MetS and consequently to reduce the MetS burden within the inpatient population.

The project identified the need to simplify the current MetS Screening Tool to increase ease of use for staff. A two page colour coded document, which offered no interventions for care, was reduced to a one page, easy to read document with only the five risk criteria for Metabolic Syndrome on it. Diagnosis of MetS is made when three of those five criteria return abnormal findings (Alberti et al. 2009, p. 1640). The tool then triggers referral to the GP, physiotherapist and dietician.

The concurrent projects, undertaken with a collaborative approach and holistic care principles, have proven to help improve the physical health of not just individuals but groups of mental health consumers

The form has been designed to be adaptable to all the environments across our service and the project runs across five sites, including inpatient mental health, community mental health and forensic mental health services (both inpatient and community).

According to initial six month audit results, compliance with MetS Monitoring Tools by the participating community mental health team rose from zero to 42 per cent, with 72 per cent of clients audited being linked with a GP for further monitoring. A 14 bed male psychiatric inpatient ward had nil completed MetS Tools at the baseline audit, compared with 61 per cent at the six month audit. Twelve month audits will be carried out in June 2018 before final assessment of the outcomes of this project can be made.

The service now plans to implement the MetS Screening Tool for use within all areas. The tool is also being considered for use at other general health and mental health sites in Western Australia and interstate. It can be used within inpatient or community services, both within mental health and general health settings.

Conclusion and future direction

With such extensive research and insights into the poor physical health of mental health consumers it is now no longer acceptable for mental health patients to die younger than the general population due to poor physical health. The concurrent projects, undertaken with a collaborative approach and holistic care principles, have proven to help improve the physical health of not just individuals but groups of mental health consumers.

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Improving the physical health of people experiencing mental illness through integrated care: challenges and opportunities

Integrated care presents a broad spectrum of opportunities to improve the physical health of people experiencing mental illness. This article explores the barriers now limiting integrated care, and opportunities that include 'community coalitions' and having the mental health and broader nursing workforce working to its full scope of practice.



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In July 2017 I listened as Professor Alan Fels delivered the opening address at the National Press Club to launch the National Equally Well Consensus Statement on behalf of the National Mental Health Commission. There were audible gasps from the audience as Professor Fels provided a snapshot of some of the shameful statistics:

- People with a mental illness are twice as likely to experience co-existing cardiovascular disease, diabetes or metabolic syndrome and comprise around one-third of all avoidable deaths, the vast majority of which are not attributable to suicide.
- People with complex mental illness die up to 23 years younger than the general population and are six times more likely to die from cardiovascular disease, even if aged under 45.
- People with schizophrenia are 90 percent more likely to be diagnosed with bowel cancer.

Challenges

Integrated care presents a broad spectrum of opportunities to improve the physical health of people experiencing mental illness. Yet there is a risk that integrated care

becomes a frequently used phrase that promises much, but fails to deliver in practice if it comes without comprehensive planning, effective strategies, identification and implementation of clear roles, and collaboration at the individual health professional, service, organisation and system level (Rodgers et al. 2016).

The reasons for poor physical health of people experiencing mental illness are complex, and the Equally Well Consensus Statement acknowledges there is no single (or simple) solution. For example:

- Action needs to be taken to better monitor and mitigate against the damaging physical side effects of psychotropic medications, especially those known to carry a particularly high risk.
- Co-constructed care plans need to involve workable strategies to improve lifestyle factors to address high rates of smoking, alcohol consumption, poor diet, lack of exercise and substance misuse.
- Strategies need to be implemented to better educate health professionals and protect against 'diagnostic overshadowing' - where people with mental illness experience harmful delays

in diagnosis and treatment of physical illness due to the physical health symptoms not being treated as equally as they would be for someone without a mental illness.

- Action is needed to address any bias or discrimination from health professionals that may result in attribution of blame on the person for their poor physical health, rather than viewing components of the mental illness itself and its treatment as having a significant impact.
- Outreach and targeted engagement may be necessary for people who are at high risk for physical illness, to prevent them from being lost to care due to symptoms arising from their mental illness or its treatment with psychotropic medication – for example, difficulty with planning/organisation, difficulty remembering appointments and following treatment plans.

The complex factors contributing to comorbid mental and physical illness, combined with high levels of unmet need for integrated care can mean little action is taken.

All health professionals – including mental health professionals, primary health care professionals, service and program managers, and support workers – need to recognise their role in improving the physical health of people with mental illness.

The complex factors contributing to comorbid mental and physical illness, combined with high levels of unmet need for integrated care (Mason et al. 2015, p. 18) can mean little action is taken. Kelly (2014) refers to clinicians' awareness of the interrelated factors impacting on health as potentially "paralysing" and "overwhelming". These feelings intensify when clinicians can identify opportunities to respond to factors impacting on health, but artificial funding, policy, program, service and even legal boundaries prevent action from being taken.

Barriers with continuity of care are often identified where funding is structured to address a particular health outcome (for example, between mental illness, chronic disease, suicide prevention), rather than supporting an holistic and person-centred approach through funding and collaborations that are responsive to health comorbidity and the changing needs of individuals.

In the UK, a review of integrated care models supporting the physical health needs of people experiencing mental illness identified that health professionals with responsibility for coordinating care face significant barriers in providing integrated care unless they have the authority to influence other people involved in the person's care (Rodgers et al. 2016). We are already aware of these complexities, and we all need to improve what we do.

Opportunities

A range of activities at federal, state and territory level in Australia, such as the Primary Health Care reform, a strong focus on care integration and broader debates surrounding health expenditure and investment in prevention, present significant opportunities to advocate for the promotion of better physical health of people experiencing mental illness.

Kelly (2014) identifies innovative collaborations or 'community coalitions' that cross traditional sectoral boundaries of health care as one way for services and clinicians to maximise their response to the social determinants of mental health. In Australia, examples of this may include health services collaborating with:

- other local health professionals and services (e.g. establishing collaborations between general practice, specialist mental health services, community health services, and dedicated nursing and allied health roles such as mental health nurses, diabetes nurses, dieticians etc.)
- Diabetes Australia
- The Heart Foundation
- Cancer Council Australia
- the Alcohol and Drug Foundation
- Quitnow.gov.au
- education, employment, justice and housing sectors (social determinants).

Role of nurses in integrated care

The UK review (Rodgers et al. 2016) found very strong support in the literature for the implementation of liaison services to improve the physical health of people experiencing mental illness.

Specifically, the review found substantial evidence for mental health nurse consultant liaison services; in both general practice and community health services, as well as evidence supporting in-reach services into specialist mental health services (for example, in-reach services provided by diabetes nurses, dieticians, exercise physiologists etc.). The National Mental Health Commission also identified the opportunity to improve mental health care through an expansion of mental health nursing services in its 2014 Review of Mental Health Programs and Services.

Mental health nurses have a proven track record in improving outcomes and care integration for people with severe and complex mental illness (McLeod 2017; Lakeman 2013; Richards 2013; Healthcare Management Advisors 2012).

Working to its full scope of practice, the mental health and broader nursing workforce has enormous potential to address the physical health inequity of people experiencing mental illness.

The mental health nursing Scope of Practice considered all aspects of a person's life that may be contributing to their presentation and their opportunities for recovery. This Scope of Practice recognises that mental health nurses are not only specially trained mental health clinicians but are also Registered Nurses (RN). As such, mental health nurses can identify and respond to complex social factors and physical health needs – including the adverse effects of psychotropic medications on physical health. Their roles may include identifying risks and symptoms, making appropriate referrals and undertaking physical health care within the RN Scope of Practice.

The skillset of the mental health nurse is particularly pertinent to those with complex mental illness, who are more likely to experience co-occurring physical health and social challenges requiring a response alongside their evidence-based clinical mental health intervention and treatment. It also means that barriers which could reduce or interfere with clinical mental health treatment outcomes are identified by the mental health nurse and addressed in collaboration with the broader care team.

Furthermore, mental health nurses are qualified to provide additional services under a number of MBS items, such as making diagnoses and prescribing and reviewing relevant medications. This can provide a timely response to the physical health factors arising from the use of particular psychotropic medications, including adjusting dosages or changing medications, particularly in areas where access to a psychiatrist is limited.

Working to its full scope of practice, the mental health and broader nursing workforce has enormous potential to address the physical health inequity of people experiencing mental illness.

The Australian College of Mental Health Nurses (ACMHN) is developing a Mental Health Standards of Practice for General Practice Nurses (GPN) in Australia, and an online and face-to-face training program aimed at meeting the standards. The training will include identification of the role of GPNs in relation to mental health risk factors, screening, assessment and referral. Upskilling GPNs and supporting them to provide mental health care to all patients/consumers at the appropriate stepped care level will improve access to integrated physical and mental health care for all Australians. It will also facilitate early intervention/prevention, monitoring, improved quality of care and care coordination between the person, their GP and mental health provider/s.

The ACMHN also offers Chronic Disease and Mental Health e-learning and perinatal mental health e-learning via its online CPD Portal, available to both members and non-members, as well as a range of webinars covering topics such as mental health and metabolic syndrome, cardiovascular disease, diabetes, cancer, chronic obstructive pulmonary disease and psychopharmacology.

The ACMHN is currently planning to build on the Mental Health CPD for Nurses and Midwives program. This continuing professional development (CPD) will be developed by nurses for nurses and midwives specifically, to address the day-to-day clinical practice issues which nurses and midwives encounter that are unique to their scope of practice and model of care.

The ACMHN is also currently undertaking a project funded by the Commonwealth Department of Health to review the mental health content in undergraduate/pre-registration nursing courses. The outcome of this project is expected to assist in providing guidelines to the Registered Nurse Accreditation Standards Review which is being undertaken by the Australian Nursing and Midwifery Board.

Improving the mental health education in pre-registration nursing programs is vital, particularly given the evidence base for the reciprocal relationship between physical health/ chronic disease and mental health (National Mental Health Commission 2017).

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Smile for Health: An evidence-based oral health promotion program for people living with severe mental illness

'Oral health is fundamental to overall health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment.' (Council of Australian Governments' Oral Health Monitoring Group, 2015)

People living with severe mental illness are at increased risk of oral health problems and face significant challenges in accessing appropriate oral health care (Baghaie et al. 2017, Kisely 2016, Kisely et al. 2015, Lalloo et al. 2013, Kisely et al. 2016). Just as mental health and physical health are inextricably linked (Glew and Chapman 2016), there is also a bidirectional link between mental health and oral health (Kisely 2016).

People living with severe mental illness often experience anxiety and phobia related to dental treatment (Crego et al. 2014, Lenk et al. 2013, Pohjola et al. 2011). Psychotropic medications (e.g. antidepressants, antipsychotics, anti-anxiety drugs) can cause dry mouth, increasing the risk of oral diseases (Lalloo et al., 2013). One systematic review found people living with severe mental illness are almost three times more likely to have lost all of their teeth, compared to the general population (Kisely et al. 2015).

Fear, stigma, cost of care, and communication issues are barriers to accessing timely dental care (Ho et al. 2017, McKibbin et al. 2015, Lenk et al. 2013, Crego et al. 2014). The behavioural risk factors for oral diseases (e.g. poor diet, smoking and unsafe alcohol consumption) are also associated with other chronic health conditions (e.g. diabetes, cardiovascular disease, respiratory diseases, cancer) (Dental Health Services Victoria (DHSV) 2011) These links are important to consider in the development of more integrated approaches to promoting and supporting general health and wellbeing.



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The majority of dental diseases are preventable, and oral health promotion programs are essential in prevention, screening and early detection efforts. (DHSV 2017). Australia’s National Oral Health Plan 2015-2024 recognises people living with mental illness as a Priority Population group requiring targeted oral health support and care (Oral Health Monitoring Group 2015).

There is strong evidence that non-dental professionals (e.g. aged care professionals, midwives) can play an important role in promoting oral health (Lewis and Fricker 2009, Johnson et al. 2015, Rogers 2011, George et al. 2016). Community mental health professionals are ideally placed to initiate conversations with consumers about oral health, to offer basic oral health information and to facilitate consumer access to oral health services (Neami National, Meldrum et al. 2018). To date, this approach to oral health promotion has been limited in the mental health sector.

Building capacity with ‘Smile for Health’

‘Smile for Health’ is a partnership program between Neami National (a community mental health service) and the Melbourne Dental School (The University of Melbourne). Utilising the New South Wales Framework for Building Capacity to Improve Health (NSW Health Department 2001) the program developed contextually appropriate professional development for Neami Community Rehabilitation and Support Workers (CRSWs) to improve oral health promotion practices.

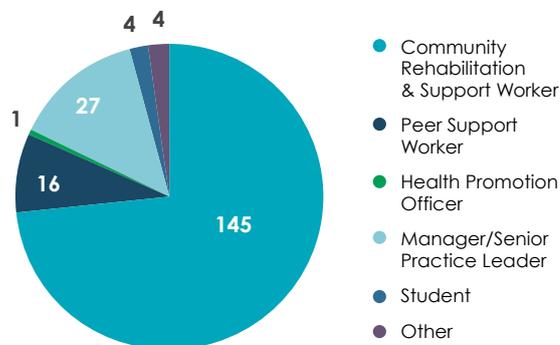
The program utilised a Participatory Action Research approach, involving a repetitive cyclic process of planning, acting and reflecting (Townsend 2013). Participatory action research was translated into practical, evidence-based approaches to deliver oral health support for people living with severe mental illness. Staff training focused on applying existing communication and support skills (e.g. motivational interviewing, recovery coaching) to oral health.

Professional development included a mix of short, 30 minute, face-to-face training sessions (delivered at weekly team meetings) and an eLearning module, which was designed in collaboration with Neami consumers and staff. Health Promotion Site Champions (HPSCs) in each site coordinated program implementation within their team. Bachelor of Oral Health students from the University of Melbourne delivered the face-to-face training sessions at Neami sites in Victoria.

Smile for Health was initially implemented in Victoria, before expanding into New South Wales in 2016. Mixed methods (quantitative and qualitative) were used in collecting relevant process, impact and outcome evaluation data. Ethics approval was granted by the University of Melbourne Human Research Ethics Committee and by the Neami National Research and Evaluation Committee.

The program was simple to implement and relevant to the way in which Neami services are delivered.

Figure 1. Training participants' role within Neami



Evaluation of the program

In 2015, 118 Neami staff in 12 Victorian sites participated in face-to-face training sessions. This increased in 2016 to 141 staff in 17 Victorian sites participating in face-to-face training and 144 in Victoria (eight sites) and New South Wales (ten sites) enrolled in the online training module. Over 90 per cent (n=178) of those who participated in oral health training had a role at Neami which involved direct consumer support, meaning they have opportunities to engage consumers in oral health related conversations.

Post-training surveys indicated that three-quarters (n=145, 73.6%) of training participants were CRSWs (see Figure 1). It was expected that almost all training participants would be CRSWs, who are responsible for providing the majority of consumer rehabilitation and support services, so the engagement of other Neami staff members was an unanticipated positive result.

Annual appraisal of health promotion action within Victoria found that Neami staff reported significant improvements in their oral health knowledge in 2015-16 and 2016-17. After training, staff reported high levels of understanding and confidence in relation to oral health (see Figures 1 & 2). The majority were also ‘very’ or ‘extremely’ satisfied with the training provided (see Figure 4).

Process, impact and outcome evaluation of the oral health program included post-training surveys (paper-based and web-based), semi-structured interviews and focus groups, and an anonymous cross-sectional survey of Neami CRSWs. The evaluation found that support workers who had oral health training provided consumers with significantly more oral health support than those who did not have training. Support workers generally had positive attitudes to oral health promotion, however, those who had oral health training perceived fewer barriers to promoting oral health when working with consumers.

Figure 2. Self-rated understanding after oral health training

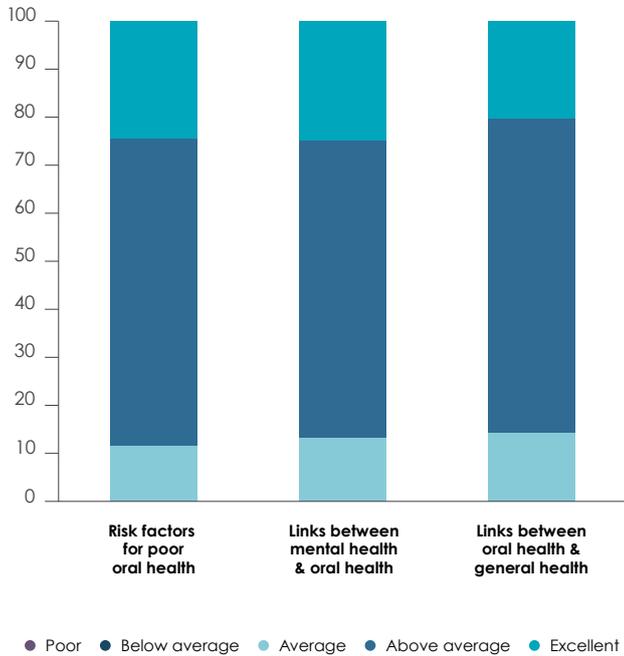
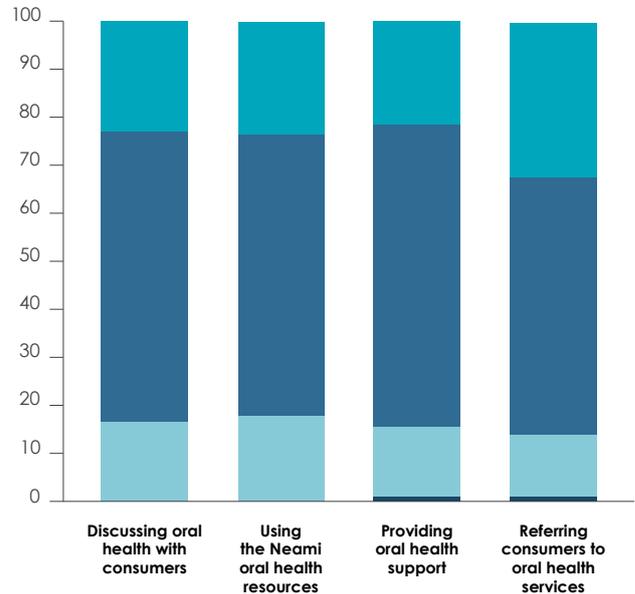


Figure 3. Self-rated confidence after oral health training



Qualitative feedback from staff highlights that:

- They understand the importance of oral health and recognise they have a role to play in supporting consumers to address their oral health needs.
- The program was simple to implement and relevant to the way in which Neami services are delivered.
- They found the training valuable and contextually appropriate, as it was tailored to the needs of the consumer group that they work with and aligned with the Collaborative Recovery Model used at Neami to create a professional working alliance between consumers and support workers, and to facilitate an environment of learning, growth and empowerment (Marshall 2008).
- They prefer face-to-face training, as it provides opportunities to ask questions, discuss scenarios where oral health promotion may prove challenging, and share success stories where consumers have been supported to improve their oral health. (Post-training survey evaluation also found that staff satisfaction with training was significantly higher after face-to-face training than after online training $t(195) = -1.417, p=0.044$).

Smile for Health proved an innovative, low-cost, and sustainable oral health promotion program in a community mental health setting.

“ [The consumer] had been on a waiting list for about 3 years and they had called during that period to try and get a sense of when they could get an appointment. . . . so they had been experiencing pain for a reasonable period of time without accessing, or having capacity to access dental health or see a dentist. And then, from the moment of sending through the referral, literally within days, they’d been contacted and days after that had an appointment. ”

(Quote from Neami HPSC about supporting a consumer)

Where to from here?

To the best of our knowledge, this is the largest scale oral health promotion program conducted in a community mental health service, both nationally and internationally.

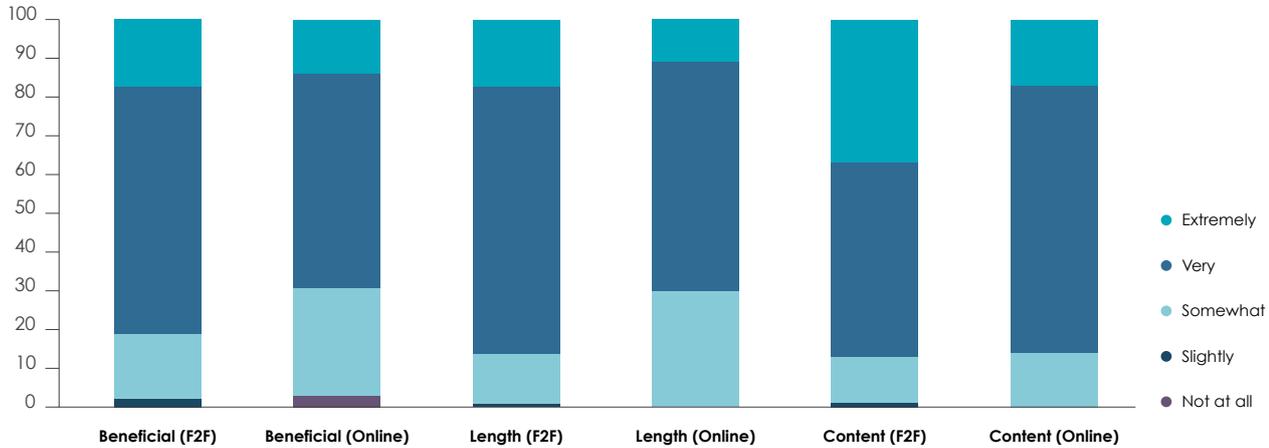
Initially implemented in Victoria and New South Wales, it is planned to be rolled out in other Neami sites in Queensland, South Australia and Western Australia.

It is also envisioned that the eLearning module will be made available across the broader mental health sector, contributing to a sustainable and evidence-based approach to promoting oral health for people living with severe mental illness (Neami National).

Conclusion

Targeted oral health promotion strategies are essential to improve oral health for people living with mental illness. The Smile for Health project demonstrated that contextually appropriate oral health training can increase the provision

Figure 4. Satisfaction with oral health training



of oral health support to people living with severe mental illness, including oral health advice and referrals to dental services.

Integrating oral health messages into existing health promotion activities proved an effective and acceptable approach. Smile for Health proved an innovative, low-cost, and sustainable oral health promotion program in a community mental health setting. It has been implemented in Neami sites in Victoria and New South Wales, and will be rolled out nationally in 2018.

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Offering help for people with mental illness to quit smoking

Tobacco smoking is the leading cause of preventable death among people living with mental illness. This article is a call for action to improve the physical health of people with mental health conditions by offering best practice smoking cessation interventions.

Two out of three smokers will die from a smoking-related illness (Banks et al. 2015), and it is estimated that, for every death, 30 people experience a serious tobacco-related illness. The toll on life expectancy and physical health is significant for people with mental illness, who are two-to-four times more likely to smoke than the general population (Australian Institute of Health and Welfare 2016).

Tobacco smoking is the leading cause of preventable death among people living with mental illness. Smokers with mental illness typically die 20 years earlier than the general population, largely due to smoking-related diseases (Callaghan et al. 2014). Smokers with mental illness or substance use disorders are far more likely to die from their smoking than as a result of their psychiatric condition or substance use. Many people overcome substance use disorders, only to die from a tobacco-related illness (Mendelsohn & Wodak 2016).

Smoking as a social justice issue

While smoking rates have fallen in the general population, rates remain high for people with severe mental illness (Cooper et al. 2012). People with a mental health condition who smoke experience a disproportionate burden of tobacco-related harm. Smoking exacerbates financial stress and perpetuates the cycle of poverty and disadvantage often experienced by people with mental illness (Lawn, 2001).

To illustrate, among the 3 per cent of the adult population who had ever been homeless, 61 per cent were current smokers and 54 per cent had experienced mental illness in the previous 12 months (Lawrence et al. 2013).

Smoking should be considered a problem of social justice due to the unequal circumstances experienced that make the disadvantaged more likely to become smokers and less likely to stop (Voigt 2010). Recent Australian data confirms that both mental illness and lower socioeconomic status are independently associated with current smoking and difficulty quitting (Lawrence et al. 2013).

Why do smoking rates remain high?

Most smokers, including those with mental health conditions and substance use disorders, want to quit and have made recent quit attempts. Evidence suggests that people with mental disorders are just as motivated to quit smoking as the general population (Siru et al. 2009).

The average smoker makes at least two failed attempts to quit per year (Borland et al. 2012). In a study of Australian mental health inpatients, approximately 47 per cent reported having made at least one quit attempt within the past 12 months, despite nearly three quarters (71 per cent) being classified as in a 'precontemplative' stage of change (Stockings et al. 2014).



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People with severe mental illness and substance use disorders make a quit attempt every year (Ferron et al. 2011). The problem is few receive best practice smoking cessation support (Bartlem et al. 2015; Ferron et al. 2011). An Australian study of community mental health consumers found that 87 per cent said they would have accepted advice to quit and 89 per cent would have accepted referral for smoking cessation, yet most did not receive either (Bartlem et al. 2015).

Psychiatric services have moved away from a culture of viewing smoking as a right. There is no recognised 'right to smoke' in any Australian law or current international standard or treaty that applies to public hospitals. However, the following views continue to contribute to people not receiving the smoking cessation help they need.

1. "Smoking is a personal choice"

Nicotine dependence is a recognised condition in DSM-V. The physical cravings for a cigarette make volitional choice problematic, especially among those with low levels of rewards in their lives or limited self-regulatory capacity, and those living in environments where smoking is the norm. Almost all smokers start regular smoking in adolescence, so it is unlikely to be an informed choice.

2. "Smoking helps manage stress"

Many clients use smoking to manage stress or chase positive feelings. Much of the perceived 'benefit' from smoking is due to the temporary relief of nicotine withdrawal symptoms (e.g. restlessness, irritability, difficulty concentrating), which erroneously creates the impression that smoking is relaxing. Talking about smoking is an opportunity to help clients develop and deploy effective stress management strategies.

3. "Stopping smoking can worsen a person's mental health or quality of life"

While getting through nicotine withdrawal can be challenging, systematic reviews have shown that stopping smoking for at least six weeks is associated with reduced depression, anxiety, stress and improved quality of life for smokers both with and without mental illness, with effect sizes equal to or larger than those of antidepressant treatment for mood and anxiety disorders (Taylor et al. 2014). If one also considers the cost of smoking – smoking a pack a day costs thousands of dollars each year – the balance of evidence is that quitting enhances quality of life rather than compromises it.

4. "It is not the right time to tackle smoking"

Smoking can be addressed whilst treating mood, substance use and other conditions (Baker et al. 2018) and cessation of six weeks or more can improve mood and other outcomes (Taylor et al. 2014). Monitoring of common nicotine withdrawal symptoms (e.g. depression, anxiety and anger/irritability) can help to distinguish temporary withdrawal symptoms from any relapse of a mental health condition (Segan et al. 2017).

Concurrent treatment of smoking and other substance use disorders is recommended (Mendelsohn & Wodak, 2016). Patients treated simultaneously for smoking and other drug problems are 25 per cent more likely to achieve long-term abstinence from alcohol and other drugs than those who do not receive a smoking intervention (Mendelsohn & Wodak, 2016).

Best practice smoking cessation support

The most effective way to quit smoking, for those with and without a mental illness, is a combination of behavioural interventions (either in person or via telephone), and pharmacotherapy (nicotine replacement and/or medication) (Kotz et al. 2014). Below is an evidence-based menu of options that mental health professionals, in all sorts of roles and settings, can use to help their clients who smoke move towards quitting.

Smoking should be considered a problem of social justice due to the unequal circumstances experienced that make the disadvantaged more likely to become smokers and less likely to stop.

Brief interventions

What can mental health and other support services do to help clients to quit smoking? Firstly, work out when and where to include smoking cessation advice (intake or assessment). Asking about smoking is an opportunity to deliver a brief intervention (see Practice Tips in box).

Care plan reviews are an ideal time to follow up on smoking cessation. A medication review by a doctor may be necessary as smoking cessation can increase the blood levels and hence side effects of alcohol, caffeine and some medications (e.g., clozapine, olanzapine, and fluvoxamine) and dose reduction may be required (see RACGP 2011; Mendelsohn et al. 2015).

It is important to note that chemicals in cigarette smoke (not the nicotine) usually cause the body to break down some substances more quickly than usual. Nicotine and nicotine replacement therapy (NRT) do not affect medication or caffeine levels. The exception is alcohol which does interact directly with nicotine.

Another opportunity for brief intervention is community care following an inpatient admission. While many inpatients express dissatisfaction regarding being detained in a smoke-free environment, there is a high uptake of smoking cessation interventions when offered (Stockings et al. 2014). Linking inpatients with post-discharge smoking cessation supports increases the likelihood of the person making quit attempts (Stockings et al., 2014). A systematic review found that smoke-free psychiatric hospitalisations have a positive impact on patients' smoking-related motivations and behaviours, both during admission and at three months post discharge (Stockings et al. 2014).

Behavioural interventions

Behavioural interventions can be delivered in person (individual or group) or over the telephone. Telephone interventions have been found to be just as effective as face-to-face treatment for people with severe mental illness (Baker et al. 2018). A course of treatment involves several sessions, both before and after quitting. It involves skills in facilitating decision making, goal setting, maintaining motivation, and enhancing self-efficacy, plus smoking-specific work:

- assessment of smoking history and tobacco dependence
- identification of triggers to smoke
- education about tobacco use including the role of nicotine, how to use nicotine replacement products, effects of cessation on medications, caffeine and alcohol levels
- skills to manage cravings and other triggers, including strategies to allow cravings to extinguish (RACGP 2011).

Quitline provides an effective behavioural intervention via free telephone callback counselling (Stead et al. 2013). Making a referral is shown to increase the likelihood of the person quitting and is preferable to providing Quit's phone number (13 78 48) because many smokers, while willing to accept a call, are reticent to call for themselves. Quit specialists will schedule counselling calls with the client.

Mental health practitioners can share care by referring to Quitline to address smoking whilst dealing with the client's other presenting issues. There is also an Aboriginal and Torres Strait Islanders' Quitline. Quit Victoria offers a tailored service for people with mental health conditions; this includes an extended call-back counselling service that offers monitoring of mood and potential medication side-effects over the period of the quit attempt.

Go to www.quitnow.gov.au/ to see what Quitline offers in your state.

Smoking can be addressed whilst treating mood, substance use and other conditions and cessation of six weeks or more can improve mood and other outcomes.

Pharmacotherapy

Pharmacotherapy is important as people with mental health conditions are likely to be highly nicotine dependent and thus experience more severe nicotine withdrawal. Pharmacotherapy includes Nicotine Replacement Therapy (NRT) products (patches or intermittent forms) and medicines. If the client is using NRT, recommend using patches, which release a steady low dose of nicotine, together with an intermittent product (e.g. gum, lozenge, spray, inhalator) for when cravings hit.

While these products can be purchased off the shelf, support is often needed to use these products correctly. Patches are significantly cheaper if prescribed by a doctor. NRT is most effective when the client also engages in behavioural intervention (Kotz et al. 2014). Varenicline (Champix) is a prescription medicine which reduces the pleasurable effects of smoking by preventing nicotine's stimulation of neural receptors. Varenicline is shown to be effective and adverse neuropsychiatric side effects are found to be rare for people with and without mental health conditions (Anthenelli et al. 2016). Under the Pharmaceutical Benefits Scheme (PBS), varenicline is to be prescribed with provision of, or a referral for, behavioural intervention.

Self-help options

QuitCoach is an automated online program that asks the person questions about their smoking, motivation, past quit attempts and uses the answers to provide a personalised quitting plan. QuitCoach is free and has helped thousands to successfully quit as demonstrated in randomised trials (Borland et al. 2015).

QuitTxt provides motivational messages, advice on coping with cravings and provides distraction from cravings when needed and is also effective (Borland et al. 2013). There is no Level 1 evidence of effectiveness of smart phone applications but a recent review (Thornton et al. 2017) found some to be high quality for motivational tracking, e.g., I Quit, My Quit Buddy, QuitStart and Smart Quit. Quitnow.gov.au has a wide range of self-help materials, posters and other resources and links to state quitlines.

Practice Tips – 3 Step Brief Intervention

Ask: "Do you smoke (tobacco or anything else)?"

Advise: Seek permission to give advice about smoking and how it might be interacting with the presenting condition: "Stopping smoking improves mental health and wellbeing."

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

Quit Victoria offers free online training (accessible outside Victoria) to support the delivery of brief interventions:
www.quit.org.au

Conclusions

This is a call to action for mental health practitioners to address smoking. Mental health practitioners are well placed to deliver smoking cessation interventions. These can be delivered within the context of usual treatment using a menu of evidence-based options. The most effective way to stop smoking is a combination of behavioural interventions and pharmacotherapy. Routinely offering brief intervention to consumers, regardless of their level of interest in stopping smoking, can trigger a quit attempt and empowers consumers by providing the opportunity to access evidence-based smoking cessation help.

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Unresolved childhood trauma and physical and mental health

Trauma is a state of high arousal in which severe threat or the perception of severe threat overwhelms a person's capacity to cope. It comprises a range of events, situations and contexts. These include natural disasters, accidents, betrayal in interpersonal relationships, and diverse forms of abuse.



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There are differences between the main categories of trauma. Single incident trauma, commonly associated with Post Traumatic Stress Disorder (PTSD), relates to 'one off' events, while complex trauma is cumulative, underlying, and largely interpersonally generated (Shapiro 2010). As well as being more extensive in its effects (Courtois & Ford 2009), complex trauma is more frequent and prevalent (van der Kolk 2003), with complex trauma from childhood experiences being particularly damaging. Unresolved trauma, especially childhood (complex) trauma often has substantial impacts, on both mental and physical health (Banyard et al. 2009) into adult life.

The perception of extreme and overwhelming threat activates the physiological 'survival' responses of 'fight-flight-freeze'. These innate, biologically programmed responses 'cannot be helped' as they are not thought about or reflected upon. Their trigger/s are often not clear. Recovery from trauma is not about 'will power' or deciding to 'move on'.

However it is important to remember that people can and do recover from even early childhood trauma, but that to do so, they need the right services and support (Siegel 2003).

Childhood trauma and health

Multiple systems of the body are interconnected. Trauma, particularly childhood trauma, disrupts the connections between the various systems of the body, and compromises a person's physical and psychological health as well as their daily functioning (Cozolino 2002). The greater the severity and duration of childhood trauma 'the more severe are the psychological and physical health consequences' (Middleton 2012).

Overwhelming childhood experiences compromise the hormonal, endocrine immune and other body systems, but because chronic conditions evolve slowly these connections are often not recognised (Karr-Morse & Wiley 2012).

Children, like adults, develop coping strategies to protect them from being overwhelmed and help them manage the physiological and psychological effects of the dysregulated arousal, emotions and behaviour which occur with trauma. Such coping strategies are often creative and effective in the short to medium term, but risky and can damage health in the longer term.

Recovery from trauma is not about 'will power' or deciding to 'move on'.

The ground-breaking Adverse Childhood Experiences (ACE) Study (Felitti et al. 1998) established the relationship between childhood coping strategies and the development of the 'symptoms' of impaired well-being and ill health later in life for unresolved underlying trauma. These findings have been repeatedly replicated in further research.

Childhood trauma and mental health

Childhood (complex) trauma can seriously affect a person's ability to function, their sense of themselves, and their capacity to regulate arousal, emotions and behaviour. It impairs self-conception and cohesion, one's sense of meaning, and the capacity to relate to others (Howell & Itzkowitz 2016). Unlike PTSD, complex trauma disrupts a person's identity, severely adversely affecting a person's relationship to themselves, others and the world.

A history of childhood trauma is '[t]he single most significant predictor' of subsequent contact with the mental health system' (Middleton 2012). People who have complex trauma histories receive diverse psychiatric diagnoses because their trauma presents in many forms, with severe, wide-ranging and comorbid symptoms.

Comorbidity is the norm rather than the exception. Coexisting depression and anxiety are common, as is the diagnosis of personality disorder, particularly Borderline Personality Disorder. While not all childhood trauma leads to psychosis, and not all psychosis is trauma-related, greater insights into the vulnerability of the developing brain to stress are informing our understanding of psychopathology (Howell 2005).

Psychosis features poor reality-testing and inability to distinguish the internal from the external: '[i]t is exactly this distinction that trauma disrupts' (Howell 2005). Childhood trauma is a well-documented potential risk factor for psychosis (Aas et al. 2016; Szalavitz 2012). Presentations related to trauma, particularly around dissociation and dissociative disorders can also be confused with psychosis, including within the mental health system. (Spiegel et al. 2011).

The greater the severity and duration of childhood trauma 'the more severe are the psychological and physical health consequences'.

Childhood trauma and physical health

Overwhelming stress such as occurs with childhood trauma negatively impacts the hypothalamic-pituitary-adrenal (HPA) axis which controls a person's reaction to stress and trauma (Siegel 2012). Stress triggers the HPA axis, i.e. 'the relationship between the hypothalamus (H), the pituitary gland (P) and the adrenal glands (A) that produces finely tuned chemical messages that connect the central nervous, endocrine and immune systems' (Karr-Morse & Wiley 2012).

A history of childhood trauma is 'the single most significant predictor' of subsequent contact with the mental health system.

Increased stress hormones lead to an elevated inflammatory/immune response, which is associated with poor health outcomes and increasing cardiovascular, pulmonary and auto-immune disease (Shonkoff & Garner 2012). Chronically overstimulated immune responses can also cause the system to attack the organs, leading to autoimmune disease such as psoriasis and lupus. They can also 'catalyse inflammation at various sites in the body', paving the way for conditions such as osteoarthritis, fibromyalgia and irritable bowel syndrome (Karr-Morse & Wiley 2012).

Other diseases linked to overproduction of cortisol include functional gastrointestinal disease, diabetes, anorexia nervosa, hyperthyroidism and Cushing's syndrome (Karr-Morse & Wiley 2012). A number of publications substantiate the serious physical impairments associated with trauma in general and complex trauma in particular. For example, research shows that '[t]hose with complex childhood trauma have roughly double the rate of fibromyalgia, chronic fatigue, and disorders of musculoskeletal, digestive, circulatory, endocrine and immune systems' (Banyard et al. 2009).

Physical health issues such as cancer, diabetes, heart disease, and asthma are also highly correlated with early life stress (Karr-Morse & Wiley 2012). The Adverse Childhood Experiences Study replicates these findings, with changes in the ACE score, i.e. number of adverse childhood experience categories, establishing links between childhood experience and adult biomedical disease including liver disease, chronic obstructive pulmonary disease, coronary artery disease and autoimmune disease (Felitti & Anda 2010).

Trauma and primary care

Primary health care plays a critical role in health promotion, prevention, screening, early intervention and treatment. For these reasons, primary health care providers need to be able to intervene early and effectively with patients with a lived experience of trauma to promote better care and health and well-being outcomes.

Epidemiological data suggests that on a daily basis a significant proportion of patients attending general practices have trauma histories (Felitti & Anda 2010). Primary care practices work with patients who present with co-morbid mental health challenges, drug and alcohol issues, suicidality and self-harm, sexual health issues as well as cardiovascular disease, asthma, diabetes, obesity, and cancer. All of these challenges can be and often are associated with unresolved trauma in general, and childhood trauma, in particular. Yet primary health services do not routinely screen for trauma.

If people have not connected their distress and health problems to their prior trauma they can't share their concerns. Even patients who suspect their issues are trauma-related might not speak about them fearing a negative response to disclosing.

The financial costs of not providing adult survivors of childhood trauma in Australia with the services they need are conservatively estimated at \$9.1 billion annually.

As many primary care personnel are not adequately equipped to respond effectively to patients who experience the impacts of trauma, they are unable to intervene in trauma-related problems and address the cumulative negative individual, community and systemic legacies.

The health, social and economic costs of unrecognised, untreated or inappropriately treated trauma are substantial. They not only impact the individual health and psychosocial burdens of survivors but also reverberate through families, friends, communities, and society at large. If people don't receive the right support their trauma not only undermines their psychological and physical health but also erodes their capacity for healthy relationships, educational opportunities, and ongoing work participation.

Lost productivity and direct costs also impact substantially on health, welfare and criminal justice budgets. Health budgets are stretched by repeated hospitalisations, crisis intervention, frequent use of services and medication, and the burden of chronic disease, compounded morbidity and premature mortality. The financial costs of not providing adult survivors of childhood trauma in Australia with the services they need are conservatively estimated at \$9.1 billion annually (Kezelman et al. 2015).

Not only does trauma literacy highlight the burden of trauma-related disease, morbidity and mortality, but it also provides opportunities for enhanced treatment outcomes when practitioners and practice personnel work from a trauma-informed frame. We owe it to those with a lived experience of trauma to safely screen for, recognise, identify and appropriately address the needs of those affected.

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